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Doctoral Thesis

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A qualitative exploration of emergency practitioner's perspectives towards functional seizures and self-harm behaviours

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	Main Text	Appendices (inc. tables, figures, references, footnotes, and title page)	Total
Thesis Abstract	273	n/a	273
Literature Review	7,943	11,878	19,821
Research Paper	7,997	3,653	11,650
Critical Appraisal	3,982	784	4,766
Ethics Section	4,787	7,723	12,510
Total	24,982	24,038	49,020

THESIS ABSTRACT

This thesis presents three papers relating to the qualitative exploration of emergency department (ED) practitioners' perspectives of 1) caring for people who accessed ED care for self-harm behaviours 2) caring for people living with functional seizures (FS), 3) a critical appraisal of both papers.

The first section presents a meta-synthesis of 13 qualitative research papers which explored ED clinicians' perspectives of caring for people who presented with self-harm behaviours. These were analysed through a meta-ethnographic approach and three themes were constructed: 1) Between "frustration, futility and failure": The clinicians' emotional response to self-harm, 2) Attitudes on a self-harm spectrum, 3) The ED in a challenging context. Findings highlight the need for increased training and support to help reduce the risk of burnout in this staff population. This has implications for the role of clinical psychology in the ED which are discussed.

The second section presents an empirical research paper which explores eight ED consultants' perspectives of caring for people with FS. Semi-structured interviews were conducted with each participant, and the data was analysed using reflective thematic analysis. Three themes were constructed: "the personality of the ED and the role of the ED consultant" "how FS is conceptualised" and "the ED consultant lived experience of caring for FS patients". This paper offers an essential understanding of the ED consultants' perspectives and contributes to existing literature relating to other healthcare professionals' views of working with people living with FS. The final section presents a critical appraisal, which incorporates the findings of both papers, and discusses strengths, limitations, reflections, and motivations for engaging in these topics. Recommendations for future research are also shared.

DECLARATION

This thesis presents research undertaken between March 2020 and March 2022 as partial requirement of the Lancaster University Doctorate in Clinical Psychology. The work documented here is my own except where due reference has been made in the text. This thesis has not been submitted for an award of a higher degree elsewhere.

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Date: 18th May 2022

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RUNNING HEAD: SELF-HARM IN THE EMERGENCY DEPARTMENT

Section 1: Systematic Literature Review

Self-harm in the emergency department: A qualitative meta-synthesis of the emergency practitioners’ perspectives of self-harm

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Abstract

Purpose

This systematic literature review explores the perspectives of emergency department (ED) clinicians caring for people who have self-harmed. Self-harm is a global issue, with high prevalence in the ED. People with self-harm behaviours experience significant barriers in accessing community care, which increases workload in the ED. Quantitative research indicates some ED clinicians can hold negative attitudes towards people accessing ED care for self-harm behaviours. This paper offers a qualitative synthesis of research relating to ED clinicians' perspectives towards people who had self-harmed.

Methods

A systematic search was conducted across four databases: MEDLINE, APA PsychInfo, CINAHL and Academic Search Ultimate. A final 13 papers were included and analysed using a meta-ethnographic approach.

Results

Three themes were constructed: 1) Between "frustration, futility and failure": The clinicians' emotional response to self-harm, 2) Attitudes on a self-harm spectrum, 3) The ED in a challenging context

Conclusion

Findings suggest that the ED clinicians are at risk of burnout and work within a challenging and stretched healthcare system, which can impact attitudes towards people who present with self-harm behaviours. This paper identifies training and supervision needs to support staff wellbeing and satisfaction, as well as reduce stigmatising attitudes and improve patient care.

Keywords:

Self-harm, non-suicidal self-injury, self-injurious behaviour, attempted suicide, emergency department, clinicians, perspectives

Introduction

The UK National Institute for Health and Care Excellence (NICE) defines self-harm as an “intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act” (NICE, 2020, p.1), inclusive of both non-suicidal self-injury (NSSI) and attempts to complete suicide. Self-harm and death by suicide is considered a worldwide health issue, with a global estimate of 14.6 million incidents of self-harm every year, with females more at risk of self-harm and males more at risk of death by suicide (Knipe et al., 2022; Global Burden of Disease Study., 2020). People from low- and middle- income countries are most at risk of self-harm and account for 80% of completed suicides worldwide; yet only 15% of the research is focused on these populations (Knipe et al., 2022). These figures are expected to rise following the current COVID-19 pandemic, with the socioeconomic crisis having a lasting impact on people’s wellbeing (Gunnell et al., 2020).

However, these numbers may well be an underestimate. Research indicates racial differences in accessing care, as young black and ethnic minority peers were less likely to receive psychiatric care following self-harm in the UK, and non-white people are less likely to access support prior to an attempt on their life (Abar et al, 2018; Cooper et al., 2010). Research also shows there are equal rates of deliberate self-harm between men and women, yet men may be discouraged to seek appropriate support through experience of stigmatising responses, which in turn may escalate their need (Lloyd et al., 2018; NICE, 2020). Additionally, shame is identified as a correlate to self-harm and may be a risk-factor (Sheehy, et. al, 2019), which again would impact disclosure. Ultimately, the prevalence of self-harm in the general population is difficult to determine, given many people do not present to mental health services and the topic continues to be regarded as a societal taboo (Patient Safety Expert Working Group, 2020).; McAllister, 2003).

Given the difficulties in seeking or accessing support, self-harm is often managed in the emergency department (ED), responding to individuals in crisis. For example, there are 220,000 reported cases of self-harm in the ED in England each year; with one in six people repeating attendance within the year (NICE, 2020; Xanthopoulou et al., 2021). A case record review of ED attendances reported 43% of individuals who died by suicide attended the ED the year prior, were likely identified as frequent attenders, with most common reasons for attendance being self-harm and asking for psychiatric help (Da Cruz et al., 2011). This is likely a conservative representation of self-harm in the ED, as one in three suspected self-harm presentations are recorded as ‘undetermined’ (Bethell & Rhodes, 2009), or attributed to other causes, such as accidents or domestic violence.

Despite the ED being recognised as a key component in patient pathways, care received from the patient perspective is inconsistent. For example, a UK study found that some people experienced care for self-harm and suicidality as person-centred, meaningful, collaborative, and validating, which facilitated disclosures and offered a psychological understanding (Xanthopoulou et al., 2021). However, others in the study experienced care in the ED as risk-focused and trivial, which left the person feeling hopeless, judged, unworthy of care, ultimately losing trust in professionals (Xanthopoulou et al., 2021). In other studies, people receiving care for self-harm behaviours felt that they were denied of patient status as their needs were determined as self-inflicted, resulting in deprioritised care, a perceived lack of empathy for their psychological needs and a focus on physical health (MacDonald et al., 2020; Taylor, et. al., 2009; Owens et al., 2016; Brown & Kimball, 2013). This contributed to feelings of embarrassment and worthlessness, and that they were burdening healthcare professionals (HCPs) time (Hunter et al., 2013). People accessing care also felt unempowered to report their negative experiences which reinforced a sense of worthlessness (Owens et al., 2016).

Additionally, the physical ED environment can provide a barrier to accessing care for people who have self-harmed. People who presented in distress to the ED following self-harm are met with limited privacy, long wait times for treatment and often experience premature discharge, and a lack of follow up or contact community services (Byrne, et. al., 2021; Taylor, et. al., 2009). People with self-harm also perceive ED professionals to lack knowledge regarding self-harm management. Expectation of unresponsiveness and lack of compassion are also barriers to accessing the ED (Taylor et al., 2009; MacDonald et al., 2020; Byrne, et. al., 2021).

This is inherently problematic, as not only are there perceived barriers to accessing emergency care, but O'Keefe et al. (2021) reports how the wider healthcare system fails people who self-harm. Inaccessible primary care and strict secondary care referral criteria, can often exclude people who have self-harmed, leaving only crisis care available which increases attendance at the ED (O'Keeffe et al., 2021). This has been described as a vicious cycle which escalates an individual's risk, through increased frequency and severity of self- harm to prove legitimacy of their difficulties to ED professionals (Byrne, et. al., 2021). This compounds the ED professional's workload and could perpetuate the systemic challenges, promoting stigmatising responses and negative experiences (O'Keeffe et al., 2021).

Given these patient contacts and pressures on the ED, it is imperative to understand the ED professionals' experience of caring for people with self-harm behaviours. A quantitative literature review identified that ED nurses can hold mixed and sometimes negative attitudes towards people who self-harm, including antipathy (Rayner, et. al., 2019). Although not statistically significant, findings indicated that female staff, and more experienced clinicians scored higher on an antipathy scale, and as such were more likely to hold negative attitudes towards people who self-harm (Rayner, et. al., 2019). Negative attitudes can develop when ED practitioners assess that they lack skills to manage self-harm, as they are less likely to consider their work worthwhile (McAllister, 2002). Other factors that can contribute to development of challenging attitudes include perceived gaps in knowledge, lack of training, insufficient mental health liaison in the ED, blurred professional roles, cynicism of suicide prevention from leadership, and reliance on tokenistic risk conversations rather than safety planning (Betz, et. al., 2018; McAllister, 2003; Friedman, et. al., 2006; Betz, et. al, 2018). Conversely, ED nurses with greater knowledge, perceived empathy, and confidence in caring for people with self-harm report lower negative attitudes (Ngune et al., 2021). Compassion is also increased with greater exposure to caring for people who have self-harmed (McHale & Felton 2010; Rayner et al., 2019).

Moreover, exposure to the ED environment could impact ED professionals' attitudes. McCann, et. al., (2006) suggested older, experienced ED nurses showed more caring beliefs than younger, inexperienced nurses. However, other literature suggests the opposite, in that younger or more inexperienced staff reported more positive beliefs and stronger confidence in skills when caring for people who have self-harmed (Cleaver, 2014; Ngune, et. al., 2021; McCarthy & Gijbels, 2010). Nonetheless, some research has shown ED practitioners hold hope for individuals presenting with self-harm, as they were able to challenge stigmatising narratives and were sensitive to the seriousness of the self-harm (McCann et al., 2007).

Consequently, ED practitioners' beliefs towards people who self-harm is evidently a complex and a multifactorial dynamic. Whilst the quantitative literature available highlights interesting findings, nuances and complexity in the professionals' experience and beliefs cannot be explored in depth. An exploration of available qualitative literature is required to offer new understandings into the ambiguity and complexity highlighted in the quantitative research presented and to explore the area in depth. Therefore, this systematic literature review presents a synthesis of the qualitative research on the emergency practitioners' perspectives of self-harm.

Method

Meta-synthesis approach

A meta-ethnographic approach was conducted for the purpose of this review. This iterative seven stage approach was developed by Noblit and Hare (1988) and continues to be a popular analysis method in current literature (Sattar, Lawton, Panagioti & Johnson, 2021). This approach was adopted for the purpose of this review as it is considered optimal in smaller samples ($n \leq 40$) and is designed to support interpretation of findings, to offer novel concepts and insight that descriptive analyses would not account for (Campbell et al., 2011).

Search Strategy

The systematic search strategy was developed in consultation with an academic librarian, with 4 databases identified as appropriate (MEDLINE Complete, APA PsychInfo, CINAHL and Academic Search Ultimate). These databases broadly related to health care, medical professionals, qualitative methodology and attitudes.

A Boolean methodology was employed in each database, which utilised database-specific subject heading terms and free-text terms to search title or abstracts. The search string was built on four main concepts: the emergency department, a spectrum of self-harm related behaviours, attitudes, and qualitative methodology. Furthermore, each database search string was then tested with relevant research papers identified through an initial scoping search. The free-text search strings were then modified to ensure inclusivity. The final search within each database was completed on 9th August 2021. A rigorous search strategy was maintained through adherence of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance. The review was also registered on Prospero, reference 285969 (Appendix 1-A).

[Table 1-A here]

This paper is guided by the definition of self-harm proposed by NICE (2020), which encompasses all self-harm behaviours, irrespective of perceived intention and thus includes suicidal behaviours. Therefore, terms relating to both self-harm and attempted suicide were included in the search strategy to encompass the spectrum of self-harm related behaviours.

Criteria

For inclusion papers must be: (1) Available in English, (2) Peer-reviewed, (3) Focused on the perspectives of ED nurses and doctors towards people presenting with self-harm or suicide behaviours (4) Qualitative or of mixed methodology. Exclusion criteria were: (1) Papers focused on attitude change in evaluating service development or training (2) ED nurses and doctors contributions not explicitly presented (3) Papers relating to other crisis management services, (4) Papers focused on completed or assisted suicide.

Outcome of Search

A total of 3,683 papers were obtained through this search strategy, 636 of which were identified as duplicates and removed accordingly. The title and abstract of 3,041 papers were assessed for relevance and appraised against the search eligibility criteria, where 2,676 papers were excluded. 360 papers were accessed in full as it was not possible to determine the suitability based on information within the abstract; of which 347 were excluded, leaving 13 as eligible for inclusion. A final reference check of the 13 papers was completed, with no further suitable papers identified.

[Figure 1-A here]

[Table 1-B here]

Quality Appraisal

The Critical Appraisal Skills Programme (CASP) qualitative appraisal tool was applied to the 13 identified papers in this meta-synthesis as a means of quality evaluation. Some findings suggest the tool is less sensitive to aspects of validity than other available qualitative tools (Hannes et al., 2010), however the CASP tool is still considered as the most widely accepted appraisal tool in qualitative health research (Long et al., 2020). The tool offers a 10-question framework to assess the validity, results, and transferability of findings of qualitative papers (CASP, 2018). A rating points system proposed by Duggleby (2010) was also applied to questions 3-10 (1 – limited information available, 2 – partial, 3 full information and justification offered). The quality appraisal of papers was conducted by the lead author, with selected papers cross-referenced with a colleague. Discrepancies in ratings were resolved through discussion and reached a consensus on the final ratings. Ratings provided in table 1-B.

Analysis

This review adhered to Noblit and Hare’s seven stages: 1) “Getting started”, 2) “Deciding what is relevant to the initial interest”, 3) “Reading the studies”, 4) “Determining how the studies are related”, 5) “Translating the studies into one another”, 6) “Synthesising translations” and 7) “Expressing the synthesis” (Campbell et al., 2011). Interpretation of the data was achieved through exploration of three possible relationships between the studies: reciprocal translation, which highlighted similarities between studies; refutational translation, where differences in studies were explored and line of argument analysis which drew on wider inferences across all studies and investigated how they were related to each other.

The meta-ethnographic analytic approach is considered a third order construct, described by Schütz (1962), as the researcher’s interpretation of another author’s analysis of their data. In Schütz's (1962) analytic framework a first order construct would be the data offered by each participant, whereas a second order construct would be the original authors' interpretation of their responses (Schütz, 1962). To commence this process, each of the final papers were read and annotated thoroughly, with second order constructs and annotated codes collated in a table (appendix 1-B: example of coding). Reciprocal translation highlighted commonalities across the papers, with discrepancies and refutations also identified. This generated three key themes across the data set and developed the line of argument analysis.

[Table 1-C here]

Results

Three themes were generated from the meta-ethnographic process: 1) Between "Frustration, Futility and Failure": The clinicians' emotional response to self-harm, 2) Attitudes on a Self-harm Spectrum, 3) The Emergency Department in a Challenging Context. Each theme will be discussed in detail as follows, with first order quotations indicted with double quotation marks, and second order authors' quotes demonstrated with single quotation marks.

Theme One: Between "Frustration, Futility and Failure": The Clinicians' Emotional Response to Self-harm

Clinicians described how the act of self-harm can be incongruent to the professional values of the ED (subtheme one), which generated mixed emotions and contributed to experiences of usefulness and helplessness (subtheme two). In response, clinicians often reported a need to protect themselves from these complex emotions, which was further impacted by unspoken expectations in the ED (subtheme two).

1. How Self-harm Challenges the ED's professional values

Findings suggest working with this patient group can challenge the ED clinicians' professional values; described as providing physical care and “preserving life” (Pallikkathayil & Morgan, 1988 p. 247; Hadfield et al., 2009). Whilst physical care for people who self-harmed was addressed in the ED, some ED clinicians described how it was not their role to treat psychological distress or understand the context of attempted suicide: “We practice comfort. We do not discuss why he [the patient] did it, we don’t have this approach” (Fontão et al., 2018, p. 2201). Nurses in particular valued fast-paced workflow of patients, and an act of harming oneself or attempting to take one’s life, caused conflict to their professional values (Pallikkathayil & Morgan, 1988). However, strong professional identity, shared values of kindness and respect, and putting the patients’ needs first united clinicians (Artis & Smith, 2013; Doyle et al., 2007).

The perceived challenge to the ED culture generated difficult emotions for clinicians, with frustration commonly reported (Artis & Smith, 2013; Chapman & Martin, 2014; Doyle et al, 2007; Vedana et al., 2017). Some clinicians described ‘an emotional balancing act’ (Artis & Smith, 2013, p. 232), in attempting to remain empathic but boundaried with people who had self-harmed, whilst also meeting competing expectations of the department. ED doctors particularly experienced internal conflict between the medical cultural expectations of them and caring for people who engaged in self-harm behaviours:

> “…To have that protocol there ensures the patient’s safety really, more than ours. . . It ensures that you are giving best treatment and also it’s good because by having a set protocol you’re removing any emotional thoughts about the patient yourself . . . no matter what you think, you know what you have to do. It’s probably the same way soldiers were”. (Hadfield et al., 2009, p. 761).

Caring for people who had engaged with self-harm or suicide behaviours also generated many mixed emotions for professionals. Feelings of ‘shock, sadness, anger, guilt, self-doubt, frustration, helplessness, disappointment, dissatisfaction and incompetence’ but also ‘altruism and compassion’ (Vedana et al., 2017, p. 348) were reported, as well as anxiousness, stress, discomfort and fear (Doyle et al., 2007; Hadfield et al., 2009; Petrik et al., 2015; Roy et al., 2017). These strong emotions were often in response to patient risk and at times perceived patient instability, aggression, or violence, as well as system pressures (Artis & Smith., 2013; Chapman & Martin, 2014; Doyle et al., 2007; Hadfield et al., 2009). Vedana et al., (2017, p. 348) acknowledged it was challenging for some clinicians to communicate these complex emotions, which often were expressed through ‘criticism, distancing, rejection, judgment, discrimination and negative attitudes’.

Hypervigilance in nursing staff was also reported, in preventing absconding or further self-harm behaviours in the ED. This was particularly challenging given people who had self-harmed often stayed in the ED longer than other people with different reasons for admission due to psychiatric bed availability (Doyle et al., 2007). Prolonged hypervigilance, exposure to ‘stress’ and ‘worry’ in an already stretched ED could easily lead to ‘exhaustion’ and ‘burnout’, driving clinicians’ perceived inability to effectively perform duties for this patient group (Roy et al., 2017; Vedana et al., 2017).

2. A dichotomy of usefulness and helplessness

Some clinicians felt useful when caring for people who engaged in self-harm behaviours, and ‘enjoyed the challenge’” this work brought (Chapman & Martin, 2014; Vedana et al., 2017). Other clinicians felt their duty of care was fulfilled when the patient’s urgency of physical need was reduced (de Oliveira Santos et al., 2017). Some clinicians’ perceived effective skills in offering psychological care for people who had self-harmed were of listening and compassion, and offering person-centred care (Doyle et al., 2007; Artis &

Smith, 2013). One paper reported direct personal experience of self-harm supported clinicians to feel empowered and confident in addressing psychological needs of people who presented with self-harm behaviours in the ED, developing skills to respond in ‘mutually validating ways’ as opposed to ‘silencing the self’ in not discussing their personal and emotional responses (Hadfield et al., 2009).

However, most clinicians reported helplessness or powerlessness; both in making meaningful change and from feeling inadequate from their appraisal of their own skills, training and expertise required to meet the patients’ psychological needs (Chapman & Martin, 2014; Artis & Smith, 2013; Doyle et al., 2007; Fontao et al., 2018; Ngune 2020). Perceived lack of communication skills was considered a particular barrier to supporting people who had self-harmed, as dynamics were difficult to manage when these individuals were seen as “uncooperative” or ‘unwilling’ or ‘aggressive’; leaving staff feeling ‘out of their depth’ (Doyle et al., 2007; Santos et al., 2017).

Some clinicians also felt constrained to deliver any effective behaviour change through the available ED interventions (Doyle et al., 2007). This contributed to clinicians’ distress; in evaluating “what is offered is not good enough” (Santos et al., 2017) and “our care is not that good” (Fontão et al., 2018, p. 2201), clinicians felt underprepared for the needs of people who self-harmed (Ngune et al., 2020). This also contributed to a lack of professional accomplishment, leaving clinicians wishing they could “balance hope and reality” (Pallikkathayil & Morgan, 1988, p.242).

In response to the perceived helplessness, clinicians described a feeling of self-protection and preservation for their own wellbeing when supporting this patient group. This was considered a defence mechanism in protection from the emotional experience of helplessness and powerlessness. Clinicians described trivialising and dismissing self-harm and generating flippant attitudes towards the presentation (Hadfield et al., 2009). However, in doing so, ED clinicians may avoid addressing the patient's distress (Hadfield et al., 2009; Pallikkathayil & Morgan, 1988).

This could also be impacted by unspoken rules of the ED as there was suggested stigma around accessing support in the staff group, that 'formal support is only for the big things' (Artis & Smith, 2013). This paper also reported on a normalised pressure in the ED to persevere and always regulate emotions (Artis & Smith, 2013). Some clinicians also felt judged by their colleagues, which impacted their practice and emotional experience. They recognised their feeling of discomfort working with this patient group, stemmed from colleagues questioning their clinical decision making, considering them to be "over triaging", and thus spending more time, or prioritising this patient group over others whose behaviour had not contributed to their admission (Ngune et al., 2020, p.3).

Theme Two: Attitudes to Self-harm on a Spectrum of Empathy

A range of attitudes towards people accessing the ED for self-harm was reported in the literature, presented here as a spectrum dependent on frequency of admission and perceived lethality of behaviour (subtheme one). Building on this understanding, it is reasonable to consider how different attitudes were expressed. Clinicians often drew on their personal, cultural, religious, and moral beliefs rather than professional and clinical expertise (subtheme two) to help try to understand an 'incomprehensible' and 'impenetrable phenomenon' of suicidal behaviours (Vedana et al., 2017).

1. The Impact of Lethality and Frequency on Attitudes

The clinicians' attitudes towards people who had self-harmed, was influenced by frequency of accessing care and perceived lethality of their behaviour. Clinicians reported increased empathy for the first-time attender, with a heightened sense of urgency and responsibility to respond appropriately and effectively. Clinicians were also able to consider the context of self-harm behaviours for people with known mental health diagnoses (Hadfield et al., 2009). This is possibly driven by clinicians' attributions, as those accessing care for first-time incidents of self-harm were believed to have less agency over their actions. Similarly, people with co-morbid mental health diagnoses were perceived as incapable of rational decision making and were emotionally dysregulated. In detracting from the patients' own responsibility for their actions, clinicians in turn reported feeling empowered in supporting these individuals (Hadfield et al., 2009). Increased compassion, empathy, time and a "willingness to listen" was afforded to people whose self-harm behaviours were deemed authentic or serious suicide attempts (Doyle et al., 2007; Artis & Smith, 2013; Chapman & Martin, 2014).

However, attitudes were inherently negative when self-harm behaviours were considered minor or less life threatening (Chapman & Martin, 2014; Artis & Smith, 2013). Whilst some clinicians considered high frequency access to the ED a cause for concern (Wolf et al., 2018), the majority also reported negative attitudes towards people accessing ED care at high intensity (Hadfield et al., 2009; Vedana et al., 2017; Chapman & Martin, 2014; Ngune et al., 2020; Doyle et al., 2007). Language referring to this cohort of people was mainly scornful, identifying them as "serial presenters" and "frequent offenders" amongst others (Chapman & Martin, 2014, p. 142). This elicited strong frustration for clinicians, grounded in the belief that these individuals are 'undeserving' or taking clinician's time from 'genuine' patients (Hadfield et al., 2009; Chapman & Martin, 2014). Additionally, perceptions that this cohort of people were "attention seeking" or "playing games" were reported, considering people who engaged with intentional self-harm behaviours did so to manipulate ED clinicians for secondary gains (Pallikkathayil & Morgan, 1988, p.245; Ngune et al., 2020, p. 3; Roy et al., 2017). This reinforced the felt helplessness and futility of ED interventions, reducing clinicians' confidence, and left some wondering "what do you want from me?" (Hadfield et al., 2009, p.759).

2. The Impact of Moral, Cultural and Religious Influences on Attitudes

Moral, cultural, and religious differences in clinicians' attitudes were noted throughout the retrieved studies; representative of a range of locations including Brazil, Australia, UK, US, and Ghana. Clinicians from the US and Ghana held attitudes towards people who had engaged with suicidal behaviours, which were influenced by religious beliefs and shared views that "suicide is wrong" as life belongs to God, and individuals should be able to cope through the power of their religion (Osafo et al., 2012; Pallikkathayil & Morgan, 1988, p.246). A Brazilian paper reported a belief that people who had engaged with suicidal behaviours were "weak people, both from an emotional and spiritual point of view" (Santos et al., 2017, pg 11). However, contrary to this belief system, Osafo et al., (2012) also acknowledged how suicidal behaviour is communicative, "We nurses say ''every behaviour is purposeful'" and "it's better for us to delve deeply into it and find [a] solution to it than seeing [self-harm] as an evil behaviour" (Osafo et al., 2012, p. 695).

Cultural and societal beliefs towards suicidal and self-harm behaviours also impacted clinicians' attitudes (Osafo et al., 2012; Vedana et al., 2017; Santos et al., 2017; Artis & Smith, 2013). In Brazil and Ghana, suicidal behaviours were described as a societal "taboo" clinicians did not come across in their training (Santos et al., 2017, p.10; Osafo et al., 2012). Ultimately, suicidal behaviour was described as being "very difficult for us to be able to understand them" and feeling that "it's not right to take our own life". (Vedana et al., 2017, p. 348). Caring for people with 'deliberate' suicidal behaviours was particularly challenging and elicited strong moral judgements that these individuals 'deliberately despise and waste their own life', and were 'confused, selfish, irresponsible, a coward, and occasionally considered brave' (Vedana et al., 2017 pg 348). However, a UK clinicians' perspective on societal influence considered self-harm behaviours "contagious" and being a "status symbol" (Artis & Smith, 2013, p.263).

Moreover, Osafo et al (2012) reported ED nurses preferred the criminal conceptualisation of suicidal behaviour [for context, suicide is a criminal act in Ghana], compared to psychologists who identified the need for specialist care. Attempted suicide was conceptualised as a 'murderous tendency', targeting blame with the patient, and generating fear of them, placing treatment of such individuals within a moral belief system over healthcare expertise, grounded in punitive measures, and calling for public discouragement as a deterrent for others (Osafo et al., 2012).

Theme Three: The Emergency Department in a Challenging Context

Theme three explores the specific nature of the ED environment and the impact on clinicians' ability to care for people who had self-harmed. The ED was widely reported as not the right environment for supporting this patient group (subtheme one). This poses significant challenge for ED clinicians in a social and political context (subtheme two), and highlights clinicians' view on areas for development (subtheme three).

1. Environmental Challenges

Environmental factors were consistently reported across the retrieved papers, regardless of country of origin. These constraints were described to significantly impact ED clinicians' ability to care for people who had self-harmed, with lack of time reported as the greatest barrier (Artis & Smith, 2013; Chapman & Martin, 2014; Doyle et al., 2007; Santos et al., 2017; Fontao et al., 2018; Ngune et al., 2020; Pallikkathayil & Morgan, 1988; Petrik et al., 2015; Vedana et al., 2017; Wolf et al., 2018). However, clinical experience sometimes increased clinicians' confidence to act against the challenging time pressures (Artis & Smith, 2013). Lack of privacy and confidential space required clinicians to be directive and creative in their approach; “I will often take the patient to the bathroom to obtain the information [or] I will ask family or friends to leave the room” (Petrik et al., 2015, p.583). Given the challenging ED dynamics, clinicians were reluctant to have conversations which explored self-harming patients’ psychological needs.

Other pressures included lack of resources and staff levels, as well as access to supervision. Environmental pressures also hindered effective communication (Wolf et al., 2018), where ineffective information sharing to support risk assessment often resulted in unnecessary repetition (Petrik et al., 2015). Clinicians also felt they were not supported by management to appropriately respond to people who had self-harmed (Chapman & Martin, 2014). Reduced psychiatric bed availability also hindered patient flow through the department, increasing an already overwhelming workload “It is all so hectic, sometimes we cannot stop to listen to the person” (Fontao et al., 2018, pg 2202; Artis & Smith, 2013; Chapman & Martin, 2014; Santos et al., 2017; Doyle et al., 2007).

2. Societal and Political Challenges

The clinicians’ confidence to effectively intervene was also hindered by a lack of community services to discharge the patient to (Petrik et al., 2015). This was grounded in perceived failure of psychiatric services to meet the patient’s needs, and a sense of professional abandonment from mental health services (Doyle et al., 2007; Hadfield et al., 2009, Wolf et al., 2018).

> “The only area that, apart from the area I mentioned about manipulative patients, that presents that heart-sink moment for me is if I realize that I am actually going to have to contact psychiatric services” (Hadfield et al., 2009,

p. 759)

This resulted in a disjointed care pathway for these patients and frustration towards the “fragmented” and inherently flawed system (Fontão et al., 2018). Clinicians argued that secondary care services continue to perpetuate this dynamic, through withholding power and control from the patient and reducing their agency in their own care (Hadfield et al., 2009). Interestingly, when asked about the care they would wish to receive themselves for hypothetical self-harm, clinicians responded with psychological care and inclusion in decision making, despite prioritising physical needs in the care they themselves provided (Pallikkathayil & Morgan, 1988).

Additionally, a lack of training opportunities was consistently reported as a barrier to providing effective care for people who had self-harmed (Artis & Smith, 2013; Chapman & Martin, 2014; Santos et al., 2017; Fontão et al., 2018; Ngune et al., 2020). Some clinicians attributed this to political financial cutbacks and global recession at the time of their research. Training in mental health was also removed from the nursing syllabus (Artis & Smith, 2013). Clinicians found themselves seeking education independently and based their learning on their practical experience (Ngune et al., 2020). This was understandable but could be skewed based on attitudes and understanding of colleagues, given the group norm experience (Artis & Smith, 2013).

3. A Call for Change

Through identification of personal, environmental, and contextual challenges, clinicians spoke of an identified need for improvement of services and patient care. Clinicians highlighted a need for creation of education and training opportunities, which was anticipated to improve preparedness in supporting individuals who self-harm (Fontão et al., 2018; Ngune et al., 2020). Clinicians also called for increased training across the lifespan of the patient, noting considerable difference in patient need at different life stages (Chapman & Martin, 2014). Improved confidence was also attributed to post-graduate education in mental health (Ngune et al., 2020). ED professionals with additional mental health training were a strong advocate for patients who self-harmed, with colleagues perceiving that they were ‘better able to cope’ than themselves, and lead on service delivery improvements for these patients (Artis & Smith, 2013).

Improved effective multi-disciplinary working was also advocated. Clinicians recognised the importance of social care and psychology professionals in the ED, with joint working as having a positive impact on colleagues’ attitudes in encouraging a non-judgmental perspective (Osafo et al., 2012; Fontão et al., 2018). A cohesiveness across multi-disciplinary teams, both internal and external to the ED was considered to improve effectiveness of intervention, with the ED being referred to as a “cog” in a wider organisational machine (Artis & Smith, 2013, p.266). One paper suggested a departmental role model or designated clinician was identified as a possible improvement measure, with a clearly defined professional identity to communicate with this patient group, in turn relieving “guilt” from the ED clinician (Pallikkathayil & Morgan, 1988, p.246).

Considering the complex emotions faced by the ED clinicians, stronger emotional support was also requested. Clinicians relied on informal emotional support from their colleagues, seeking opportunity to offload, reflect and “relieve the burden” (Artis & Smith, 2013, p. 265) allowing them to continue with their challenging role. This was noted to improve service delivery and increase empathy (Artis & Smith, 2013).

An Overall Model

Figure 1-B illustrates the complexity of the patient who self-harmed - ED medical practitioners dynamic (from the ED practitioners’ perspective).

[figure 1-B here]

People who present to the ED with self-harm behaviours can challenge an ED professionals’ perception of their role, which perpetuates a sense of helplessness (theme one). Helplessness can also be impacted by experience of group norms and professional culture in the ED (theme one) as well as ED environmental pressures and a lack of community support (theme three). This often leads to ED professionals feeling under-skilled and needing to protect themselves from the difficult emotions associated with working with people presenting with self-harm behaviours (theme one). However, this in conjunction with lack of community support can perpetuate an unmet need for people who have self-harmed.

People presenting with self-harm behaviours often have no other option but to return to the ED to help manage their distress. However, frequency of attendance has direct influence on ED professionals’ attitudes towards people presenting with self-harm (theme two). Perceived lethality of the self-harm behaviour, complexities and co-morbidities, and ED practitioners’ personal beliefs also influence professional attitudes, which arguably also inadvertently perpetuate this cycle of difficult unmet need (theme two).

Discussion

This meta-synthesis aimed to explore the qualitative research pertaining to ED practitioners’ perspectives of self-harm, through a meta-ethnographic approach. The findings elevate existing knowledge and offer a rationale for why ED practitioners may respond in potentially helpful or sometimes pejorative ways.

Theme one explored the ED professional’s emotional responses in caring for people who presented with self-harm behaviours. This theme covered contrasting emotional experiences associated with perceived usefulness and helplessness, potentially driven by perceived challenge to the ED practitioners’ identity and working culture. Professional identity, as a concept in healthcare professions, is formed through knowledge and skills acquisition, shared behaviours and actions of the professional group and internalisation of core values and beliefs (Fitzgerald, 2020). This is pertinent to the findings of theme one, which described shared professional actions of providing physical care, with values of kindness and prioritising patient needs (Hadfield et al., 2009; Pallikkathayil & Morgan, 1988; Artis & Smith, 2013; Doyle et al., 2007; Fontão et al., 2018). The self-harm behaviours could challenge the ED practitioner's group identity of preserving life, as the behaviours were the reason for accessing ED care or often had continued intent to harm themselves whilst receiving care, resulting in hypervigilance of the ED staff group.

Prolonged exposure to workload stressors increased risk of burnout in ED clinicians (Moukarzel et al., 2019). Burnout amongst healthcare professionals in general is described as a global problem, with no exception to ED practitioners, who are also considered vulnerable to this (Howlett et al., 2015; Dunne et al., 2019; Moukarzel et al., 2019). Maslach et al., (1996) described burnout to comprise of three key components, 1) "emotional exhaustion" which can present as reduced motivation and enthusiasm, 2) "depersonalisation" meaning a reduced level of empathy with amplified scepticism for the patients, 3) "reduced personal accomplishment" (p. 193), leaving practitioners feeling their work is ineffective and had lost a sense of meaningfulness (Howlett et al., 2015).

Therefore, experience of burnout was potentially reflected across findings in theme one, through description of the intense emotional impact of caring for people who had self-harmed. The 'self-preservation' strategies outlined in theme one could be an example of depersonalisation, as some ED practitioners were described to be sometimes flippant or avoidant of the psychological needs of people accessing ED care for self-harm behaviours (Hadfield et al., 2009; Pallikkathayil & Morgan, 1988). This was also described more generally by Hetherington et al., (2020) who reported reduced compassion was an outcome of coping strategies adopted by ED nurses, in response to the emotional impact of working in the ED, which ultimately challenged their professional values. Additionally, theme one findings also depicted a sense of reduced professional satisfaction, as ED practitioners reported a sense of futility in available ED interventions for caring for people with self-harm behaviours (Doyle et al., 2007; Santos et al., 2017; Fontão et al., 2018; Ngune et al., 2020; Pallikkathayil & Morgan, 1988). Therefore, findings of theme one provided strong evidence that ED practitioners who contributed to the included papers were at risk of or experiencing burnout. This reflects the findings of Sheehan et al (2021) who indicated up to 75% of their ED participants experienced burnout and acknowledged the compounding negative impact of the COVID-19 pandemic on the wellbeing of this workforce. This has implications both for staff wellbeing and satisfaction in their role, and retention of experienced staff, as over a quarter of ED nurses reported intention to leave their role and turnout was identified as a significant challenge in the department (Sawatzky & Enns, 2012).

Moreover, theme two highlighted a spectrum of ED practitioners' attitudes towards people accessing ED care for self-harm behaviours. Lethality and frequency of the self-harm behaviour, complexity, ED practitioners' own beliefs and cultural context seemingly influenced the ED practitioners' attitudes, often leading to negative attributions towards people who presented with suicidal or self-harm behaviours. However, this is problematic when unchallenged and stigmatizing responses can perpetuate. The theorist Goffman (2006) described stigma as a relational and social phenomenon, where a person forms negative attributions about another person based on difference, which serves to discredit their identity and deny them of whole personhood, reducing them to be perceived as a 'tainted' or 'weak' individual. Stigma can exist in all levels of interactions, from individual to social and organizational contexts (Hebl & Dovidio, 2005; Jensen & Sandström, 2015). Findings of theme two can be understood in a stigma theoretical framework, where individuals requiring emergency care for self-harm or suicidal behaviours are likely stigmatized in ED healthcare settings. These stigmatising attitudes can create a barrier for people accessing required care for self-harm, through worries of being perceived as ‘attention-seeking’ and other stigmatising reactions, whereas being treated with respect facilitates help-seeking behaviours (Rowe et al., 2014).

Furthermore, theme three also depicts the challenging context which ED practitioners operate within. Theme three described challenges both at an operationalised level within the department, as well as wider social and political difficulties which impacted the ED practitioners’ ability to provide effective patient care. ED pressures of theme three can be considered within the wider context of the healthcare system, depicted by Ferlie and Shortell’s (2001) systemic model of the healthcare system. This is a person-centred model, which illustrated the healthcare systems around a person, starting with immediate frontline staff, which the ED practitioners could be considered representatitve of, then wider organisational contexts such as the hospital the ED is situated in, and then wider still, the contextual social and political environment.

Subtheme one of theme three highlighted the organisational factors which directly impacted the ED clinicians working with this system, such as time, overcrowding and patient flow through the wider hospital system. A multicultural, systematic literature review by Johnston et al (2016) on ED practitioners perspectives of their working environment described ED clinicians report higher levels of stress than clinical colleagues in other settings. Overcrowding in the ED has been described as a crisis globally (Yarmohammadian, et. al., 2017; di Somma et al., 2015; Hoot & Aronsky, 2008). This corroborated with findings of theme three. However, interestingly workload was not always reported as a direct stressor, but specifically time pressures were consistently reported in the systematic literature review (Johnston et al., 2016). Furthermore, an overwhelming workload was considered a norm and engrained in the ED; it was particularly patient load and workflow that felt problematic to practitioners (Johnstone et al., 2016). However, ED clinicians also considered themselves as unique to their other colleagues, with greater teamwork and independence in their work counteracting the significant stress levels of the department (Johnston et al., 2016). This is important for clinical implications in strengthening the skill set of the ED in ameliorating stress management.

Furthermore, these organisational difficulties can be considered further compounded by the social and political environment in which they operate. Findings of the current literature review indicated that there is a lack of community support to refer patients to at the point of discharge, and also limited multi-disciplinary working with mental health services (Petrik et al., 2015; Doyle et al., 2007; Hadfield et al., 2009, Wolf et al., 2018). An overarching sense of pressure and difficulties exists at all levels of the system, which has potentially changed how people access healthcare, increasing footfall to the ED, which further compounds clinicians' workload pressures. This is also pertinent to clinical implications of these findings, as it highlights that intervention is required at all levels of the system around people accessing care for self-harm behaviours.

Clinical Implications and Future Research

Firstly, clinical implications focusing on staff welfare could reduce risk of burnout. Increased access to supervision could be supportive, given the unspoken stigma around ED clinicians accessing support. It could be useful for ED managers to encourage conversations around individual coping styles in clinical supervision, as Howlett et al (2015) suggested ED practitioners who adopted emotional coping styles were more at risk of burnout, compared to 'task-orientated' coping. However, the impact on both practitioners and patients of raising awareness or even changing coping styles is not clear. Therefore, future research could explore the impact of raising ED practitioners' awareness to personal coping styles on self-harm behaviour management. It will also be important to explore the impact on the patient, as being task-orientated may protect from burnout but has previously been identified as problematic from a patient perspective (Xanthopoulou et al., 2021).

Additionally, reflective practice groups for ED staff have also been found to be effective in improving patient care (Saban et al., 2021). Although Saban et al. (2021) did not directly measure staff wellbeing as an outcome, another study found engaging healthcare professionals in reflective learning opportunities improved resilience and wellbeing, and reduced stress (McDonald et al., 2012). Facilitating reflective practice is a core skill of clinical psychologists (CP), who arguably have a significant role in ED in supporting staff wellbeing in this setting. A future area for research would be exploring the effectiveness of such interventions in this staff group, both on staff wellbeing and patient care.

Arguably, all aspects of a CP's role are pertinent to the ED, with more CPs needed worldwide to support healthcare settings. Khan (2008) recognised this need in the UK and outlined the role of the CP to provide clinical services, consultation, teaching and research in hospital settings. CPs could offer training around coping skills and cognitive-behavioural techniques, which have been found to reduce burnout in other at-risk populations (Howlett, et. al., 2015. Communications training for ED practitioners is also a key implication, as it had been shown to improve patient satisfaction and confidence in the care received, through increased perceived compassion and attention offered by ED staff, as well as reduced patient complaints (Lau, 2000; Ak et al., 2011).

Furthermore, training for ED clinicians on self-harm related behaviours could be supportive to raise understanding and awareness of the clinical presentation and encourage a compassionate approach. This is pertinent given the stigma perpetuated in accessing physical care for psychological needs. The medical language reduces self-harm behaviours to acts of damaging bodily tissues and disregards the psychological harm endured, as shame has been identified as a correlate to self-harm and may be a risk-factor (Sheehy, et. al, 2019). McAllister (2002) suggested ED nurses who felt skilled in caring for people who had deliberately self-harmed, considered their efforts worthwhile and were less likely hold negative attitudes. Therefore, offering a clinical psychological perspective to the ED team may help challenge stigmatising attitudes.

However, solely requesting change of the ED is problematic in itself, given the significant pressures impacting the system across all levels. Therefore, intervention is required to also support and strengthen community services as the way people access healthcare has shifted. General patients often attend the ED without contacting their GP first, as they expect accessible and timely expert care, they consider their needs greater than can be helped through primary care, or their general practitioner (GP) is not available (Kraaijvanger, et. al., (2015). This reflects a current societal belief of accessing care and wider calls for a shift in the delivery of care away from hospitals to more support in the community and continuity of care for those identified as being at risk of self-harm behaviours, through mental health awareness for GPs and access to clinical psychology through the GP, extending patient pathways and reducing reliance on inpatient services (Jones et al., 2013). Jones et al. (2013) also indicated improved primary and social care resources and crisis responses will in turn reduce ED attendances. However, this is a difficult task given the stretched system these departments operate in, and notably the research presented here pre-dated the COVID-19 global pandemic which is likely to exacerbate pressures further.

Strengths and Limitations

A core strength of the current literature review is that it draws on research conducted in a range of countries including the UK, Australia, Brazil, Ghana, and Ireland. This provides a cross-cultural perspective to global difficulties of systemic pressures in the ED, as well as staff perceptions of caring for people accessing the ED for self-harm behaviours.

Wider literature suggests there are subtle differences in emotional impact of the work dependent on professional backgrounds. Out of the 13 included papers, 12 reported on emotional impact of working with this people who present with self-harm behaviour. Eight of these comprised of only ED nurses views, and the remaining six papers comprised of three reporting mixed teams, and two reported solely ED medical practitioner views. Therefore. there is a majority focus of ED nursing professions which could indicate a research bias in the field toward nursing professions and how they manage the emotional impact of caring for people presenting with self-harm behaviours. Furthermore, there are limitations to any meta-synthesis, given the nature of collating information from a variety of sources means that certain personal experiences are diluted or lost. Despite efforts to represent all ED clinicians, this literature review could contribute to the bias given the skewed number of studies solely focusing on ED nursing staff or mixed teams.

Conclusion

This review explored 13 papers focused on a qualitative understanding of ED practitioners’ perceptions and caring for people with self-harm behaviours. Using a meta-ethnographic analysis, three themes were constructed, which explored the emotional response and attitudes towards people who have self-harmed, situated in the challenging ED context. Training to support better understanding and reduce stigmatising responses is needed, as this will ultimately improve patient care and job satisfaction, build confidence in the workforce to manage psychological distress, all with the hope of lessening the perpetuating cycle as described figure 2. However, systemic changes in the care for individuals who self-harm are also needed to reduce the burden on the ED department.

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FIGURE 1-A: PRISMA DIAGRAM

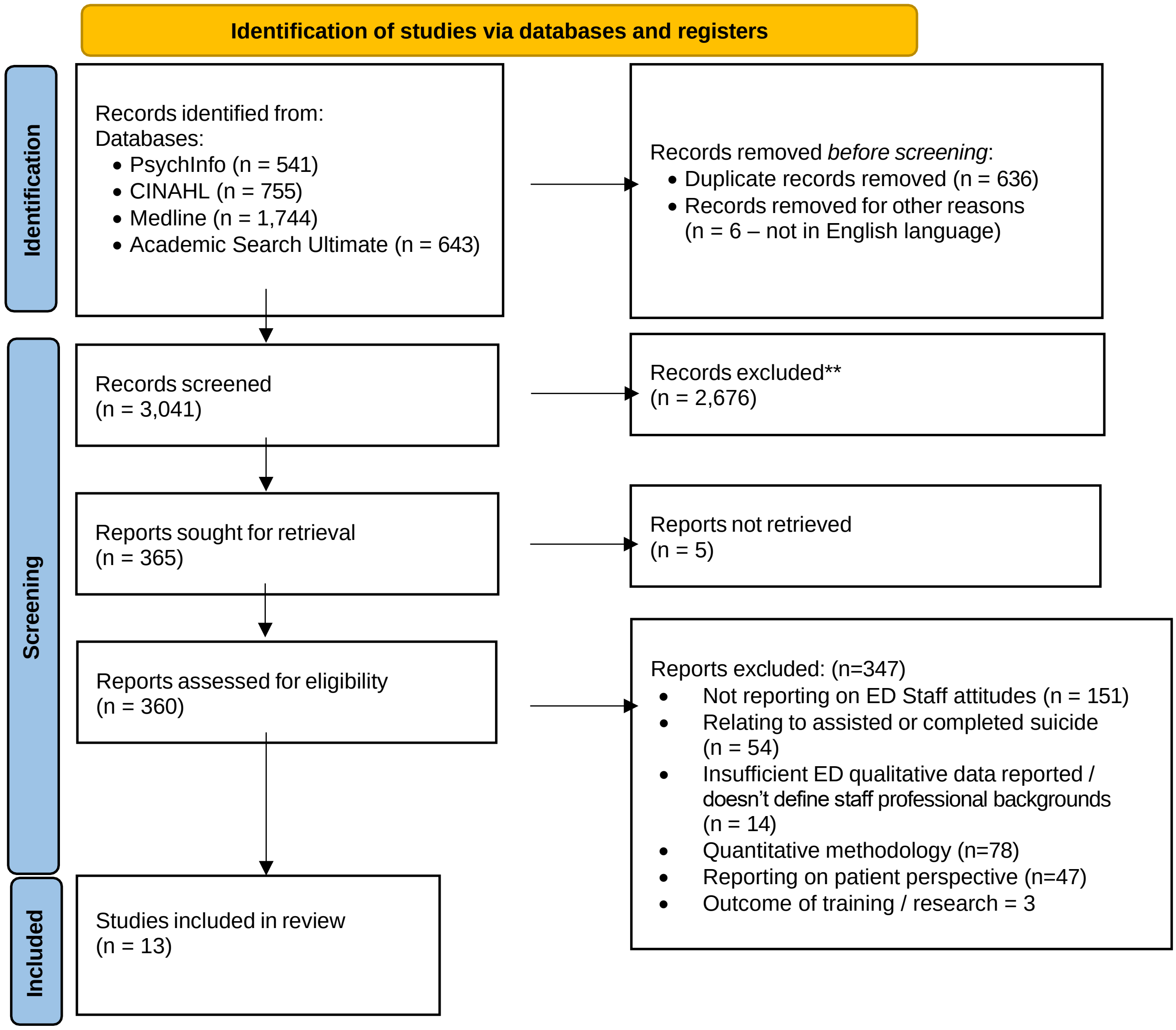


FIGURE 1-B: An overall model diagram of the findings, illustrating the patient-practitioner dynamics (from the ED practitioners' perspective).

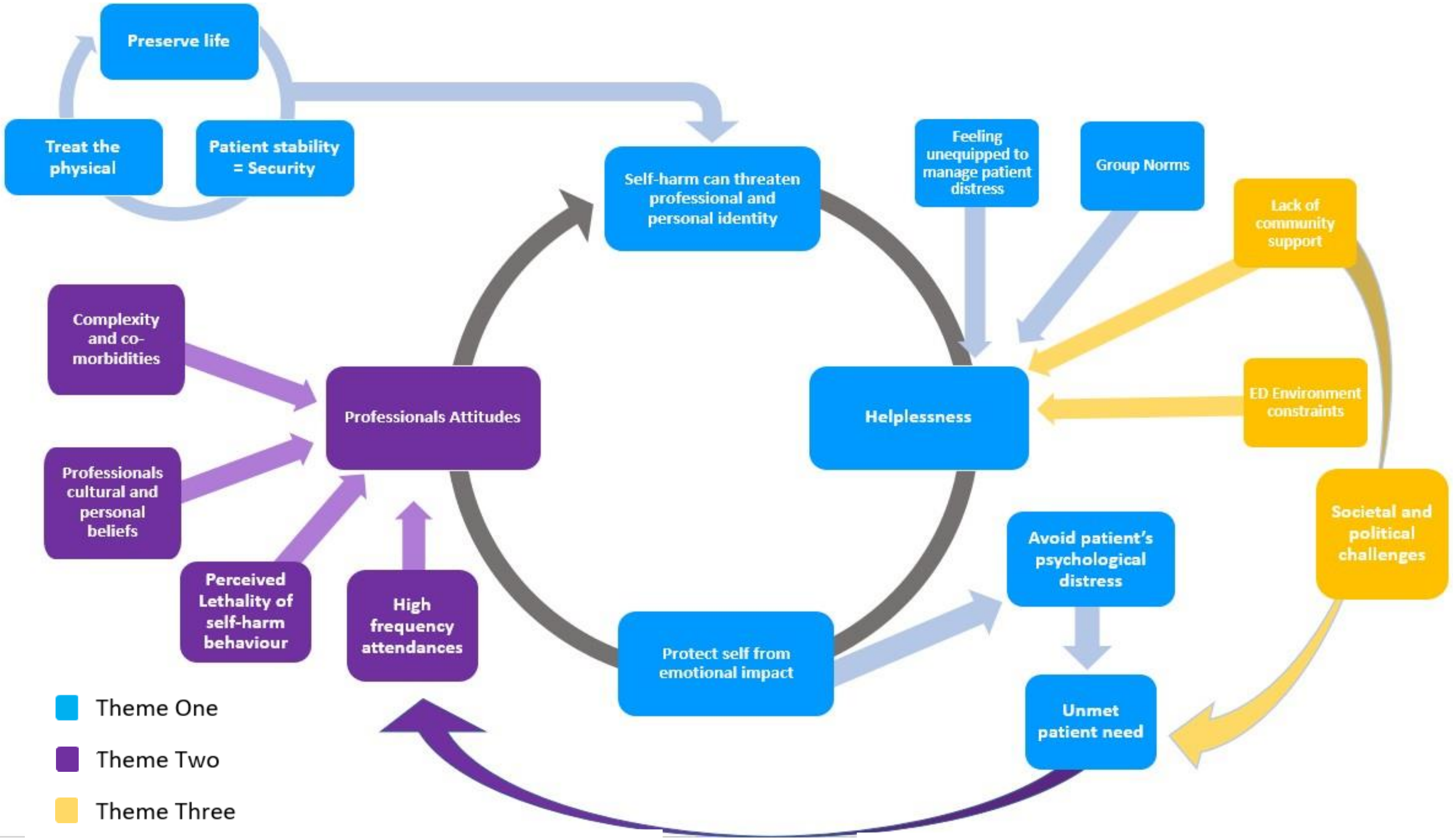


TABLE 1-A: Table 1-A presents the search strings and strategy used to explore literature in each database

CINAHL		
Subject Headings	String 1	((MH "Emergency Nurse Practitioner+") OR (MH "Physicians, Emergency+") OR (MH "Emergency Medical Technician Attitudes") OR (MH "Emergency Service+") OR (MH "Psychiatric Emergencies") OR (MH "Emergency Services, Psychiatric+") OR (MH "Emergencies") OR (MH "Emergency Patients") OR (MH "Emergency Nurses Association") OR (MH "College of Emergency Nursing Australasia Ltd.") OR (MH "Education, Emergency Medical Services") OR (MH "Emergency Medical Services") OR (MH "Emergency Nursing") OR (MH "Emergency Medicine") OR (MH "Emergency Medical Technicians") OR (MH "Emergency Care (Saba CCC)") OR (MH "Society for Academic Emergency Medicine") OR (MH "Emergency Treatment") OR (MH "Emergency Medical Treatment and Active Labor Act") OR (MH "Emergency Care (Iowa NIC)") OR (MH "Emergency Care") OR (MH "Trauma Nursing") OR (MH "Trauma") OR (MH "Triage (Iowa NIC)") OR (MH "Prehospital Care"))
	String 2	((MH "Injuries, Self-Inflicted+") OR (MH "Self-Injurious Behavior") OR (MH "Risk for Self-Mutilation (NANDA)") OR (MH "Self Mutilation Risk (Saba CCC)") OR (MH "Risk for Violence, Self-Directed or Directed at Others (NANDA)") OR (MH "Suicide Self-Restraint (Iowa NOC)") OR (MH "Self Neglect") OR (MM "Suicide, Attempted+"))
	String 3	((MH "Attitude+") OR (MH "Attitude of Health Personnel+") OR (MH "Attitude to Mental Illness") OR (MH "Attitude to Disability") OR (MH "Emergency Medical Technician Attitudes") OR (MH "Nurse Attitudes") OR (MH "Physician Attitudes") OR (MH "Physician Assistant Attitudes") OR (MH "Qualitative Studies+") OR (MH "Reflexivity (Research)") OR (MH "Phenomenology") OR (MH "Multimethod Studies") OR (MH "Meta Synthesis") OR (MH "Grounded Theory") OR (MH "Field Studies") OR (MH "Content Analysis") OR (MH "Interviews") OR (MH "Narratives") OR (MH "Observational Methods") OR (MH "Self Report") OR (MH "Surveys") OR (MH "Focus Groups") OR (MH "Vignettes") OR (MH "Naturalistic Inquiry") OR (MH "Videorecording"))

		PSYCHINFO
Subject Headings	String 1	DE "Emergency Personnel" OR DE "First Responders" OR DE "Emergency Medicine"
	String 2	(DE "Self-Destructive Behavior" OR DE "Attempted Suicide" OR DE "Self-Inflicted Wounds" OR DE "Self-Poisoning" OR DE "Self-Mutilation" OR DE "Self-Injurious Behavior" OR DE "Head Banging" OR DE "Self-Inflicted Wounds" OR DE "Self-Mutilation" OR DE "Self-Poisoning")
	String 3	(DE "Attitudes" OR DE "Attitude Change" OR DE "Attitude Formation" OR DE "Employee Attitudes" OR DE "Health Attitudes" OR DE "Ideology" OR DE "Preferences" OR DE "Stereotyped Attitudes" OR DE "Work (Attitudes Toward)" OR DE "Implicit Attitudes" OR DE "Explicit Attitudes" OR "Implicit Bias" OR DE "Emotions+" OR DE "Empathy" OR DE "Content Analysis" OR DE "Qualitative Methods+" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis" OR DE "Digital Content Analysis" OR DE "Empirical Methods" OR DE "Experimental Design" OR DE "Interviews" OR DE "Mixed Methods Research" OR DE "Observation Methods" OR DE "Phenomenology" OR DE "Qualitative Measures" OR DE "Systematic Review" OR DE "Questionnaires" OR DE "Data Collection")
		MEDLINE
Subject Headings	String 1	((MM "Emergency Service, Hospital+") OR (MH "Emergency Treatment+") OR (MM "Emergency Nursing+") OR (MH "Emergency Medicine+") OR (MH "Emergency Medical Services+") OR (MH "Emergency Medical Technicians+") OR (MH "Emergency Services, Psychiatric") OR (MH "Emergency Medical Tags") OR (MH "Emergency Medical Dispatcher") OR (MH "Emergency Medical Dispatch") OR (MH "Evidence-Based Emergency Medicine") OR "emergency department" OR (MH "Physicians") OR (MH "Emergency Responders") OR (MH "Personnel, Hospital") OR (MH "Medical Staff") OR (MH "Nurses") OR (MH "Nursing Staff") OR (MH "Allied Health Personnel") OR (MH "Emergency Nursing") OR (MH "Nurse Practitioners") OR (MH "Nursing") OR (MH "Emergency Medicine") OR (MH "Emergency Medical Services") OR (MH "Nursing Assistants") OR (MH "Nurse Clinicians") OR (MH "Students, Nursing") OR (MH "Psychiatric Nursing") OR (MH "Emergency Medical Technicians") OR (MH "Nursing Services") OR (MH "Nurse Specialists") OR (MH "Emergency Services, Psychiatric") OR (MH "Clinical Nursing Research") OR (MH "Nursing Service, Hospital") OR (MH "Nursing Staff, Hospital") OR (MH "Evidence-Based Nursing") OR (MH "Evidence-Based Emergency Medicine") OR (MH

		"Physicians") OR (MH "Physician Assistants") OR (MH "Medical Staff, Hospital") OR (MH "Nursing Service, Hospital") OR (MH “Health Personnel”))
	String 2	((MH "Suicide, Attempted") OR (MH "Self-Injurious Behavior+") OR (MH "Self Mutilation"))
	String 3	((MH "Qualitative Research") OR (MH "Meta-Analysis as Topic") OR (MH "Observation") OR (MH "Hermeneutics") OR (MH "Grounded Theory") OR (MH "Empirical Research"))
ACADEMIC SEARCH ULTIMATE		
Subject Headings	String 1	(DE "EMERGENCY nursing" OR DE "EMERGENCY Medical Clinics" OR DE "HOSPITAL emergency services" OR DE "AMBULANCE service" OR DE "EMERGENCY room wait times" OR DE "HOSPITAL observation units" OR DE "TRAUMA centers" OR DE "HOSPITAL emergency services -- Utilization" OR DE "EMERGENCY services in psychiatric hospitals" OR DE "EMERGENCY medical services" OR DE "AMBULANCE service" OR DE "EMERGENCY medical personnel" OR DE "EMERGENCY services in psychiatric hospitals" OR DE "HOSPITAL emergency services" OR DE "MEDICAL triage" OR DE "PEDIATRIC emergency services" OR DE "POISON control centers" OR DE "SEXUAL assault evidentiary examinations" OR DE "EMERGENCY medicine" OR DE "EMERGENCY medical personnel" OR DE "EMERGENCY medical services" OR DE "EMERGENCY nursing" OR DE "FIRST aid in the workplace" OR DE "TRAUMATOLOGY" OR DE "EMERGENCY medical services safety measures" OR DE "EMERGENCY management" OR DE "EMERGENCY medical technicians" OR DE "EMERGENCY medical personnel" OR DE "AMBULANCE drivers" OR DE "EMERGENCY medical technicians" OR DE "EMERGENCY physicians" OR DE "HOSPITAL medical staff" OR DE "HOSPITAL admission & discharge" OR DE "EMERGENCY physicians" OR DE "EMERGENCY medical personnel malpractice" OR DE "EMERGENCY medical diagnosis" OR DE "MEDICAL emergency management" OR DE "MEDICAL emergencies" OR DE "EMERGENCY physicians -- Malpractice" OR DE "EMERGENCY medical technician & patient" OR DE "MEDICAL staff of public hospitals" OR DE "HOSPITAL personnel attitudes" OR DE "HOSPITAL consultants" OR DE "MEDICAL care")
	String 2	(DE "SELF-injurious behavior" OR DE "SELF-injurious behavior in adolescence" OR DE "SELF-mutilation" OR DE "SELF-mutilation" OR DE "CUTTING (Self-mutilation)" OR DE "HESITATION wounds" OR DE "SELF-torture" OR DE "ATTEMPTED suicide")

	String 3	(DE "QUALITATIVE research" OR DE "CONVERSATION analysis" OR DE "EDUCATION -- Qualitative research" OR DE "FOCUS groups" OR DE "META-synthesis" OR DE "PARTICIPANT observation" OR DE "PHENOMENOGRAPHY" OR DE "QUALITATIVE research methodology" OR DE "SYMBOLIC interactionism" OR DE "NARRATIVE inquiry (Research method)" OR DE "MIXED methods research" OR DE "META-synthesis" OR DE "ATTITUDE+ (Psychology)" DE "EMOTIONS+" OR DE "OPINION + (Philosophy) in literature")
		ALL DATABASES
Free Text Terms, Title and Abstract	String 1	((("accident and emergency" OR a&e OR (emergency N3 (room* OR department* OR unit* OR ward OR nurse* OR doctor* OR clinician* OR staff OR physician* OR consultant* OR professional* OR HCSW OR HCW OR practitioner*)) OR casualty OR EW OR ER)
	String 2	("deliberate self-harm" OR "Self-Inflicted Wound*" OR “Self-Mutilat*” OR “Self-Poison*” OR "attempt* suicide" OR "Self-Injurious Behav*" OR “self-harm” OR “self-injur*” OR ((self OR self-inflicted OR intentional OR deliberate) N3 (wound* OR injur* OR mutilat* OR violen* OR poison*)) OR “self-injur* behaviour” OR “non-suicidal self-injury” OR “non-suicidal self-harm” OR “non-fatal suicide”)
	String 3	((opinion* OR attitude* OR perception* OR experience* OR belief* OR perspective*) OR (opinion* OR attitude* OR perception* OR belief* OR perspective*) OR “interview” OR “thematic analysis” OR “phenomenol*” OR “narrative” OR “focus group” OR “discourse analysis” OR “grounded theor*” OR “content analysis” OR “hermeneutic*” OR “heuristic*”))

TABLE 1-B: Table 1-B presents characteristics and CASP rating of the included papers,

Title	Year	Author	Country	Aim	Participants	Methods	Analysis	CASP Rating
Emergency Department Staff Attitudes Toward People Who Self-Harm	2013	Artis & Smith	UK	To explore social factors which may contribute to staff attitudes towards people who have self-harmed	8 ED Drs & nurses 1 HCA 1 manager	Semi-structured interviews	Thematic Framework Analysis	20
Perceptions of Australian emergency staff towards patients presenting with deliberate self-poisoning: A qualitative perspective	2014	Chapman & Martin	Australia	To explore staff perspectives towards people accessing ED care for deliberate self-poisoning.	186 clinicians: ED doctors & nurses	A questionnaire with 2 open-ended questions	Qualitative data analysis procedures	16
Caring for patients with Suicidal Behaviour: an Exploratory Study	2007	Doyle et al	Ireland	To explore ED nurses experiences of caring for people accessing the ED with suicidal behaviour	43 ED Nurses	Semi-structured questionnaire	Thematic analysis	14
Nursing care to people admitted in emergency for attempted suicide	2018	Fontão et al	Brazil	To explore ED nurse's perceptions of caring for people in the ED who had attempted suicide	8 ED nurses and 8 ED nurse technicians	Semi-structured interviews	Content analysis	15
Analysis of Accident and Emergency Doctors' Responses to	2009	Hadfield et al	UK	To explore how ED doctors respond to people who presented with self-harm behaviours	5 ED Doctors	Interviews	Interpretative phenomenological analysis	20

Treating People Who Self-Harm								
Perceptions of knowledge, attitudes and skills about non-suicidal self-injury: A survey of emergency and mental health nurses	2020	Ngune et al	Australia	To explore the experiences of ED nurses when caring for people who had presented with self-harm behaviours	18 ED Nurses	Interviews	Inductive content analysis	17
Attitudes of psychologists and nurses toward suicide and suicide prevention in Ghana: A qualitative study	2012	Osafo et al	Ghana	To explore the experiences of healthcare professionals when caring for people with suicidal behaviour	8 clinical psychologists and 8 ED nurses (only data from ED nurses were included in the analysis)	Semi-structured interviews	Interpretative phenomenological analysis	19
Emergency Department Nurses' Encounters with Suicide Attempters: A Qualitative Investigation	1988	Pallikkathayil & Morgan	UK	To explore the ED nurse's attitudes, emotional response and self-care practises used when caring for people with suicidal behaviour in the ED	20 ED Nurses	Semi-structured interviews	Giorgi's method of qualitative data analysis	18
Barriers and facilitators of suicide risk assessment in emergency	2015	Petrik et al	USA	To explore ED practitioner's perceptions of the factors that contribute to	92 ED practitioners: nurses, technicians,	Online questionnaire with open-ended questions	Inductive thematic analysis approach	17

departments: a qualitative study of provider perspectives				effective risk assessment of suicidal behaviour in the ED	physicians, assistants, residents, fellows, and social workers			
Suicide Risk Assessment and Management: Real-World Experience and Perceptions of Emergency Medicine Physicians	2017	Roy et al	USA	To explore the experience and perspectives of ED physicians on risk assessment and caring for people with suicidal behaviour in an urban ED	10 ED attending physicians, 6 ED resident physicians	Focus groups	Thematic analysis	17
The look of the emergency nurse at the patient who attempted suicide: an exploratory study	2017	Santos et al	Brazil	To explore the perspectives of ED nurses who cared for people accessing the ED for suicidal behaviour	13 ED Nurses	Semi-structured interview	Exploratory qualitative approach	16
Emergency Nursing Experiences in Assisting People with Suicidal Behavior: A Grounded Theory Study	2017	Vedana et al	Brazil	To explore the ED nurses experiences of caring for people presenting with suicidal behaviour	19 ED nurses	Unstructured Interviews	Grounded theory	20
Assessing for occult suicidality at triage:	2018	Wolf et al	USA	To explore experiences and the responses to risk of ED nurses caring for people	41 ED Nurses	Semi-structured focus groups	Saldana coding techniques and	10

experiences of emergency nurses	with suicidal ideation during triage	theme generation

TABLE 1-C: Table 1-C presents the theme contributions from each of the included papers.

Author	**Theme One: Between Frustration, Futility and Failure": The Clinicians' Emotional Response to Self-harm**	**Attitudes on a Self-harm Spectrum**	**The Emergency Department in a Challenging Context**
Artis & Smith (2013)	• Balancing on a knife edge – competing expectations: frustrations of balancing needs of patient and needs of the system • Empathic and supportive without being too nice • Emotional balancing act – professional distance whilst building rapport – taking a step back to be able to continue to do the job • Don't have the skills to treat the psych • Mixed emotions and links to behaviour vague • More horrific the story = the more sympathy felt allowing staff more time with these patients • Frustrated and annoyed when little harm Done	• Person centred: What works for one won't necessarily work for another • Should be treated the same as any other patient respect and dignity • Psychological distress deeper than physical wounds • Don't have the skills to treat the psychological • Treat physical vs psychological impact on perceptions of SH in the ED • Empathic and supportive without being too nice • Defined as deliberate acts of harm to self, could include excessive alcohol and smoking. Difficulty defining because of changing definitions.	• Social context of SH seen as contagious and a status symbol • Life being too comfortable / SH linked to low socio-economic status • Treat physical wounds not psychological ones • Media: Comic relief reported as influencing, getting people talking about MH • Group norms • Fluid ED team, changing to the needs of the patient • Cogs in a machine – everyone needs to make it work • Support is for the big stuff

	• Taking time away from genuine patient's *empathy runs a little thin* • More negative attitudes in others than themselves *perfunctory, short-tempered, less communication.* Own practise – could get caught up in negative comments *continuum of what is acceptable.* • Overestimated negativity – lots of people judgemental • Alienation: Curb behaviour to fit with the norm, being very busy to avoid challenging negative narrative. • Pluralistic ignorance (when individual in a group believes others have stronger values) • Frustration futility and failure • Attracts certain qualities hardworking humorous and confidence	• Reasons for SH: reactive to an event, manipulation, attention seeking, cry for help • Lethality = sympathy • Follow an assessment procedure and build rapport • Patient attributes: disinterested in change / disruptive to the environment • Past poor encounters may influence patient engaging with staff • Patients may feel futility which mirrors staff's emotions • More horrific the story = the more sympathy felt allowing staff more time with these patients ○ Frustrated and annoyed when little harm done • Taking time away from genuine patient's empathy runs a little thin	• Keep going and keep emotions in check • Barriers: staff attributes, organisational constraints role limitations • Time most significant: even increased resource wouldn't have time to implement learning. • More relaxed with experi3ence – take more time despite system pressures • Not the right environment: no private rooms / increase patient supervision • Means I can't do my job properly • Lack of training / cutbacks and recession impacted training opportunities

Chapman & Martin (2014)	• Frustrations that I can’t help them / can’t change their behaviour • Time away from patients that didn’t contribute to their presentations • Time consuming for staff • Frustration • Some felt they lacked the skills, some enjoyed the challenge • Some felt useful when caring for this patient group • In the ED the focus on care is emergency physical don’t have time to explore MH	• Reactions are dependent on reason for admission – actual suicide attempt / reason to receive psychiatric care • Exasperated and annoyed if patient self-harmed to minor degree to get help • Compassion, sympathy, concern, and empathy for patients that have made a ‘real’ attempt • *One off socially stressed you feel sorry for* • Repeat presentations • Frustrations regarding deliberate SH as these patients are more aggressive, can’t help the patient change their behaviour and or change the way the patient dealt with a situation. • DSP is harder work than other physical patients • Physically not a problem but emotionally time consuming • Skills better used elsewhere than DSP ‘serial attenders’	• Not the right environment to explore this – deal with emergencies • Not backed by management in risk and safety • DSP takes a lot of resource • Not the time, training or expertise • Lack of available resources within the ED • Training across the lifespan and communication skills would be supportive

		• Treated everyone the same regardless of presentation • Time away from patients that didn’t contribute to their presentations	
Doyle et al (2007)	• Uneasy and stressed, corresponded with patient violence / aggression / instability. • Frustration contributed to helplessness at perceived lack of failing psychiatric system • Compassion and willingness to listen, sad and sympathetic • Nursing values of helping the patients to the best of their ability permeates practise • Feeling secure when patients physically stable • Feeling as though they are out of their depth • Required to be hyper-vigilant for risky patients, taking longer time and	• Treatment through assessment, manage risk and create safe environment • Prioritise the physical and refer to psychiatric services • Caring for psych wellbeing not part of their role • Attitudes influenced if there was a tragic event / frequent attenders / history of suicidal behaviour • Repeated presentation = frustration • Nurses made judgement of “genuineness” towards the attempt, which influenced the care they received • Willing to invest time if circumstances were authentic	• ED in state of crisis, leaving not enough and appropriate time for any patient. Impacts these patients for appropriate time to address psychological care • Lack of skills, particularly communication, impacts negatively on their interventions • Threatening suicide / violence and aggression is difficult • Substance misuse impacts also • Insufficient resources • Lack of acute psychiatric beds • Increased workload – try to prevent patients leaving ED when there is a delay in the ED workflow

		• More utilitarian approach and patients no different to other ED patients • Not equipped to deal with uncooperative manipulative and distressed patients	
Fontao et al (2017)	• Don't feel much prepared – deficit of care for these people • Our care is not that good • Nursing team makes the minimum – social care and psychology greater impact • Treat the clinical, psychiatric ignored and not done. Support to family is unstructured until psychology steps in • Practise more technical clinical care – other MDT members treat the psychological • Physically stabilise the patient • We practise comfort, not why they did it • Guidance for working through the nursing care systematization = care provided more related to physical	• Always try to talk to the patient but it's complicated through the demand and workflow • We do our approach, not the approach to the patient. I am going to do the best I can, but delegate to the psychologist	• ED not an adequate environment for these patients • Tumultuous – demands we have cease to give better listening and reception • No physical space compatible with nursing guidelines – keep space peaceful and calm • Better structure would allow patient not to escape • We cannot do a follow up in the ED – integral care is not done. • More immediate fragmented care. Assume service support patient. • We should have better environments • Health system today works in a system which is fragmented – care units do

not communicate. Nobody assumes the person are loose in the system

- Not the appropriate place to receive treatment for MH and should be transferred to psychiatric hospital
- Psychiatric asylums closed but no reference where people should go
- Flawed system based on admittance – between MH and broken bones
- Work overload – not mentally and emotionally prepared for a proper job
- Intense dynamics – no time to build a relationship or connection with the patient
- Working with psychology in MDT – to explore motivation to attempt
- Already overloaded – all very fast and in a hurry
- More staff to attend to these patients would be better. It’s so hectic we cannot listen to the patient

			• Being unable to perform nursing care as they would like to and develop the work comprehensively impacts wellbeing. Work dynamics and process precludes me from giving adequate care • Calls for better preparation for MH care: training on the job / through education institutions • More training and joint work with psychology • Call for a single place for treatment, with a prepared team
Hadfield et al (2009)	• Motivations for working in ED = offer solutions to physical problems, help patients feel better • Treating SH directly challenges this – staff feeling disillusioned with abilities to help • Self-protection: Trivialising the patients SH as self-protection from powerlessness, placing discomfort to the patient's *whole*	• <u>First time</u>: sense of urgency, discomfort in treating them, patients have little sense of agency, staff heightened responsibility • <u>Frequent attend:</u> helpless, despair, frustration. Physical treatment is futile (ineffective), and staff compelled to give something of themselves they are unable to offer. *Why what do you want from me?*	• Treating the physical silences, the patient, and staff • Working within the medical culture: self-denial and feelings of powerlessness exacerbated by expectations of Drs working to strict guidelines for physical health, and devoid of autonomy and emotion *the*

	team can be flippant, oh they are back again / make a joke out if / dismissive • Self-preservation: Fearful of addressing patients underlying emotions • Treating the physical silences, the patient, and staff – protects staff from feeling powerless by distancing themselves • In contrast, some person experience of SH led to feel more confident, agency in care received – respond in mutually validating ways • Treat the physical at the expense of individual’s distress • SH based on wounds or level of poison, manage risk • Helpless to address emotional aspects of self harm as this is beyond their expertise	• Psychiatric diagnosis: social difficulties (bereavement / relationships / poverty) vs psychiatric diagnosis of schizophrenia / bipolar – valid reasons for SH, incapable of rational decision making, patients not responsible, staff feeling empowered. • Manipulation: Reason to SH was to manipulate others, undeserving of treatment as this was gained through manipulation of others. Evoking anger, spend least possible time with this group due to intense feelings and risk to professionality • Repeat presentations = failing of psychiatric services. Feeling abandoned, attempts to help were dismissed as hopeless. Heightened feeling of distress and powerlessness *Its alright as you have documented everything*	*same way soldiers were. No matter what you think, you know what you have to do* • Societal responses: social isolation, lack of control evokes pity for patients, frustration within the 2ndary care system mirroring the promotion of helplessness through protecting people from stark realities of life *they just exist.* • Social and cultural context reinforce staff response of treating the body and silencing the self.

Ngune et al (2020)	• Uncomfortable asking why when first qualified – didn't know how to ask the Q's • Mixed emotions and feeling judgemental • *It's a skill you learn, not routinely taught* • Culture from colleagues affects level of comfort – over triaging. Not got anything physical wrong so why escalate their treatment? • Feeling more comfortable led to change in their attitudes • View their role as multifaceted and key role in their care, probably play a bigger role than doctors • Making the person feel safe and comfortable in ed environment • Physical care and pain relief first • Advocate for them • Establishing the context of self harm	• Reasons why are always different – different SH, patients • Judgement towards frequent attenders • Self harm way of getting attention – experience, exposure and understanding why	• SH role model supports comfortability – time with psychiatric liaison nurse • Backing from seniority to help keep the patient safe and security • Lack of knowledge is a barrier to interactions • Lack of time to provide care leave too soon to provide optimal health • Patients' inability to verbalise what help they want • Lack of service to refer people on to • More MH nurses trained in ED • Comfortability comes from understanding why people SH, experience and providing person-centred care. • It's a skill you learn, not routinely taught

			• More self harm training in undergrad contributes to feeling unprepared and learning on the job • Needing to educate themselves • Toolbox of skills and questions • Education ongoing as CPD for empathy • Education through understanding lived experience / simulation • Postgrad academia also supportive
Osafo et al (2012)	• Moralistic judgements, grounded in religion, ownership of life to God • Suicide is taboo • Expectations around values of life should hold hope for the future – should be able to cope through religion • Criminality • Social hazard theory – risky behaviour affects others • Deterrent: Put in jail		• Close working relationship with psychology harboured non-judgement

	• Crime = punishment but individual needs care • Morality vs health relationship • Protective but insulting to draw attention to their culpability • Steps out of ethical professional requirements • Emphasises impact of beliefs on professionalism • Patients as needing help Needing help • Underlying driver for further work is moral obedience		
Pallikkathayil & Morgan (1988)	• Feelings: sorrow / anger / feeling sorry / only 2 reported mixed / 1 no feelings • Quote around responsible and accountable, angry, and not loving / counter violence • Self-performance thoughts: no feeling of accomplishment / lack of control / wish I could balance hope and reality • Judgement on lethality	• Repeat attempters playing games • YP act not acceptable • Means of escape / needing help / manipulation / last resort / attention seeking / a waste • Self-care = protection from emotional turmoil: business like, humour, emotional detachment	• Nurses felt the emergency department was highly stressful • Failure of the health system to provide an effective disposition • Time and staffing most common factor • Insufficient time to provide the desired care goes beyond the control of the ED Nurse

	• Dealing with feelings: psychosocial intervention by talking to the attempter • Conflicting sense of duty to the professional: resulted in some use of force i.e., restraint to support compliance and protection from physical harm • Helplessness and frustration • Attitudes: wrong from a religious standpoint • *Taking life conflicts with professional value of preserving life* • Perceived self as much more positive than their co workers • Something around the specific role of the nurse – likes short term intervention, keep things moving etc	• Negative conditional intervention i.e., what if behaviours: aggressive vs leave in a mess • Preserving life and prioritising nursing assessment and intervention for physical health • Responded to thoughts and feelings through what they should and shouldn't do • Utilised family members in dealing with their thoughts and feelings • Attitudes: wrong from a religious standpoint • Judgement on lethality – not taken enough to die • Suicide is a complex multifaceted phenomenon • Time consuming 1:1 nature of care for these patients • Brought it on themselves taking away from time for people seriously ill through no fault of their own	• Mindset of lack of control manifested behaviourally through providing essential physical care detachment and acting out angry feelings • Psychiatric services were weak and ineffective which contributed to repeat attempts • Psychiatric services failing on their primary function contributed to feelings of helplessness and anger • What would help: increasing knowledge • A dedicated resource person to communicate to SH and assist them – frees the nurse of duties and guilt

		• Psychosocial second to physical, and only when time permitted • Lifesaving physical intervention gave rise to value conflict (causing stress) between personal values and professional values and responsibility to provide care, and one’s own right to take one’s life • Stressful presentations: repeaters – why hard to understand, playing games and manipulative • Young people • Substance misuse • Family dynamics: unknown, demanding, not comprehending seriousness of event • Opinions regarding the act of suicide • They would want to be treated with psychosocial intervention, despite prioritising lifesaving physical care	
Petrik et al (2015)	• Fear • Discomfort	• Patient unwillingness to engage • Substance misuse	• Time

	• Preference to consult MH Professionals to assess for risk	• Secondary gains / avoid psychiatric hospitalisation • Patients are defensive and reluctant to cooperate	• ED workflow and family presence reduces private space for confidential risk assessment • Dearth of aftercare options • Fewer patient volume • More time to build rapport • Ask family to leave • Utilising bathroom / private space for confidential discussion • Interpersonal communication – eye contact non-judgemental body language • Direct and conversational communication • Communication with other providers became a barrier across MDT • Routine standardised care • Collaborating with MDT professionals including social worker and psychiatric professionals • Insufficient CPD and training

			• Insufficient mental health resources both in the ED and community
Roy et al (2017)	• Uncomfortableness • Anxiety around missing suicide risk • Dismissed suicide risk as something they cannot control • Positive signs of suicide risk in ED overwhelms clinicians' capacity to provide care – worry promotes burnout	• Patients reluctant to talk, rejecting help, secondary gain agendas, acute intoxication withdrawal • Patients seeking substance misuse support and threatening suicide in not gaining right care • Manipulative behaviour • Screening increases resource` • Patients become volatile in response to suicide questions	• Minimal documentation of suicidal risk to save on time constraints • Helpful to delegate to support staff • Nurses interrupt workflow to assess other patients • Overcrowded and no privacy
Santos et al (2017)	• Distressed as what is offered is not appropriate • Difficulties approaching attempted suicide and not empowered to do so • Don't know how to talk to them, rely on social worker • Not prepared - should be discussed in Education	• In reality, care was exclusively clinical and not taking in to account the biopsychosocial context of the individual • Treated so their lives are not at risk, go home the same way they came so no continuity • Should be offered humanised care but don't offer this	• Care based on biomedical model in the absence of environment conducive to more humanized practises = ED • Sector doesn't have sustainable environment for this pt. • External factors affected with the context of suicide • Not the right resources

	• Topic generates discomfort – taboo not experienced in training	• Causes are intrinsic to the patient and doesn’t depend on the care • No time to talk • Take the patient away from the urgency has fulfilled duty of care • They are weak people from emotional and spiritual point of view	• Can’t give the pts the right attention as the work overload is too much • No time to talk / greet • More courses to offer more dialogue • Study psych theory and practise but not common in daily practise • Focus on communication with the family can help reduce reoccurrence
Vedana et al (2017)	• Urgent unpredictable challenging and uncontrolled situation • Needs psychological and theoretical preparation • Lot of professional effort • Socially unacceptable in Brazil • Unjustifiable and non-empathic • Moralistic attitudes • Impenetrable phenomenon • Incomprehensible • Aggravates vs mitigates guilt: despair, severity of stressors mental illness and Selfishness	• Patients want to die • Resistant to treatment careless with themselves not collaborative and hide symptoms • Stronger moral judgements on people who deliberately despise their life – confused selfish, irresponsible, cowardly	• Barriers to effective therapeutic relationship • Time • Overburden • Limitations on patients’ autonomy • No guidelines for the suicidal patient • Situations is bad but no one does anything to change it – contributes to negative feelings

	• Feelings: Shock sadness self-doubt, frustration, incompetence, altruism, and compassion • Difficulty in sharing these emotions: criticism, distancing, rejection etc as well as satisfaction • Assisting: exhausting risky questionable effectiveness and burdening health services • Discomfort exacerbated by inability to perform job role • Incompetence: caring against their will, don’t have the skills • Treating the physical – nursing a secondary and limited role in supporting suicidal patients. Base their care on personal beliefs rather than training, due to lack of		
Wolf et al (2018)		• Repeat presentations in a short time frame = concern • Care- convey the nurse cared about the patient, foster the relationship in a safe and private space away from initial triage	• Time and crowding constraints • Effectiveness of intervention limited by the ED environment • Experience • Training

	• Effective nursing care: a set of actions and reactions	• Overreliance on check boxes • Emphasis on patient through put • Lack of community resources – challenge for managing these patients and 2. Contributes to colleagues' unwillingness

Appendix 1-A: Prospero Application

PROSPERO
International prospective register of systematic reviews

National Institute for Health Research

University of York
Centre for Reviews and Dissemination

Systematic review

*Fields that have an **asterisk (*)** next to them means that they **must be answered. Word limits** are provided for each section. You will be unable to submit the form if the word limits are exceeded for any section.*

Registrant means the person filling out the form.

1. * Review title.

Give the title of the review in English

A systematic review and meta-synthesis of the emergency department practitioners' perspectives of self-harm

2. Original language title.

For reviews in languages other than English, give the title in the original language. This will be displayed with the English language title.

Not applicable

3. * Anticipated or actual start date.

Give the date the systematic review started or is expected to start.

07/06/2021

4. * Anticipated completion date.

Give the date by which the review is expected to be completed.

31/03/2022

5. * Stage of review at time of this submission.

Tick the boxes to show which review tasks have been started and which have been completed.
Update this field each time any amendments are made to a published record.
Reviews that have started data extraction (at the time of initial submission) are not eligible for inclusion in PROSPERO. If there is later evidence that incorrect status and/or completion date has been supplied, the published PROSPERO record will be marked as retracted.
This field uses answers to initial screening questions. It cannot be edited until after registration.

The review has not yet started: No

Review stage	**Started**	**Completed**
Preliminary searches	Yes	Yes
Piloting of the study selection process	Yes	Yes
Formal screening of search results against eligibility criteria	Yes	No
Data extraction	No	No
Risk of bias (quality) assessment	Yes	No

Data analysis	No	No

Provide any other relevant information about the stage of the review here.

6. * Named contact.

The named contact is the guarantor for the accuracy of the information in the register record. This may be any member of the review team.

Cerys Bailey

Email salutation (e.g. "Dr Smith" or "Joanne") for correspondence:

Miss Bailey

7. * Named contact email.

Give the electronic email address of the named contact.

c.bailey6@lancaster.ac.uk

8. Named contact address

Give the full institutional/organisational postal address for the named contact.

Lancaster University Doctorate in Clinical Psychology
Health Innovation One, Sir John Fisher Drive, Lancaster University, Lancaster, LA1 4AT

9. Named contact phone number.

Give the telephone number for the named contact, including international dialling code.

01524 592691

10. * Organisational affiliation of the review.

Full title of the organisational affiliations for this review and website address if available. This field may be completed as 'None' if the review is not affiliated to any organisation.

Lancaster University

Organisation web address: https://www.lancaster.ac.uk/health-and-medicine/dhr/dclinpsy/

11. * Review team members and their organisational affiliations.

Give the personal details and the organisational affiliations of each member of the review team. Affiliation refers to groups or organisations to which review team members belong. **NOTE: email and country now MUST be entered for each person, unless you are amending a published record.**

Miss Cerys Bailey. Lancaster University
Dr Fiona Eccles. Lancaster University
Dr Will Curvis. Lancaster University

12. * Funding sources/sponsors.

Details of the individuals, organizations, groups, companies or other legal entities who have funded or sponsored the review.

There is no direct funding for this review. However, it is being completed as part of the doctorate in clinical psychology for Cerys Bailey at Lancaster University.

Grant number(s)

State the funder, grant or award number and the date of award

Not applicable

13. * Conflicts of interest.

List actual or perceived conflicts of interest (financial or academic).

None identified

14. Collaborators.

Give the name and affiliation of any individuals or organisations who are working on the review but who are not listed as review team members. **NOTE: email and country must be completed for each person, unless you are amending a published record.**

Dr Mary King. Salford Royal NHS Foundation Trust

15. * Review question.

State the review question(s) clearly and precisely. It may be appropriate to break very broad questions down into a series of related more specific questions. Questions may be framed or refined using PI(E)COS or similar where relevant.

To explore the emergency department practitioner's' perspectives of self-harm

16. * Searches.

State the sources that will be searched (e.g. Medline). Give the search dates, and any restrictions (e.g. language or publication date). Do NOT enter the full search strategy (it may be provided as a link or attachment below.)

Databases to be searched: CINAHL, MEDLINE, PsycINFO and Academic Search Ultimate
Restrictions: Papers must be in English

17. URL to search strategy.

Upload a file with your search strategy, or an example of a search strategy for a specific database, (including the keywords) in pdf or word format. In doing so you are consenting to the file being made publicly accessible. Or provide a URL or link to the strategy. Do NOT provide links to your search **results**.

https://www.crd.york.ac.uk/PROSPEROFILES/285969_STRATEGY_20211018.pdf

Alternatively, upload your search strategy to CRD in pdf format. Please note that by doing so you are consenting to the file being made publicly accessible.

Do not make this file publicly available until the review is complete

18. * Condition or domain being studied.

Give a short description of the disease, condition or healthcare domain being studied in your systematic review.

The healthcare domain to be studied is the emergency department, specifically the practitioner's' perspectives of self-harm, including deliberate self-harm.

19. * Participants/population.

Specify the participants or populations being studied in the review. The preferred format includes details of both inclusion and exclusion criteria.

The target population for review is all practitioners working within the emergency department including doctors (all levels), nurses (all levels) and health care assistants.
Inclusion:
- must have used a qualitative or mixed methods approach for data collection
- be focused on the perspectives / attitudes / views / experiences of emergency department practitioner's and not the patients' experience

- Include research relating to deliberate self-harm or attempted suicide or self injurious behaviour.

Exclusion:

- data relating to completed suicide

20. * Intervention(s), exposure(s).

Give full and clear descriptions or definitions of the interventions or the exposures to be reviewed. The preferred format includes details of both inclusion and exclusion criteria.

To explore the range of perspectives of emergency department practitioners relating to their experience of working with patients who self-harm

21. * Comparator(s)/control.

Where relevant, give details of the alternatives against which the intervention/exposure will be compared (e.g. another intervention or a non-exposed control group). The preferred format includes details of both inclusion and exclusion criteria.

Not applicable

22. * Types of study to be included.

Give details of the study designs (e.g. RCT) that are eligible for inclusion in the review. The preferred format includes both inclusion and exclusion criteria. If there are no restrictions on the types of study, this should be stated.

To include any qualitative approach or mixed methods design where sufficient qualitative data can be extracted

23. Context.

Give summary details of the setting or other relevant characteristics, which help define the inclusion or exclusion criteria.

To explore how emergency department practitioners view and conceptualise self-harm, including deliberate, attempted suicide and self-injurious behaviour. We have excluded studies related to completed suicide, as it could be argued that this may draw on different perspectives within the emergency department.

24. * Main outcome(s).

Give the pre-specified main (most important) outcomes of the review, including details of how the outcome is defined and measured and when these measurement are made, if these are part of the review inclusion criteria.

To understand the perspectives of emergency department practitioner’s relating to self-harm and how this is conceptualised in the department context.

Measures of effect

Please specify the effect measure(s) for you main outcome(s) e.g. relative risks, odds ratios, risk difference, and/or 'number needed to treat.

Perspectives and impact on service delivery

25. * Additional outcome(s).

List the pre-specified additional outcomes of the review, with a similar level of detail to that required for main outcomes. Where there are no additional outcomes please state ‘None’ or ‘Not applicable’ as appropriate to the review

Not applicable

Measures of effect

Please specify the effect measure(s) for you additional outcome(s) e.g. relative risks, odds ratios, risk difference, and/or 'number needed to treat.

Not applicable

26. * Data extraction (selection and coding).

Describe how studies will be selected for inclusion. State what data will be extracted or obtained. State how this will be done and recorded.

A highly sensitive search strategy was developed in collaboration with research supervisors and Lancaster University Librarian. This was a combined search of subject headings and free text terms, individualised to each database. The search strings were tested with already identified relevant papers. The number of collective papers across 4 databases will be reviewed for relevancy through title and abstract screening by the lead research team member, to identify the final papers to be included. Once the screening is complete, the full text of the remaining papers will be assessed against the inclusion and exclusion criteria. Any uncertainties will be discussed with the 2nd and 3rd members of the team. Data to be extracted will include dEeamcho gpraappehri cwsi llo bf ep acrotidceipda nfotsr ,d jaotba rroelleesv,a annt dto t itmhe rine sceuarrechn tq ruoeles.t ion and these codes will be tabulated.

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart will be employed to evidence a structured literature review.

27. * Risk of bias (quality) assessment.

State which characteristics of the studies will be assessed and/or any formal risk of bias/quality assessment tools that will be used.

Quality of studies identified will be assessed using the critical appraisal skills programme (CASP) checklist. It will be ensured that any themes constructed do not rely solely on the weaker papers.

28. * Strategy for data synthesis.

Describe the methods you plan to use to synthesise data. This **must not be generic text** but should be **specific to your review** and describe how the proposed approach will be applied to your data. If metaanalysis is planned, describe the models to be used, methods to explore statistical heterogeneity, and software package to be used.

The codes from each paper will be collated with a qualitative meta-synthesis approach adopted.

29. * Analysis of subgroups or subsets.

State any planned investigation of ‘subgroups’. Be clear and specific about which type of study or participant will be included in each group or covariate investigated. State the planned analytic approach.

None planned

30. * Type and method of review.

Select the type of review, review method and health area from the lists below.

Type of review

Cost effectiveness
No
Diagnostic
No
Epidemiologic
No
Individual patient data (IPD) meta-analysis
No
Intervention
No

Living systematic review
No
Meta-analysis
No
Methodology
No
Narrative synthesis
No
Network meta-analysis
No
Pre-clinical
No
Prevention
No
Prognostic
No
Prospective meta-analysis (PMA)
No
Review of reviews
No
Service delivery
No
Synthesis of qualitative studies
No
Systematic review
Yes
Other
No

Health area of the review

Alcohol/substance misuse/abuse
No
Blood and immune system
No
Cancer
No
Cardiovascular
No
Care of the elderly
No
Child health
No
Complementary therapies
No
COVID-19
No

Crime and justice
No
Dental
No
Digestive system
No
Ear, nose and throat
No
Education
No
Endocrine and metabolic disorders
No
Eye disorders
No

General interest
No
Genetics
No
Health inequalities/health equity
No
Infections and infestations
No
International development
No
Mental health and behavioural conditions
Yes
Musculoskeletal
No
Neurological
No
Nursing
No
Obstetrics and gynaecology
No
Oral health
No
Palliative care
No
Perioperative care
No
Physiotherapy
No
Pregnancy and childbirth

No
Public health (including social determinants of health)
No
Rehabilitation
No
Respiratory disorders
No
Service delivery
No
Skin disorders
No
Social care
No
Surgery
No
Tropical Medicine
No
Urological
No
Wounds, injuries and accidents
No
Violence and abuse
No

31. Language.

Select each language individually to add it to the list below, use the bin icon to remove any added in error.

English

There is not an English language summary

32. * Country.

Select the country in which the review is being carried out. For multi-national collaborations select all the countries involved.

England

33. Other registration details.

Name any other organisation where the systematic review title or protocol is registered (e.g., Campbell, or The Joanna Briggs Institute) together with any unique identification number assigned by them. If extracted data will be stored and made available through a repository such as the Systematic Review Data Repository (SRDR), details and a link should be included here. If none, leave blank.

Doctorate of Clinical Psychology, Division of Health Research, Lancaster University

34. Reference and/or URL for published protocol.

If the protocol for this review is published provide details (authors, title and journal details, preferably in Vancouver format)

Not applicable

Add web link to the published protocol.

Or upload your published protocol here in pdf format. Note that the upload will be publicly accessible.

No, I do not make this file publicly available until the review is complete

Please note that the information required in the PROSPERO registration form must be completed in full even if access to a protocol is given.

35. Dissemination plans.

Do you intend to publish the review on completion?

Yes

Give brief details of plans for communicating review findings.?

The findings will be presented in a thesis format, alongside an empirical research paper and critical analysis in partial fulfilment of the Doctorate in Clinical Psychology course, Lancaster University. The thesis will be made available online after a period of embargo. We intend to publish this review on completion, with target journals yet to be identified.

36. Keywords.

Give words or phrases that best describe the review. Separate keywords with a semicolon or new line. Keywords help PROSPERO users find your review (keywords do not appear in the public record but are included in searches). Be as specific and precise as possible. Avoid acronyms and abbreviations unless these are in wide use.

Meta-synthesis
Emergency department practitioners
Qualitative

37. Details of any existing review of the same topic by the same authors.

If you are registering an update of an existing review give details of the earlier versions and include a full bibliographic reference, if available.

Not applicable

38. * Current review status.

Update review status when the review is completed and when it is published. New registrations must be ongoing so this field is not editable for initial submission.

Please provide anticipated publication date

Review_Ongoing

39. Any additional information.

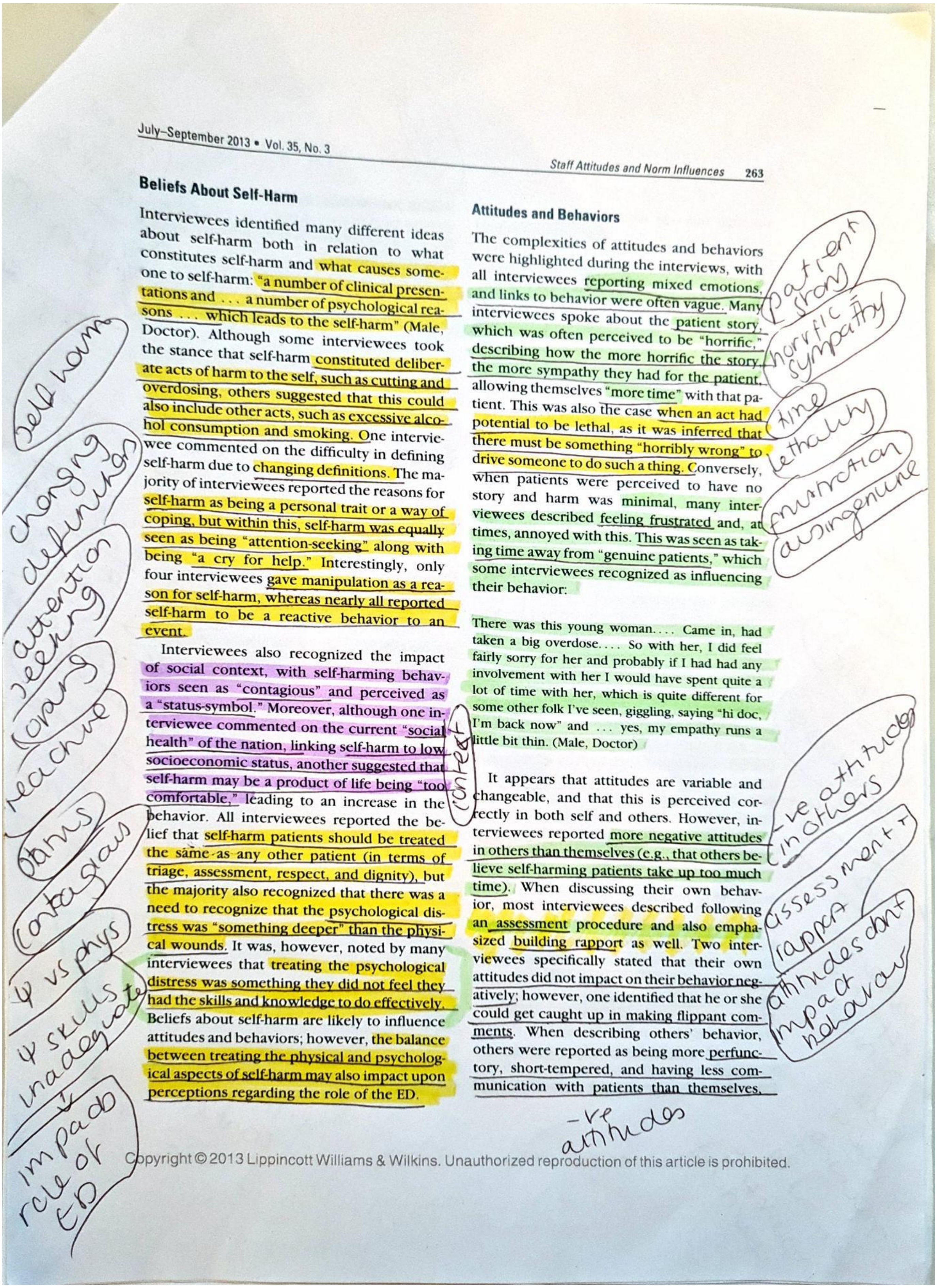
Provide any other information relevant to the registration of this review.

Not applicable

40. Details of final report/publication(s) or preprints if available.

Leave empty until publication details are available OR you have a link to a preprint (NOTE: this field is not editable for initial submission). List authors, title and journal details preferably in Vancouver format. Give the link to the published review or preprint.

Appendix 1-B: Example of two annotated papers (Artis & Smith, 2013; Vedana et al., 2017).



Beliefs About Self-Harm

Interviewees identified many different ideas about self-harm both in relation to what constitutes self-harm and what causes someone to self-harm: "a number of clinical presentations and . . . a number of psychological reasons . . . which leads to the self-harm" (Male, Doctor). Although some interviewees took the stance that self-harm constituted deliberate acts of harm to the self, such as cutting and overdosing, others suggested that this could also include other acts, such as excessive alcohol consumption and smoking. One interviewee commented on the difficulty in defining self-harm due to changing definitions. The majority of interviewees reported the reasons for self-harm as being a personal trait or a way of coping, but within this, self-harm was equally seen as being "attention-seeking" along with being "a cry for help." Interestingly, only four interviewees gave manipulation as a reason for self-harm, whereas nearly all reported self-harm to be a reactive behavior to an event.

Interviewees also recognized the impact of social context, with self-harming behaviors seen as "contagious" and perceived as a "status-symbol." Moreover, although one interviewee commented on the current "social health" of the nation, linking self-harm to low socioeconomic status, another suggested that self-harm may be a product of life being "too comfortable," leading to an increase in the behavior. All interviewees reported the belief that self-harm patients should be treated the same as any other patient (in terms of triage, assessment, respect, and dignity), but the majority also recognized that there was a need to recognize that the psychological distress was "something deeper" than the physical wounds. It was, however, noted by many interviewees that treating the psychological distress was something they did not feel they had the skills and knowledge to do effectively. Beliefs about self-harm are likely to influence attitudes and behaviors; however, the balance between treating the physical and psychological aspects of self-harm may also impact upon perceptions regarding the role of the ED.

Attitudes and Behaviors

The complexities of attitudes and behaviors were highlighted during the interviews, with all interviewees reporting mixed emotions, and links to behavior were often vague. Many interviewees spoke about the patient story, which was often perceived to be "horrific," describing how the more horrific the story, the more sympathy they had for the patient, allowing themselves "more time" with that patient. This was also the case when an act had potential to be lethal, as it was inferred that there must be something "horribly wrong" to drive someone to do such a thing. Conversely, when patients were perceived to have no story and harm was minimal, many interviewees described feeling frustrated and, at times, annoyed with this. This was seen as taking time away from "genuine patients," which some interviewees recognized as influencing their behavior:

> There was this young woman. . . . Came in, had taken a big overdose. . . . So with her, I did feel fairly sorry for her and probably if I had had any involvement with her I would have spent quite a lot of time with her, which is quite different for some other folk I've seen, giggling, saying "hi doc, I'm back now" and . . . yes, my empathy runs a little bit thin. (Male, Doctor)

It appears that attitudes are variable and changeable, and that this is perceived correctly in both self and others. However, interviewees reported more negative attitudes in others than themselves (e.g., that others believe self-harming patients take up too much time). When discussing their own behavior, most interviewees described following an assessment procedure and also emphasized building rapport as well. Two interviewees specifically stated that their own attitudes did not impact on their behavior negatively; however, one identified that he or she could get caught up in making flippant comments. When describing others' behavior, others were reported as being more perfunctory, short-tempered, and having less communication with patients than themselves.

self harm

changing definition

attention seeking

coping

reactive

status

contagious

ψ vs phys

ψ skills inadequate

↓

impacts role of ED

context

patient story

horrific sympathy

time

lethality

frustration

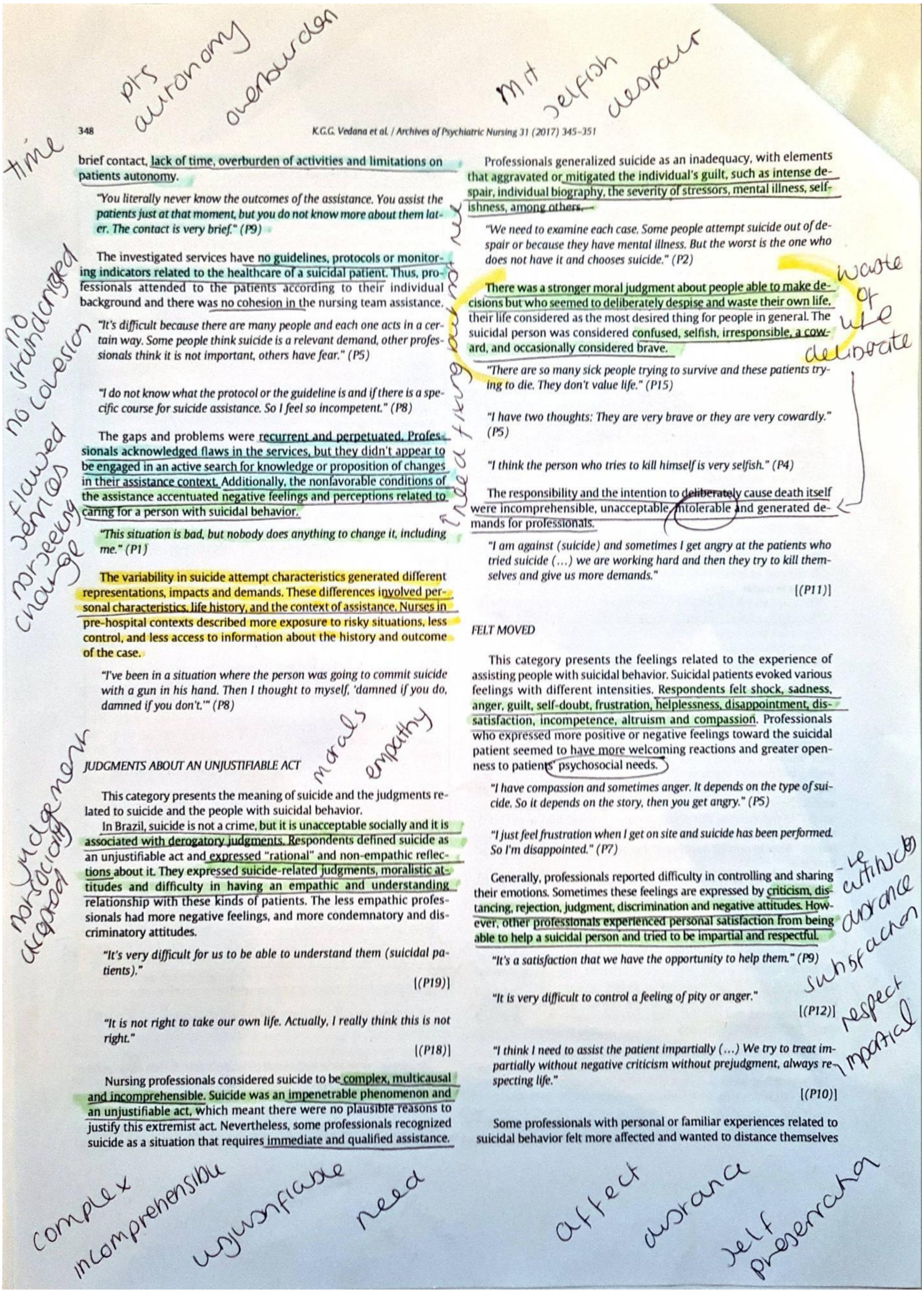
disingenuine

-ve attitudes in others

assessment + rapport

attitudes don't impact behaviour

-ve attitudes



pts autonomy overburden

MH selfish despair

time

brief contact, lack of time, overburden of activities and limitations on patients autonomy.

> "You literally never know the outcomes of the assistance. You assist the patients just at that moment, but you do not know more about them later. The contact is very brief." (P9)

The investigated services have no guidelines, protocols or monitoring indicators related to the healthcare of a suicidal patient. Thus, professionals attended to the patients according to their individual background and there was no cohesion in the nursing team assistance.

> "It's difficult because there are many people and each one acts in a certain way. Some people think suicide is a relevant demand, other professionals think it is not important, others have fear." (P5)

> "I do not know what the protocol or the guideline is and if there is a specific course for suicide assistance. So I feel so incompetent." (P8)

The gaps and problems were recurrent and perpetuated. Professionals acknowledged flaws in the services, but they didn't appear to be engaged in an active search for knowledge or proposition of changes in their assistance context. Additionally, the nonfavorable conditions of the assistance accentuated negative feelings and perceptions related to caring for a person with suicidal behavior.

> "This situation is bad, but nobody does anything to change it, including me." (P1)

no standardised

no cohesion

flawed services

not seeking change

need a fixing but not me

The variability in suicide attempt characteristics generated different representations, impacts and demands. These differences involved personal characteristics, life history, and the context of assistance. Nurses in pre-hospital contexts described more exposure to risky situations, less control, and less access to information about the history and outcome of the case.

> "I've been in a situation where the person was going to commit suicide with a gun in his hand. Then I thought to myself, 'damned if you do, damned if you don't.'" (P8)

JUDGMENTS ABOUT AN UNJUSTIFIABLE ACT

morals empathy

judgement

not socially accepted

This category presents the meaning of suicide and the judgments related to suicide and the people with suicidal behavior.

In Brazil, suicide is not a crime, but it is unacceptable socially and it is associated with derogatory judgments. Respondents defined suicide as an unjustifiable act and expressed "rational" and non-empathic reflections about it. They expressed suicide-related judgments, moralistic attitudes and difficulty in having an empathic and understanding relationship with these kinds of patients. The less empathic professionals had more negative feelings, and more condemnatory and discriminatory attitudes.

> "It's very difficult for us to be able to understand them (suicidal patients)."
>
> [(P19)]

> "It is not right to take our own life. Actually, I really think this is not right."
>
> [(P18)]

Nursing professionals considered suicide to be complex, multicausal and incomprehensible. Suicide was an impenetrable phenomenon and an unjustifiable act, which meant there were no plausible reasons to justify this extremist act. Nevertheless, some professionals recognized suicide as a situation that requires immediate and qualified assistance.

complex incomprehensible unjustifiable need

Professionals generalized suicide as an inadequacy, with elements that aggravated or mitigated the individual's guilt, such as intense despair, individual biography, the severity of stressors, mental illness, selfishness, among others.

> "We need to examine each case. Some people attempt suicide out of despair or because they have mental illness. But the worst is the one who does not have it and chooses suicide." (P2)

There was a stronger moral judgment about people able to make decisions but who seemed to deliberately despise and waste their own life, their life considered as the most desired thing for people in general. The suicidal person was considered confused, selfish, irresponsible, a coward, and occasionally considered brave.

waste of life

deliberate

> "There are so many sick people trying to survive and these patients trying to die. They don't value life." (P15)

> "I have two thoughts: They are very brave or they are very cowardly." (P5)

> "I think the person who tries to kill himself is very selfish." (P4)

The responsibility and the intention to deliberately cause death itself were incomprehensible, unacceptable, intolerable and generated demands for professionals.

> "I am against (suicide) and sometimes I get angry at the patients who tried suicide (…) we are working hard and then they try to kill themselves and give us more demands."
>
> [(P11)]

FELT MOVED

This category presents the feelings related to the experience of assisting people with suicidal behavior. Suicidal patients evoked various feelings with different intensities. Respondents felt shock, sadness, anger, guilt, self-doubt, frustration, helplessness, disappointment, dissatisfaction, incompetence, altruism and compassion. Professionals who expressed more positive or negative feelings toward the suicidal patient seemed to have more welcoming reactions and greater openness to patients' psychosocial needs.

> "I have compassion and sometimes anger. It depends on the type of suicide. So it depends on the story, then you get angry." (P5)

> "I just feel frustration when I get on site and suicide has been performed. So I'm disappointed." (P7)

Generally, professionals reported difficulty in controlling and sharing their emotions. Sometimes these feelings are expressed by criticism, distancing, rejection, judgment, discrimination and negative attitudes. However, other professionals experienced personal satisfaction from being able to help a suicidal person and tried to be impartial and respectful.

-ve attitudes

distance

satisfaction

respect

impartial

> "It's a satisfaction that we have the opportunity to help them." (P9)

> "It is very difficult to control a feeling of pity or anger."
>
> [(P12)]

> "I think I need to assist the patient impartially (…) We try to treat impartially without negative criticism without prejudgment, always respecting life."
>
> [(P10)]

Some professionals with personal or familiar experiences related to suicidal behavior felt more affected and wanted to distance themselves

affect distance self preservation

Appendix 1-C: Statement of Contributions in Accordance with The British Journal of Health Psychology

What is already known on this subject?

- People with self-harm behaviours experience significant barriers in accessing community care
- Quantitative research indicates ED clinicians can hold negative attitudes towards people who had self-harmed

What does this study add?

- A qualitative synthesis of research relating to the ED clinicians' views towards people who had self-harmed.
- A need for training and supervision for staff wellbeing, to reduce stigmatising attitudes and improve patient care.

Appendix 1-D – Notes for Contributors to the Authors for ‘The British Journal of Health Psychology’

2. AIMS AND SCOPE

The British Journal of Health Psychology publishes original research on all aspects of psychology related to health, health-related behaviour and illness across the lifespan including:

- experimental and clinical research on aetiology
- management of acute and chronic illness
- responses to ill-health
- screening and medical procedures
- psychosocial mediators of health-related behaviours
- influence of emotion on health and health-related behaviours
- psychosocial processes relevant to disease outcomes
- psychological interventions in health and disease
- emotional and behavioural responses to ill health, screening, and medical procedures
- psychological aspects of prevention

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

The types of paper invited are:

- papers reporting original empirical investigations, using either quantitative or qualitative methods, including reports of interventions in clinical and non-clinical populations.
- theoretical papers which report analyses on established theories in health psychology;
- we particularly welcome review papers, which should aim to provide systematic overviews, evaluations, and interpretations of research in a given field of health psychology (narrative reviews will only be considered for editorials or important theoretical discourses); and
- methodological papers dealing with methodological issues of particular relevance to health psychology.

Authors who are interested in submitting papers that do not fit into these categories are advised to contact the editors who would be very happy to discuss the potential submission.

Papers describing quantitative research (including reviews with quantitative analyses) should be no more than 5000 words (excluding the abstract, reference list, tables, and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures, and references). In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

All systematic reviews must be pre-registered. The pre-registered details should be given in the methods section but blinded for peer review (i.e., 'the review was preregistered at [BLINDED]'); the details can be added at proof stage. Registration documents should be uploaded as title page files when possible, so that they are available to the Editor but not to reviewers.

Please refer to the separate guidelines for **Registered Reports**.

COVID-19 Research

The BJHP has received an overwhelming number of COVID-19 related submissions. We can only consider papers that are providing new and novel data on COVID-19. We particularly welcome submissions of intervention studies. Furthermore, rapid peer review for COVID-19 submissions has now ended. COVID-19 papers will now be handled alongside other standard submissions.

4. PREPARING THE SUBMISSION

Free Format Submission

British Journal of Health Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures, or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at **https://www.editorialmanager.com/bjhp/default.aspx** and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; statement of contribution; main text file; figures/tables; supporting information.

Title Page

You may like to use **this template** for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips).
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
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- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Authorship

Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the **Project CRediT** website for a list of roles.

Abstract

For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. As the abstract is often the most widely visible part of your paper, it is important that it conveys succinctly all the most important features of your study. You can save words by writing short, direct sentences. Helpful hints about writing the conclusions to abstracts can be found **here**.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Statement of Contribution

All authors are required to provide a clear summary of 'what is already known on this subject?' and 'what does this study add?'. Authors should identify existing research knowledge relating to the specific research question and give a summary of the new knowledge added by your study. Under each of these headings, please provide 2-3 (maximum) clear outcome statements (not process statements of what the paper does); the statements for 'what does this study add?' should be presented as bullet points of no more than 100 characters each. The Statement of Contribution should be a separate file.

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files, but they must be mentioned in the text.

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

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Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

RUNNING HEAD: FUNCTIONAL SEIZURES IN THE EMERGENCY DEPARTMENT

Section 2: Empirical Research Paper

Functional Seizures in the emergency department: the perspectives and experiences of emergency department consultants

Doctorate in Clinical Psychology

Lancaster University

2019 Cohort

Word Count: 7,997

Prepared in accordance with Instructions for Authors for 'The British Journal of Health Psychology

Abstract

Objectives

This paper aimed to explore the perspectives of emergency department (ED) consultants working with people with functional seizures (FS). Exploring consultant perspectives and experience is imperative given their leadership role in the ED, and their perspectives are underrepresented in functional seizure literature.

Design

This research was of qualitative design and used reflective thematic analysis to analyse the accounts of ED consultants.

Methods

Eight ED consultants were interviewed using a semi-structured qualitative approach. Inclusion criteria were: 1) be aged 18 or over, 2) be employed as a consultant (or training) in the ED (or previously from recruitment phase two) and 3) have direct experience in caring for people with FS in ED. The data set was transcribed verbatim.

Results

Three themes were constructed: “fast-paced and evidence-based: The personality of the ED and the consultant”, “how FS is conceptualised” and “systemic pressures”.

Conclusion

It is now clear that caring for FS in the ED can directly challenge the professional identity and innate medical instincts of ED consultants. The systemic pressures on the ED also restrict care they are able to provide. Clinical implications include further training and development for ED professionals, evidence for the role of clinical psychology in the ED and suggestions of future research. This research also highlights areas where care pathways could be improved through multidisciplinary working. Also, development of national guidance for managing FS in the ED is imperative.

Keywords:

Non-epileptic attack disorder, NEAD, psychogenic non-epileptic seizures, PNES, conversion disorder, pseudo-seizures, functional seizures, emergency department

Introduction

Functional Seizures (FS), also known as nonepileptic attacks, dissociative seizures or psychogenic nonepileptic seizures, are episodes of paroxysmal disturbance in an individual's movements, consciousness, sensations, or experience (Bodde et al., 2009). These abrupt events often resemble epileptic seizures but occur in the absence of any known electrophysiological changes in brain activity and without any other direct somatic causal factors e.g., cardiac disease (Bodde et al., 2009). The majority of individuals have convulsive movements, while an estimated 30% of FS resemble fainting or loss of consciousness (Finkelstein et al., 2021).

Commonly reported with the 'psychogenic' prefix, these episodes are largely understood as a physiological response to distressing psychological stimuli (Robson & Lian, 2017) and are defined in the Diagnostic and Statistical Manual for Mental Health (5th edition; American Psychiatric Association [APA], 2013) as "somatic symptom and related disorders". However, the psychological and neurobiological processes underpinning FS remain unclear and there is no universally accepted model to understand the presentation, which has considerable heterogeneity and complexity (Rawlings & Reuber, 2016).

Ertan et al. (2021) categorise FS risk factors into three main areas: 1) psycho-social e.g., trauma, alexithymia, or relational difficulties, 2) biological e.g., brain and physical injury or co-occurring epilepsy, and 3) cognitive impairment e.g., working memory and attentional deficits. There is strong evidence that difficulties with emotional regulation, reactivity, and cognitive-emotional processing can increase vulnerability to FS; particularly avoidance of shameful experiences, high prevalence of reported anxiety, stress and depression, and traumatic early experiences (Roberts et al., 2020; Rosales et al., 2020).

This level of complexity presents challenges for professionals, particularly distinguishing the FS from epilepsy, and management of other co-occurring psychological difficulties. Certain observable characteristics such as onset, duration, and cessation of seizures can support professionals in their differentiation, with a recent move to positive diagnosis rather than a diagnosis of exclusion (Anderson et al., 2019; Lehn et al., 2016). However, despite recent advances, the journey to diagnosis remains challenging and lengthy, averaging seven years (O'Sullivan et al., 2006; Mayor et al., 2011).

Individuals with FS report confusion and frustration at 'normal' outcomes of medical investigations despite continued distress and significant impact on daily functioning (Rawlings et al., 2017b; Rawlings & Reuber, 2016). The confusion and frustration experienced by people living with FS can often lead them to feel uncertain or reject the FS diagnosis, and often report feeling unheard and "misunderstood" (Robson & Lian, 2017, p. 9) and being an "enigma" to the medical community (Rawlings & Reuber, 2016, p. 101). This can create perceived tension in interactions with HCPs, both for the professional and person accessing care (Rawlings & Reuber, 2016; Rawlings et al., 2018; Dunne et al., 2019).

While living with the FS is challenging for those with the condition, HCPs can also experience difficulties in knowing how best to help. Rawlings and Reuber (2018) conducted a key systematic literature review to explore HCPs' attitudes and perspectives to FS, incorporating neurologists and epilepsy specialists, medical and mental health professionals, and social workers. Their main findings were that HCPs experience uncertainty and frustration regarding FS. HCPs also attributed FS to psychological causes and conceptualised FS alongside other mental health diagnoses. This could have led to reported professional diffusion of responsibility. Finally, HCPs believed FS had an element of patient control and were less life limiting than epileptic seizures. These attributions were more prevalent in less specialised professions, but still evident in most (Rawlings & Reuber, 2018). Barnett et al. (2020) extended this research by reporting fear experienced by HCPs, in fear of offending the patient and trying to preserve the therapeutic alliance.

These challenges experienced by HCPs can also contribute to the perceived stigma commonly experienced, as 87% of people living with FS reported stigmatising experiences, which was found to be 42% higher than individuals with epilepsy (Rawlings et al., 2017a; Robson et al., 2018). The impact of the stigma for people living with FS is significant, as it is correlated with poorer quality of life, emotional wellbeing, social functioning, and greater worry about FS (Robson et al., 2018). Stigmatising experiences from healthcare professionals ultimately perpetuates patients' unmet needs, preventing access to appropriate care and exacerbates distress (MacDuffie et al., 2021).

Furthermore, the interplay of professional uncertainty, apprehension, and diffusion of responsibility can create a "vicious cycle" whereby the patients receive suboptimal care, which perpetuates their difficulties (Barnett, et al., 2020, p. 7). This leaves individuals living with FS no option but to frequently attend the emergency department (ED) to manage their FS (Reuber, 2019; Reuber et al., 2005). However, the difficulties in accurately diagnosing FS persist there too, with nearly 50% of prolonged and recurrent FS cases being misdiagnosed as epileptic (Lehn et al., 2021). In a retrospective analysis of ED medical records, Kholi and Vercueil (2020) reported that over 48 diagnostic terms for FS were used in the ED, describing the diagnostic process as "unclear" and "confusing" (p. 1). These challenges can result in ineffective, or even harmful treatment with antiepileptic or sedative medication (Cock & Edwards, 2018).

Rawlings and Reuber's (2018) review included two quantitative papers which incorporated perceptions of emergency care staff (Shneker & Elliot, 2008; Worsley et al., 2011). Findings showed that uncertainty was a common experience for ED HCPs dealing with FS, particularly around identifying and communicating the diagnosis, terminology, causal factors, and use of antiepileptic medication. Perceived volition was also a factor, as ED staff often attributed individual control over FS. Shneker and Elliot (2008) and Worsley et al.

(2011) provided some insight into ED staff views, however, a qualitative exploration would offer a deeper and richer understanding of the of ED practitioners' views and experiences.

Therefore, the aim of this paper is to use qualitative methodology to explore the perceptions of ED consultants working with people with FS. In particular it will investigate the medical practitioners' views, bearing in mind the experiences of people with FS, including stigma. ED consultants hold leadership, managerial and gatekeeping roles for patient pathways, which has significant impact on care for individuals with FS. The nuanced understanding provided by qualitative work, could help highlight professional and departmental needs required to provide effective care for people with FS.

Method

Design

This research adopted a qualitative design, with data collected through semi-structured interviews. This design was adopted to allow a non-judgmental exploration of potentially emotive topics, reflecting on attitudes, perspectives, and experiences. All interviews were held via video or telephone calls, a design often used in qualitative data collection particularly working with the COVID-19 pandemic (de Villiers et al., 2021). It was important to the study design to include a stakeholder perspective, to ensure the appropriate language was used to optimise engagement with this cohort of professionals. Therefore, an ED consultant and a clinical psychologist (CP) who specialised in FS were involved with the project and advised on the design, recruitment documentation, interview topic guide and write up of this research. The topic guide was developed with three areas of focus: 1) Experience caring for people with FS in the ED, 2) Consultants' conceptualization of FS, and 3) Systemic challenges that may impact their work. The topic guide was informed by quantitative literature (Shneker & Elliot, 2008; Worsley et al., 2011) other professionals' perspectives (Rawlings and Reuber, 2018), the experience of individuals with FS in the ED, including stigma (Robson & Lian, 2017; Rawlings et al., 2017b) and discussions with the ED stakeholder.

The original study design aimed to recruit 15-20 professionals working within the ED, including all grades of medical and nursing staff (see Ethics: Section 4). However, only ED consultants expressed interest in participating and thus the research focus became their experiences alone (this is discussed further in the critical appraisal). Braun and Clarke's (2019) reflexive thematic analysis (RTA) was identified as the most appropriate analysis methodology and was accepted over earlier iterations of thematic analysis to account for the researcher's position within the data. The concept of 'information power' introduced by Malterud et al. (2016) was used to determine sample size, which is accepted as suitable within RTA (Braun & Clarke, 2021). Given the homogeneity of participants, depth and quality of data collected and relatability to the aims of the paper, information power was achieved at eight participants.

Participants

There were three inclusion criteria applied; participants had to 1) be aged 18 or over, 2) be employed (or previously employed in recruitment phase two) as a consultant or training in this role within the ED[1], and 3) have direct experience in caring for people with FS in the ED. Participants self-reported their compliance with the inclusion criteria. Eight participants were recruited with between 5 and 21 years of experience in the role, (average of 11.4 years' experience, seven qualified consultants and one specialist training, all currently practicing).

Recruitment

A three-phase recruitment strategy was employed to maximise relevancy and recency of participant experience, and to ensure the most robust and rich data was received. Recruitment materials consisted of a participant information sheet and consent form (see

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[1] The original criteria for the study welcomed any grade of staff in the ED, but for the current paper the criterion is that they were ED consultants only.

Ethics: Section 4).

1. The first phase involved direct involvement with three participating NHS trusts in the Northwest of England. At each site, we worked with an individual CP or ED consultant involved as a local collaborator to support recruitment in their workplace. Dissemination of recruitment materials were through workplace emails, at handovers, and through advertisements in the department.
2. The second stage employed snowball sampling techniques to allow for wider networking to support recruitment, extending the invitation to participate, to individuals who had previous experience working with this patient population.
3. The third stage opened recruitment to professional platforms accessed through social media networks (e.g., Twitter) and involved approaching professional bodies, e.g., The Royal College of Emergency Medicine.

Data Collection and Analysis

Prospective participants indicated interest in the research through direct contact with the lead researcher, who then formally invited them by sharing the recruitment material via email. All consent was received electronically, prior to interviews. Once established, a mutually suitable time was arranged and the researcher shared an invitation via Microsoft Teams. Interviews lasted approximately 1 hour (range 53-81 minutes), and all were completed in one session. All interviews were recorded using a Dictaphone and transcribed verbatim using transcription software and by hand.

Although there are clear stages defined within RTA, the process is considered recursive. Braun and Clarke (2019) defined ‘familiarisation’ with the data set as the first analysis stage. The researcher familiarised and immersed oneself in the data through the verbatim transcription process, which required frequent listening and reading the data. The second phase of analysis was defined as ‘coding’ the data set, where ‘codes’ are developed across the data set. The researcher engaged with this phase by printing the written transcripts and annotating the codes by hand. The researcher colour coded each participant and transferred the analysis codes to colour flash cards. The next stage required collation of the ‘codes’ to construct themes across the data.

A theme is a pattern of codes grouped together by meaning which relates to the research question (Braun and Clarke, 2006). The researcher collated the code cards based on meaning, which generated 21 areas of interest in the data. These were then further collated to construct five themes. The researcher then tested and reviewed the five themes by revisiting examples within the data set, and further defined the final three key themes as reported in this paper. This is particularly key in RTA, as themes are informed by both the data and the theoretical knowledge of the researcher. The final phase was writing the analysis, which consolidated interpretation of themes and their place within the wider context and existing literature (Braun et al., n.d). See appendix 2-A for the trainee’s practical application of RTA. The researcher sought supervision throughout this process, which extended interpretation of the data and enhanced connection to the wider narrative. Consensus amongst researchers is not strived for in RTA, as the process is considered collaborative and designed to generate a “richer, more nuanced reading of the data set” (Braun & Clarke, 2019).

Quality in Qualitative Research

The researcher employed procedures offered by Yardley (2000; 2017), to determine and demonstrate high quality research was presented. The researcher was sensitive to the context of this paper, given the prior exploration of existing literature and theory, incorporating stakeholder perspective and use of supervision to reflect on language and social context around FS and ED independently. The researcher remained committed to this approach and adopted a rigorous data collection and analytic process (Yardley, 2017).

Reporting of data sufficiency is also noted as a quality marker in qualitative research, despite this not being commonly adopted (Vasileiou, Barnett, Thorpe & Young, 2018). This paper offered a transparent presentation of the research, with examples of coded data (Appendix X) and with its limitations discussed. Arguably, the research also generated a meaningful understanding of the participants' experience and contributed to existing literature.

Reflexivity

The researcher was interested to explore this topic through reading the literature around both patient and staff experiences of FS and motivated by subjective accounts of a supervisor's experience when working in the ED. Therefore, the researcher brought a theoretical understanding of stigma in FS, the challenges faced by HCPs and anecdotal awareness of ED contextual pressures. Supervision was sought to reflect on the researcher's position within the dataset to remain impartial and open to all participants' experiences. Supervision was also used to help present a balanced and nuanced understanding of the socio-cultural context that incapsulates this data, including the impact this may have had on FS conceptualisation.

Ethical Considerations

This research was approved by the Faculty of Health and Medicine Research Ethics Committee (FHMREC) and the NHS Health Research Authority. The local research and development department of each direct ED site further approved this research.

Findings

Three themes were constructed through application of RTA: 1) Fast-paced and evidence-based: The personality of the ED and the consultant 2) How FS are conceptualised and 3) Systemic pressures. See Table 2-A for participant theme contributions and Figure 2-A for the thematic diagram.

Theme One: Fast-paced and evidence-based: The personality of the ED and the consultant

Participants explained that the ED attracts certain consultant personality types i.e., those who favour fast-paced, time-effective interventions grounded in a structured, evidence-based approach (subtheme one). Along with personality, participants' own beliefs and emotional experiences (subtheme one) are also entwined in their perception of their role in caring for individuals with FS (subtheme two), with helplessness and frustration commonly reported.

1. How ED Consultants are trained to think in the ED

The participants discussed their perceived role within the ED, with six out of eight participants commenting on aspects such as leadership and managerial support, the co-ordination of decision making and risk assessment, prioritising patients based on need and importance of treating the most serious cases with quick effective interventions, using a structured approach. This was summarised by Matthew's typical description as "what is the diagnosis, rule out the serious pathology, erm, and then intervene", highlighting the idealised fast-paced patient flow in the department and goal to preserve life. In order to achieve this flow, John reported that they apply simple protocols for complex work, where deviations from "pragmatic management plans" came with experience.

Moreover, Louise reflected that ED professionals "like quick fixes, we like to do something quickly and move on, we lose interest if it takes too long, that's just our own personalities". Also pertinent to their role perception was their personal characteristics, described as "a certain breed of individual, who score strongly in the extrovert scale" (Matthew) and "a sub clinical form of ADHD" [attention deficit hyperactivity disorder] and "needing unpredictability to feel engaged" (Anne). Additionally, Nigel added that "I think we don't like uncertainty. We don't like something that there's no blood test for". Caring for FS presentations could directly challenge the ED ethos and approach. Louise explained “most emergency physicians don't like that sort of patients, erm, ‘cause it's hard, we can't fix them, we can't, you know, move them on quickly”.

This helplessness, along with frustration was a common experience throughout the dataset: “we feel that we that we don't have the ability to do anything about it and that kind of, erm, that that that makes us feel inadequate” (Nigel). This likely impacts the attitudes towards individuals with FS, as Louise reflected “our automatic emotion towards that patient is negative, erm and sometimes judgmental in a negative way”. Nigel was driven by frustration to learn more about the presentation, whilst Anne felt “it's unproductive to get frustrated”. Oliver felt frustration was a thief of job satisfaction, as it was “very easy to blame somebody to feel as though they are wasting your time”, but “you feel like you are not doing a very good job”.

2. The ED consultant’s perceived role in caring for the FS patient

All participants agreed on a “hands-off” approach to “de-escalate” and “calm” patients, relatives, and staff, when a FS was confirmed. The framing of this approach differed with one participant saying they would “ignore” the patient and others reported to adopt a passive “laissez-faire” (John & Tim) approach to allow the seizure episode to stop, with observation as the main intervention. However, some participants reframed de-escalation and prevention of triggering further episodes as an active intervention. For example, Louise said they would proactively remove medical involvement and personnel, isolating sensory input, even if this went against the usual medical instinct (subtheme 1).

Whether adopting a passive or active management approach, most participants felt reassuring patients and validating their experience with compassion was necessary (Hannah, Nigel, Louise, Tim & Matthew). Tim shared personal qualities in their approach they had found to be effective:

> “I'm being, open and kind and thoughtful and trying to calm them down, hopefully it's enough for them to realize that someone cares, someone’s listening, and my thoughts are being heard”.

Tim believed this narrative is often unheard by individuals with FS and how powerful this message is in their care. By using this compassionate approach, Matthew, Hannah, and Louise were placed in a specialist position by colleagues, claiming Matthew had a “magic touch”, and that patients “need a touch of” Hannah. Hannah attributed this to confidence in their communication and ability to hold difficult conversations.

However, despite this being the optimal approach described by some participants, there were many sources of uncertainty when treating individuals with FS. Firstly, participants explained there is no national pathway, and no evidence base or best practice guidance to support the ED practitioner (Hannah, Louise, Matthew & John). Second, the diagnosis of FS itself can be uncertain and it can be hard to differentiate it from epilepsy, meaning senior staff took the lead in assessing patients with FS. Hannah discussed “every day you think is it safer to treat the patient with lots of benzodiazepines as if they're having a true seizure? Or is it safer to just wait it out even when you're really convinced, it's really hard”. As a result of the uncertainty, John described a cautionary approach: “err on the side of caution and probably over treat and over investigate”,

This is evidently a very difficult decision-making process to navigate and is against the professional doctrine of avoidance of the potential to cause serious harm. Tim saw more far-reaching consequences of this over-treatment by adding their role is:

> “To make sure that people aren't unnecessarily

> investigated, treated medicalized erm and investigated and sort of put further into system and told there's something like really, really wrong with them, erm because then that they become their condition and that dictates their help seeking behaviour and generally by being part of the system, they don't develop any of their own coping strategies”.

This is suggestive of a ‘gatekeeper’ role in the ED, in providing necessary care to those that need it but in FS preventing unnecessary admissions as this may perpetuate illness perceptions for the individual living with FS. This quote considers the patients’ dependency on the ED, as they would not adopt any alternative, more effective coping mechanisms.

Theme Two: How FS are conceptualised

This theme captured how ED consultants understood and worked with complexity. This includes understanding the patient presentation and working with complexity (subtheme one), and also development and learning achieved through language and communication (subtheme two), and how shifts in the latter can influence the conceptualisation of FS significantly.

1. Understanding the patient presentation and working with complexity

All participants commented on the complexities inherent in understanding FS. Three participants shared their experience of difficulty in understanding FS, in not knowing what drives the FS symptoms. The lack of a universal model when compared to a physical condition such as epilepsy was noted (Oliver), whereas John likened the complexity to mental health difficulties leading to suicide attempts, where lived experience was key: “there are some concepts, you just don’t understand unless you are in the position”.

However, five of the eight participants had developed a more cohesive understanding of FS, believing it to be linked to distressing life events, traumatic experiences, physical illness, brain injury, or bereavement. Most importantly, of these five participants, four viewed FS as a physical manifestation of psychological distress, with some nuanced understanding of coping mechanisms and withdrawal from adverse stimuli. Louise reflected this is not always within the patient's conscious awareness, which is extended by Hannah's anecdotal interpretation: "if people can identify something that helps with the 'why me' it sometimes helps them stop a little bit quicker. I don't know if there's actually any evidence for that or if that's just a gut feeling". This is suggestive that the participant believed that the length of seizure is possibly extended when the patient does not recognise their own triggers. This comment also reinforces the uncertainty and lack of universal guidance for this patient cohort, with clinicians leading with their gut instinct, which again could be jarring to their professional identity.

FS were also conceptualised within the broader mental health presentations attending the ED, such as recurrent self-harm or overdose, substance use, and personality disorder (PD) (Louise, Nigel, Matthew & John). Louise described "trauma interruption in their emotional development in their formative years" as similar triggers both for FS and people who have a PD diagnosis, suggesting in both conditions such early life experiences would impact emotional regulation development. Tim corroborated this perspective by adding that people with FS were "poorly wired for modern life" as a result of social circumstances, with an inability to express their distress and a lack of voice in a broken system. This viewpoint was considered particularly relevant for urban areas, where deprivation and expression of identity was considered paramount to Tim. Six participants also conceptualised FS alongside 'medically unexplained symptoms'. Matthew felt people get "lumped into this group where people get, I don't want to say bad care, but people may not get the most appropriate care, erm because of a label".

2. Developing understanding through language and communication

Participants reflected that their knowledge and understanding of FS had developed over time, and their knowledge had been updated through exposure and experience. The language used was felt to be important, as it was commonly recognised that FS is not a new presentation within the ED environment. Most participants recognised that non-epileptiform terminology is an updated 'label' for the previously acknowledged 'pseudo-seizures'. Participants rejected the latter as a pejorative and unacceptable term in modern practice. Matthew acknowledged how "frequent attenders" is now favoured as is "high intensity users" for the same reasons. Most participants conceptualised FS patients within a high intensity user framework in the department, whereas others rejected this and felt they were not clinically prevalent (Oliver & Anne).

Despite the consensus to reject the term "pseudo-seizures", the consultants' own conceptualisations were not always clear. For example, when working with a patient Matthew reported "I kind of make it seem like it was a real thing", suggestive of validating the experience to the individual with FS, but not internalising this belief themselves. Other participants also potentially demonstrated this belief when comparing FS against "true" epilepsy (John, Hannah & Tim) or naming FS as "funny dos" (Hannah).

Findings in Theme One indicated that reassuring communication is the preferred intervention, however, some participants undervalued this based on their conceptualisation of FS. John felt these opportunities were futile and personally avoided it due to lack of "teachable moments" in FS, when compared to people accessing ED care for extensive alcohol use for example, where the impact of attending the ED was stark and prevented further admissions. This was suggestive of a possible conceptualisation of personal control over the seizures and the opportunity to have a meaningful impact is lost. Whilst others embraced the opportunities, some felt helpless to make meaningful change: “trying to remove a trigger in their life at home when you have four hours in A&E, it’s not going to happen” (Matthew). Others, who conceptualised trauma as a trigger factor, were reluctant to address this in the ED, through fear of triggering further FS, re-traumatising these people or they felt they did not have the necessary skills (Hannah & John). Oliver noticed that reluctance was reciprocated in patient interactions, as patients do not report trauma and consultants don’t explore this: “it wouldn't be the immediate connection between past trauma and an epileptic seizure. That's not what we do, it's not what you're trained to think about”. This highlighted a potential need for updated training on FS, as the current conceptualisation jarred with the ED consultant’s professional identity and approach.

Theme Three: Systemic Pressures

This Theme describes the pressures and challenges participants experience in their everyday practice. Systemic stigma (subtheme one) captures participants’ experience of pejorative attitudes to individuals with FS, and how gaps in care pathways can perpetuate this stigmatised systematic response. The Paradox of the ED: “it’s not a place to be when you’re unwell” (subtheme two) relates to the systemic pressures imposed on the ED currently, with participants reporting this is not an environment conducive to patient and staff wellbeing and could further perpetuate the systemic stigma.

1. Systemic stigma

Louise explained team attitudes of “we've got real patients to see”, and John reflected on hierarchical culture in nursing which could make challenging these attitudes and “group think” mindsets difficult at times. Louise also considered how staff withheld empathic care towards FS and mental health presentations, grounded in a misattribution that being kind would increase attendance at the ED.

Participants also described that junior doctors often internalised such attitudes from direct close experience with nursing staff, which could be hard to challenge given high turnover of their role through training placements. Participants also spoke of generational stigmatising responses through experiential learning from their senior colleagues when first exposed to FS and this being the embedded learning procedure for the ED; “I suppose I've been conditioned by what I’ve seen around me, modelled by my seniors, which is a very like these are waste of time patients, they’re you know making it up” (Louise). Whilst some participants had updated their view, reflecting on their previous perspective generated feelings of “guilt” (Matthew & Louise), in originally accepting this viewpoint and they reflected that there is no “corrective mechanism” (Louise) for this learning process.

Systemic stigma was also perpetuated along the care pathway through professional diffusion of responsibility. Hannah explained that the medical teams were reluctant to admit individuals with FS to hospital from the ED, despite sometimes there being a medical need for continued monitoring. This hinders access to appropriate care from wider services such as neurology, mental health [mental health liaison was only perceived to focus on self-harm, suicide, and PD in the ED], and epilepsy specialists, as these do not feed into direct care in the ED. Participants perceived that other disciplines e.g., neurology and epilepsy specialists express annoyance at numerous FS referrals; while they acknowledged gaps in care pathways, participants reported they were offered no support to address this. Therefore, participants concluded that you could not “blame” any patient for attending the ED, as Nigel commented “there's less places to actually attend if you're not [well mentally] because if you're in crisis, there's bloody hell, there's nowhere else you can go. So where would you wait with every door shut for you”.

Despite having previously held stigmatising attitudes, participants’ personal interest and passion led the majority to have developed a greater understanding of FS, achieved through guided learning, multidisciplinary working, soft CPD experiences with consultant colleagues and other disciplines, and general maturation as a clinician. Participants then worked hard to address stigma and negative attitudes in their departments through developing internal training opportunities and direct sharing of knowledge, grounded in trust and respect from their colleagues.

2. The Paradox of the ED: “it’s not a place to be when you’re unwell”

Most participants commented on the challenging context they were practising in at the time of interview; Anne described that the “appalling” conditions for patients were the “worst” they had experienced since qualifying, and John added it was a “chaotic” and “threatening” place, which Matthew likened the ED to “battlefield medicine”. Louise reported that the “the actual physical environment is very intrusive erm and quite oppressive at times and that’s even just for staff”. Oliver extended this by explaining “the ability to care for people is compromised and I think that’s measurably damaging for staff and patients”, resulting in “moral injury” (Louise).

When exploring this challenging environment further, time and space were consistently reported as the biggest source of stress. Additional sources were lack of privacy, limited resources to fulfil the basics of their role, ineffective information technology systems, and no headspace for reflection (John, Hannah, Louise, Oliver). These issues also inhibited space for professional development and updating learning, reported by John as challenging but essential in maintaining best practice. These pressures were also compounded by feeling helpless and dependent on the environment. Hannah reflected that these challenges were particularly acute when caring for the FS patient. For example, while isolating sensory stimulus may be an effective intervention, that was near impossible in a chaotic ED. Furthermore, lack of privacy limited the confidence to engage in the depth and sensitivity of communication required, for example when the only space or bed available was in a corridor (Hannah).

Participants reflected on these difficult experiences and the oppressive environment, and how staff burnout, ill-health, high turnover, and unfilled vacancies compounded the challenges in caring for FS further (Oliver, Anne, Tim). The lack of staff and stretched teams implied there was not the capacity to spend the required time with this patient group, and offer the empathic understanding required. Ultimately, participants commented on a “system that’s broken” (Nigel) which adversely impacted the vulnerable in society, including individuals with FS.

Discussion

The results of this study highlight the positions of consultants when working with FS in the ED, through exploration of their role, personal and departmental characteristics, and how this influences their approach and management of FS in the ED. The perceived effective management of FS is somewhat limited. Clinical challenges are compounded by systemic pressures, with the ED being described as a stretched system operating in a crisis context of persistent austerity, exacerbated further by the recent COVID-19 pandemic.

Theme One highlights that the ED attracts a particular personality style, someone who values fast-paced, evidence-based decision making, grounded in structured physiological examinations. However, the very skills required to thrive in this environment may make it more difficult to engage effectively with individuals with FS, given the complexity and heterogeneity of vulnerability factors in FS (Ertan et al., 2021). There is also a dominant narrative of frustration and uncertainty discussed in other literature exploring HCPs’ viewpoints (Rawlings & Reuber, 2018). The current findings show this is also experienced by ED consultants. The complexity in differentiating FS from epilepsy contributes to the ED consultants’ uncertainty and could be seen as another direct challenge to their professional identity, where the aim is to treat the physical crises to preserve life and maintain patient flow through the department. This is an understandable yet stark contrast to the idealised care for

FS in offering thorough assessment, a positive diagnosis over exclusion of other conditions, or confirmation of precipitating stressors which are not always present (Espay et al., 2018). Reduced clarity or challenge to professional identity can impede confidence to communicate opinions and share knowledge with other professionals (Sundberg et al., 2017).

Whilst professional identity was clearly communicated in this participant group, findings suggested some participants felt divergent from their peers in their approach. This has clinical implications for ED consultants in MDTs, smaller departments, or those feeling isolated from the team in their approach, as professional identity can easily be diminished without an established supportive network (Brown et al., 2000). Furthermore, the ED consultant's role is time pressured, by completing over 100 tasks per hour (Kee et al., 2012). Whilst this involves highly effective time-management, it may impede opportunity for professional development and for accessing 'e-resources' interpreted as online training or supplementary material (Kee et al., 2012). This could have implications for FS care in the department, as opportunity to update knowledge around this developing presentation could be hindered due to role demands.

Theme Two explored how FS is conceptualised by the ED consultant, which echoes previous research. While some participants communicated uncertainty around the causal factors for FS, the majority believed that FS are largely psychogenic; HCPs uncertainty in diagnosis was also communicated by Rawlings and Reuber (2018). Some participants had a special interest in FS, which led to them developing a nuanced understanding of FS and to seek more holistic approaches. For example, one participant worked privately with medical cannabis, whilst another engaged with hypnosis practices, and both alluded to the appropriateness of alternative approaches to FS. There is emerging evidence for cannabidiol effectiveness in epilepsy management (Reddy & Golub, 2016). However, there is seemingly a dearth of research in the efficacy of this in FS.

Despite a general movement from a biomedical to a biopsychosocial model of healthcare in recent history, criticisms remain about how this model is translated into the healthcare infrastructure and implemented in practice, which has proved to be time-consuming and inefficient for clinicians (Farre & Rapley, 2017). This could be particularly challenging to implement in the ED given the systemic pressures reported in theme three and could impact how FS are conceptualised here in theme two. Hustvedt (2013) argued dualistic “psyche-soma” (p. 169) division is problematic and prevalent in FS, and how terms such as ‘psychogenic’, ‘organic’ as well as ‘functional’, can contribute to this. This also fits with wider philosophical debates between holism versus reductionist approaches to health conceptualisation (Farre & Rapley, 2017), which are pertinent to positively diagnosing FS with a holistic conceptualisation, rather than as a result of exclusion from a solely medical and arguably reductionist medical investigations.

Moreover, understanding the conceptualisation of FS by participants was important to consider how this may influence their practice. Attribution theory discusses that decisions about another’s behaviour are often based on perceived internal factors, neglecting to consider external influences (Banerjee et al., 2020). For example, some staff may focus on the inability to cope (internal cause) rather than considering the probable traumatic and persistent challenges these individuals may face (external cause). Also, motivations to help are stronger when the individual is perceived to have no internal control over their condition (instead of external factors the individual cannot influence) (Banerjee et al., 2020). Therefore, motivation to help people with FS may be reduced by the perception that they have control over their FS. This is a perspective commonly reported in literature (Robson & Lian, 2017; Dunne et al., 2017; Rawlings & Reuber, 2018) despite this contradicting recommended practice in communicating a FS diagnosis (Yeom et al., 2021). These findings have strong implications for raising awareness and updating understanding of FS.

Furthermore, emotional dysregulation and cognitive-emotional processing difficulties are accepted as increasing vulnerability to FS (Roberts et al., 2020; Rosales et al., 2020). However, a recent literature review by Reuber et al. (in press) places a greater significance on shame in FS, proposing it disrupts cognitive function and activates emotional and behavioural observed responses in FS, as well as contributing to co-morbid diagnoses, such as PTSD and depression. This has implications for health outcomes for patients, as shame has greater physiological impact than other emotions (Reuber et al., in press). Shame is also enmeshed in stigma, which is a vital discussion point when considering the correlation of perceived stigma on quality of life (Robson et al., 2018). This is imperative given HCPs can inadvertently create or reinforce these shaming experiences, through unintentionally stigmatising responses in the ED.

Theme three provides further detail about the propagation of the stigmatizing attitudes within the ED professionals and wider care pathway. Participants experienced guilt when reflecting on previous approaches used to care for people with FS, as they relied on experiential learning with senior staff, or other professions, which often prevented opportunity to challenge generational and hierarchical conceptualisations or “group think” (John) attitudes. Participants also described professional diffusion of responsibility, which is not only problematic from their perspective in delivering appropriate care, but also reinforces the patient experience of being an “enigma” (Rawlings & Reuber, 2016, p. 101). Whether shame and stigma are a causal or maintenance factor of FS, it is fundamental that opportunities are created for ED professionals to update their understanding of how to care for FS in the ED, which will proactively reduce stigma of the presentation.

Generally, psychological safety is essential in teams to challenge decision making, create learning opportunities, and improve individual and team performance (Newman et al., 2017). This is important for the ED as psychological safety is also associated with improved patient safety and care. However, evidence suggests psychological safety is low amongst ED nurses, and leaders in the ED have been identified as key drivers in facilitating improvement in this area (Han & Roh, 2020).

Theme Three also explores the wider contextual pressures that made participants' role in caring for FS more challenging. This is understandable given the persistent, chronic ED crisis reported in the media (Kershaw, 2018; Anandaciva, 2018), further compounded by the COVID-19 global pandemic. Williams et al, (2022) reported patient satisfaction for the ED in the UK has fallen to only 39% in 2021, which is the lowest since records began in 1999. Additionally, high staff turnover could also be argued to perpetuate stigmatising responses, as there is restricted opportunity for staff to update their knowledge.

Participants often reported burnout of staff in the ED, which increased frustration and reduced empathy with this patient group, impacting patient care and likely stigmatising people with FS further. Dasan et al. (2015), found compassion satisfaction in ED consultants lessens with experience, until a 20-year turning point by which it improved. Reduced compassion satisfaction was found to increase frustration with patients and resulted in consultants offering suboptimal care (Dasan et al., 2015). Furthermore, stigmatising attitudes exist within the workforce towards colleagues who are struggling with symptoms of burnout. Feist et al. (2020, p. 2) describe "the culture of silence", where clinicians may be less likely to seek help from others, for fear of being judged by colleagues as inadequate, and these issues have been compounded by the COVID-19 pandemic.

Furthermore, participants discussed "moral injury" (e.g., Louise discussing compromised patient care due to systemic pressures) and a sense of duty to remain in the ED. Moral injury is the harm caused when an individual acts against or fails to act in line with their ethical and moral values. Giwa et al. (2021) likened moral injury in the ED to post-traumatic stress disorder, noting the COVID-19 pandemic has exacerbated burnout in this staff group. Retention of ED medics is reported as a high priority for future research, required for the sustainability of the ED, as loss of valuable experience is detrimental to patient care and financially costly (Darbyshire et al., 2021). This is also key to FS management, as a stretched workforce will not have the resources to appropriately care for this patient group, again propagating stigma towards people with FS.

Previous research suggests factors such as team cohesiveness, strategies to manage workload pressures and maintaining empathy for patients supports compassion satisfaction (Dasan, et al., 2015) all of which were also prevalent in this data set. This also has implications for patient care and potential reduction in stigmatising responses.

Clinical Implications

Participants commonly found they practiced from instinct rather than an evidence-base and this highlighted a need for guidelines to be developed. Future work is needed to collate the information that is currently known about FS in the ED, to build relevant guidelines for the department and indeed further research to find what might help people with FS in the ED environment.

This paper also raises the question of how and where ED consultants (and thus all medical staff) learn about FS. Participants indicated that FS have recently been added to the general medical syllabus, which will be important to raise awareness and understanding. This paper also highlights a need for development of a cohesive FS training package for new and existing staff in the ED, with research to explore the impact on quality of patient interactions and satisfaction. Also, participants suggested it would be helpful to develop a training video which presents the ‘patient story’ aimed at ED professionals. This could help influence empathy and understanding for this patient group.

CPs presence in the ED is not a new role. As early as 1974, Barlow reported that assessment and formulation was offered by trainee CPs to patients and staff, and effective MDT skills were required to manage “conversion reactions” (p. 255) and differentiating physiological and psychological presentations. Nearly 50 years on, the roles of CPs in the ED are arguably similar. This study found that some participants lacked confidence in sensitive discussions, particularly around trauma. Therefore, CPs could provide training and scaffolding to upskill ED professionals in this area, both consultants and other members of staff. Another potential role could provide support to ED practitioners in managing the emotional impact of this work, as outlined in theme one. This could be through reflective practice or supervision, as it could be natural for practitioners to be reluctant to engage with this cohort of people in an understandable attempt to avoid the guilt and anxiety described. However, this avoidance could in turn perpetuate the sense of shame and stigma experienced by people with FS and therefore is important to address.

Furthermore, the role of CPs in the ED could support the holistic conceptualisation of FS. CPs and medical professionals have divergent training pathways and participants recognised the existing medical syllabus does not provide opportunity to learn about these presentations. Therefore, offering a psychological perspective in the emergency medicine MDT could raise awareness and update professionals’ understanding. This could contribute to a positive culture shift to further reduce stigmatising responses experienced by people accessing the ED when living with FS.

Participants consistently reported a lack of national guidance in management of FS, and the failure of the wider health and social care system which increased demand on the ED. Williams et al (2022) mapped the healthcare journey of people living with functional neurological disorder (inclusive of FS) and described “looped” (p. 1) pathways centered around re-attendance at the ED. People living with FND were four times more like to re-attend the ED than receive a referral to clinical psychology, which was a positive indicator of reducing attendances, as well as neurology referrals and a confirmed diagnosis (Williams et al., 2022). Therefore, collaboration with these disciplines in pathway development could strengthen patient access to appropriate care, whilst reducing the perceived helplessness in the ED. This will inevitably remain challenging though during the times of persistent austerity and limited funding in health and social care.

Finally, a FS specialist interest network for ED consultants could be supportive to maintain professional identity, share best practice and collaborate on research. Some participants reported a sense of cohesiveness in the ED and that recent FS training opportunities that were provided through their professional body were beneficial. However, further networking opportunities for like-minded professionals could build confidence in their approach and strengthen practise-based evidence to develop national guidelines of clinically relevant, effective intervention for FS in the ED.

Limitations and Future Research

There are a number of limitations acknowledged with this research. Despite collaboration with three participating EDs, recruitment was largely achieved through advertisement on social media. This is likely to have biased the participant sample towards individuals who are interested in FS and who arguably hold a more updated and less stigmatising understanding of the condition. This may limit the generalisability of these findings to other ED consultants. However, the current participants gave insights into teams where more problematic outdated views were held, but it could be valuable to explore these directly, though recruitment could pose a challenge.

Moreover, the research design and recruitment strategy did not meet the original goals of the study; to obtain a sample of all ED professionals, including nurses and doctors of all stages of their career. Whilst the recruitment of solely consultants was invaluable to this study as it permitted focus on this group, further research is indicated to explore other ED professionals' perspective and experiences.

Additionally, participants were able to take part in work time but this inevitably constrained availability for interview. Using open-ended questionnaires with staff may be useful for future research as less time would be needed for face-to-face contact with the researcher. Such an approach may also remove the barriers to participants disclosing views they may be more reluctant to share face-to-face.

Conclusion

This research has been successful in exploring the perspectives and experience of the ED consultant when working with FS. The findings offer insight into the personality of the individual consultants and the department, which influences how FS are understood and managed, and how systemic challenges impact professional experience. These findings have clinical implications with suggestions of role development for clinical psychology in this field, training, and development opportunities, as well as further research suggestions.

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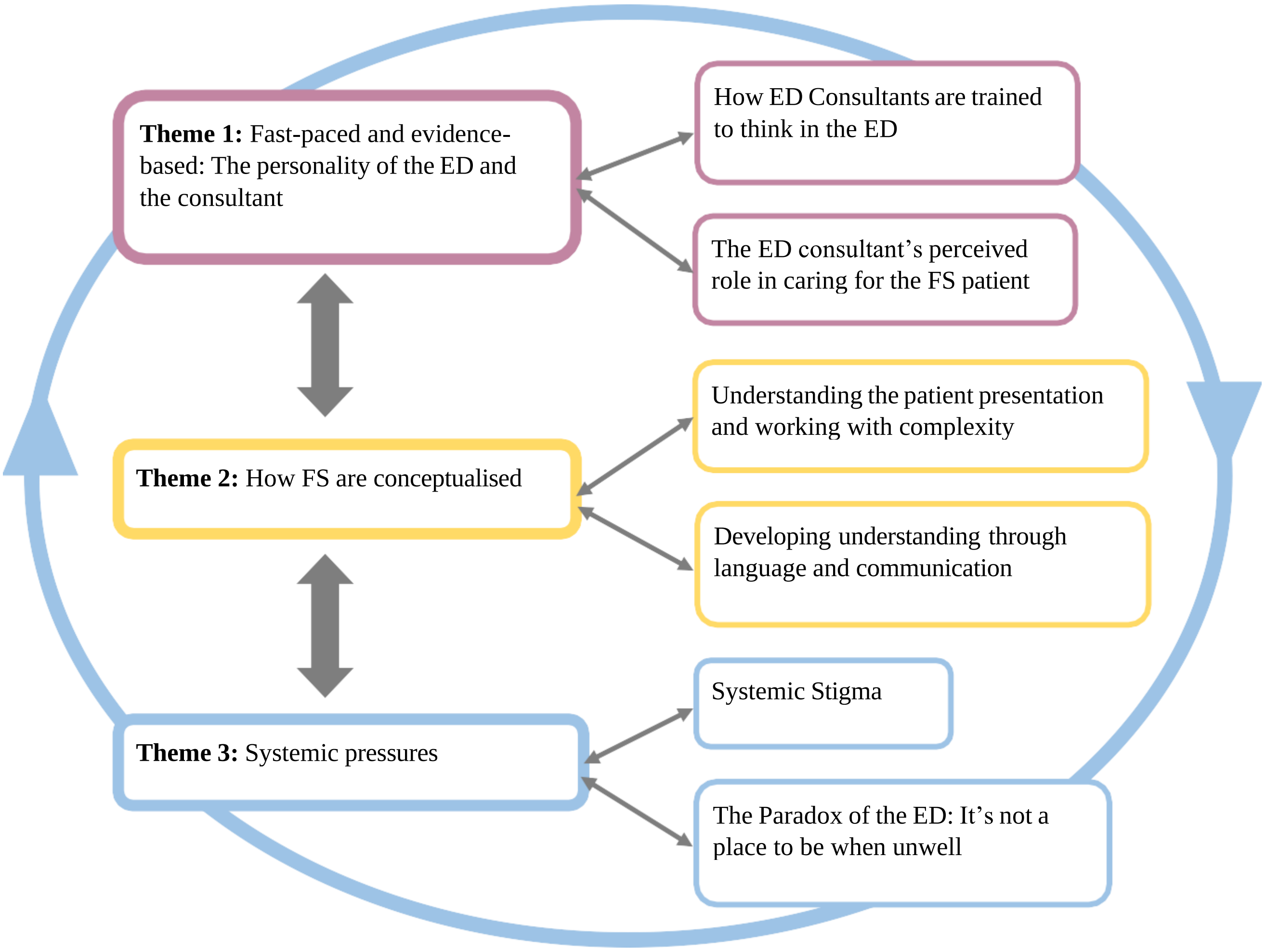
TABLE 2-A: Table 2-A presents the participant characteristics and pseudonyms assigned to each participant.

Participant	**Experience in role**
Matthew	6 years
John	20 years
Oliver	6 years
Hannah	5 years
Tim	6 years
Nigel	14 years
Louise	12 years
Anne	22 years

Figure 2-A: Figure 2-A presents a thematic diagram of the findings



Appendix 2-A: The trainee’s practical application of reflective thematic analysis

Image 1: The initial coding process

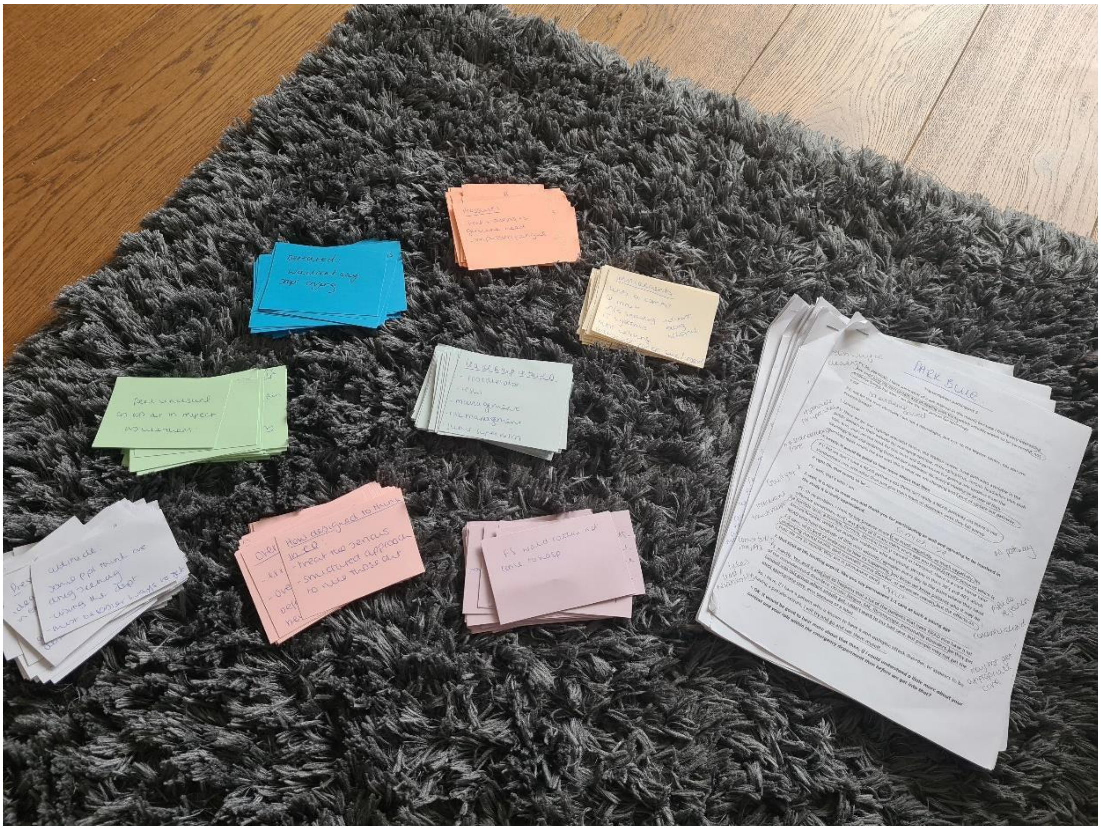


Image 2: Constructing Emerging Themes from Coded Data

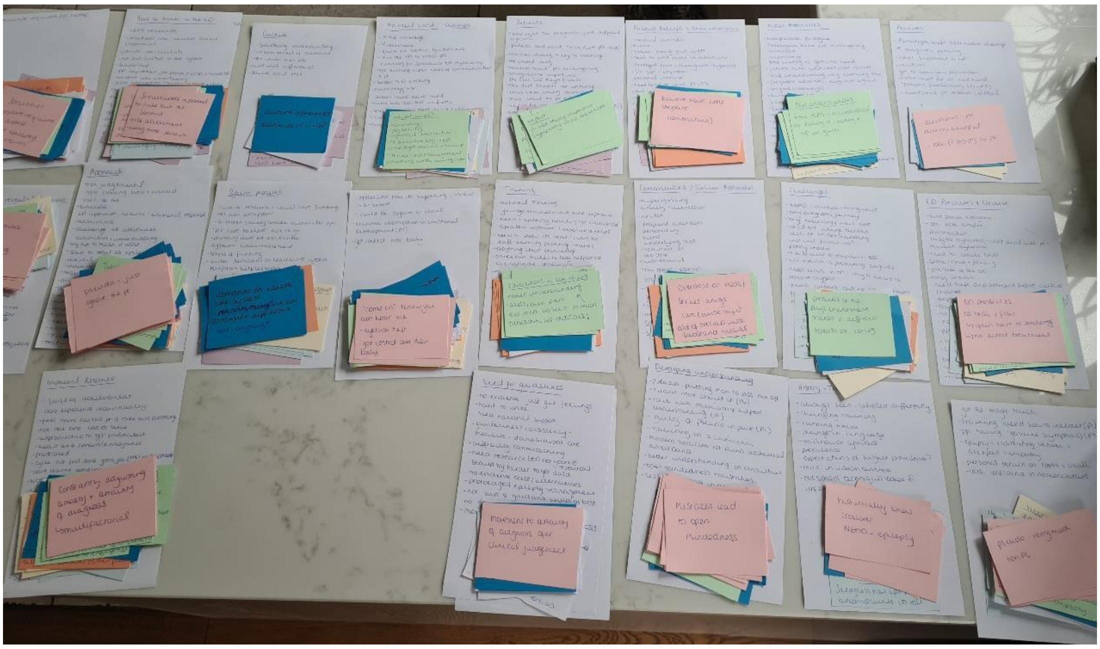


Image 3: Constructing Themes

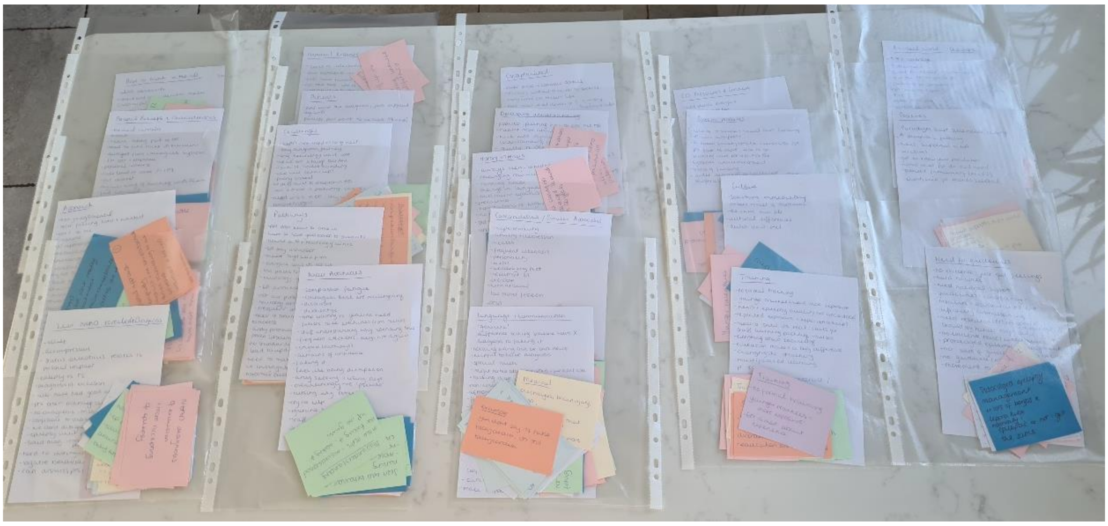


Image 4: Final three constructed themes

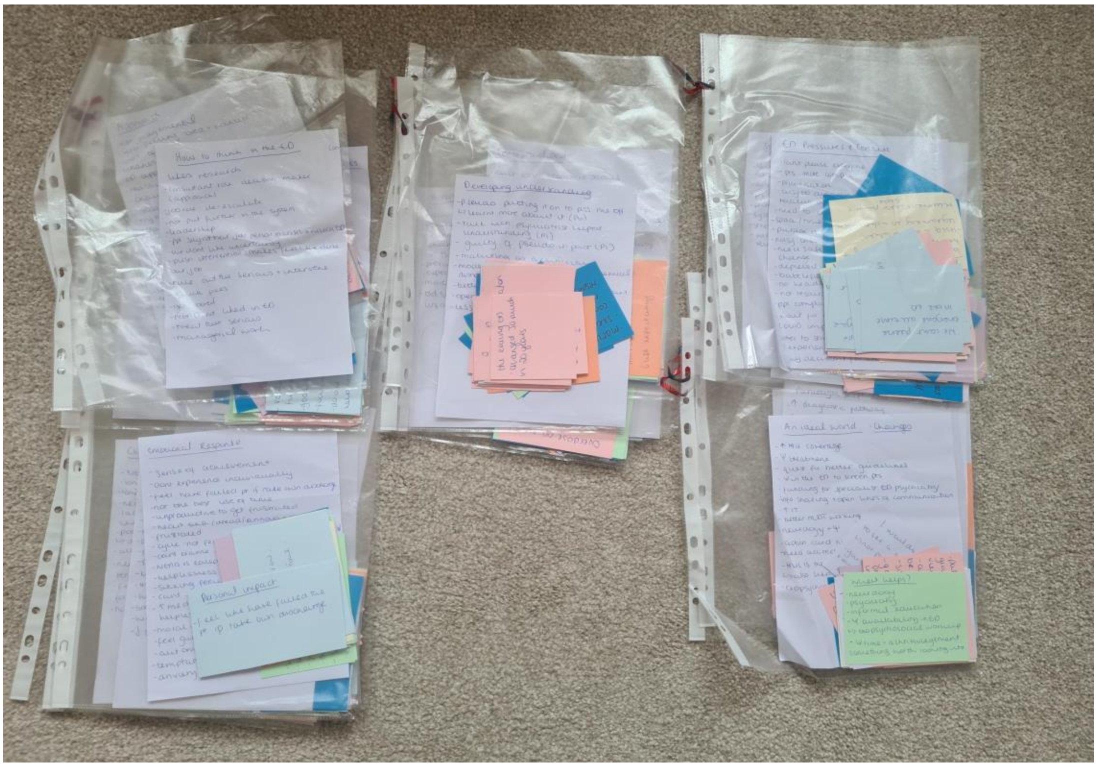


Image 5: Theme 1 Contributions

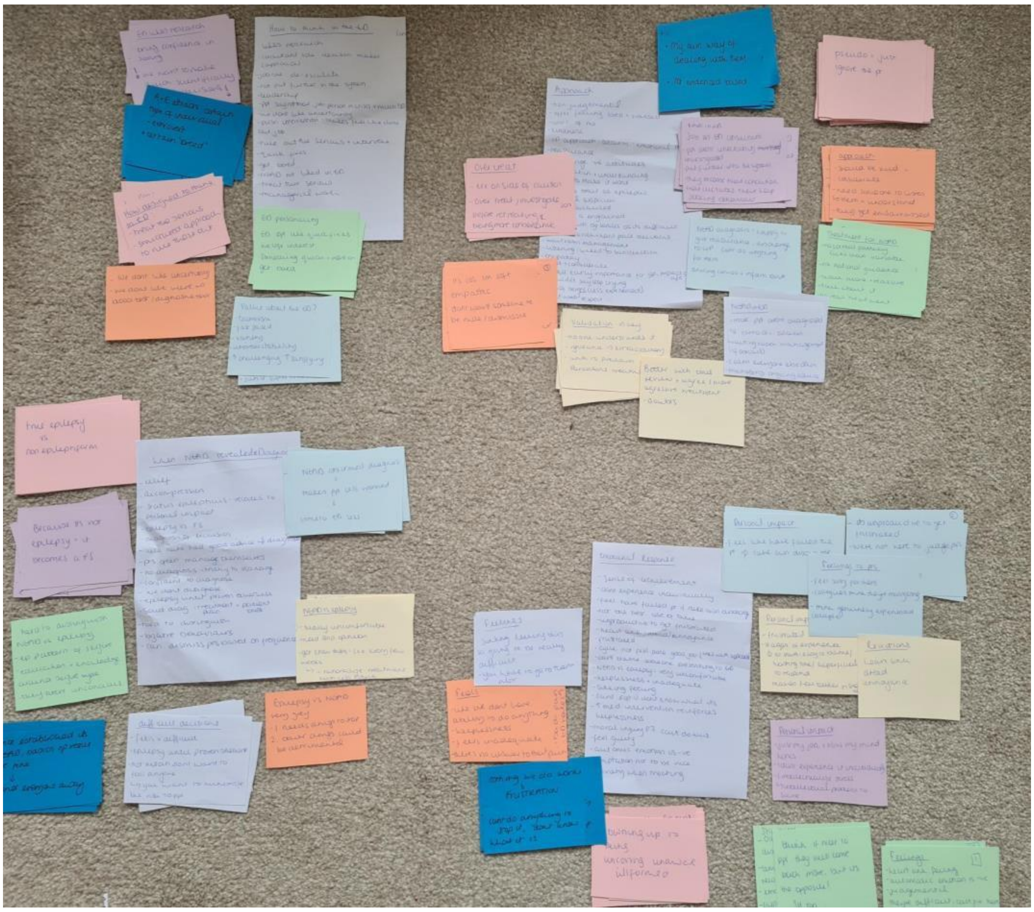


Image 6: Theme Two Contributions

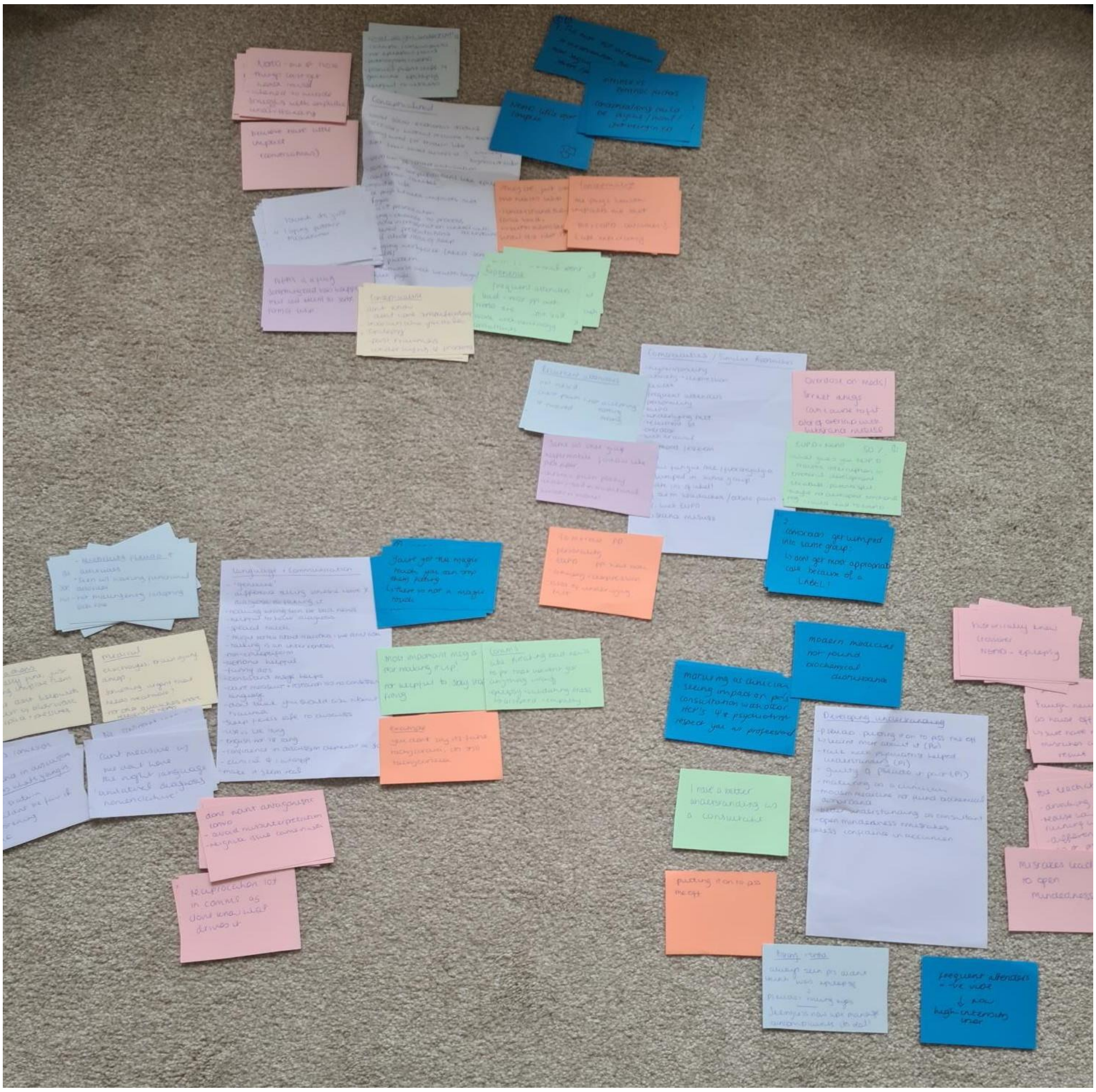
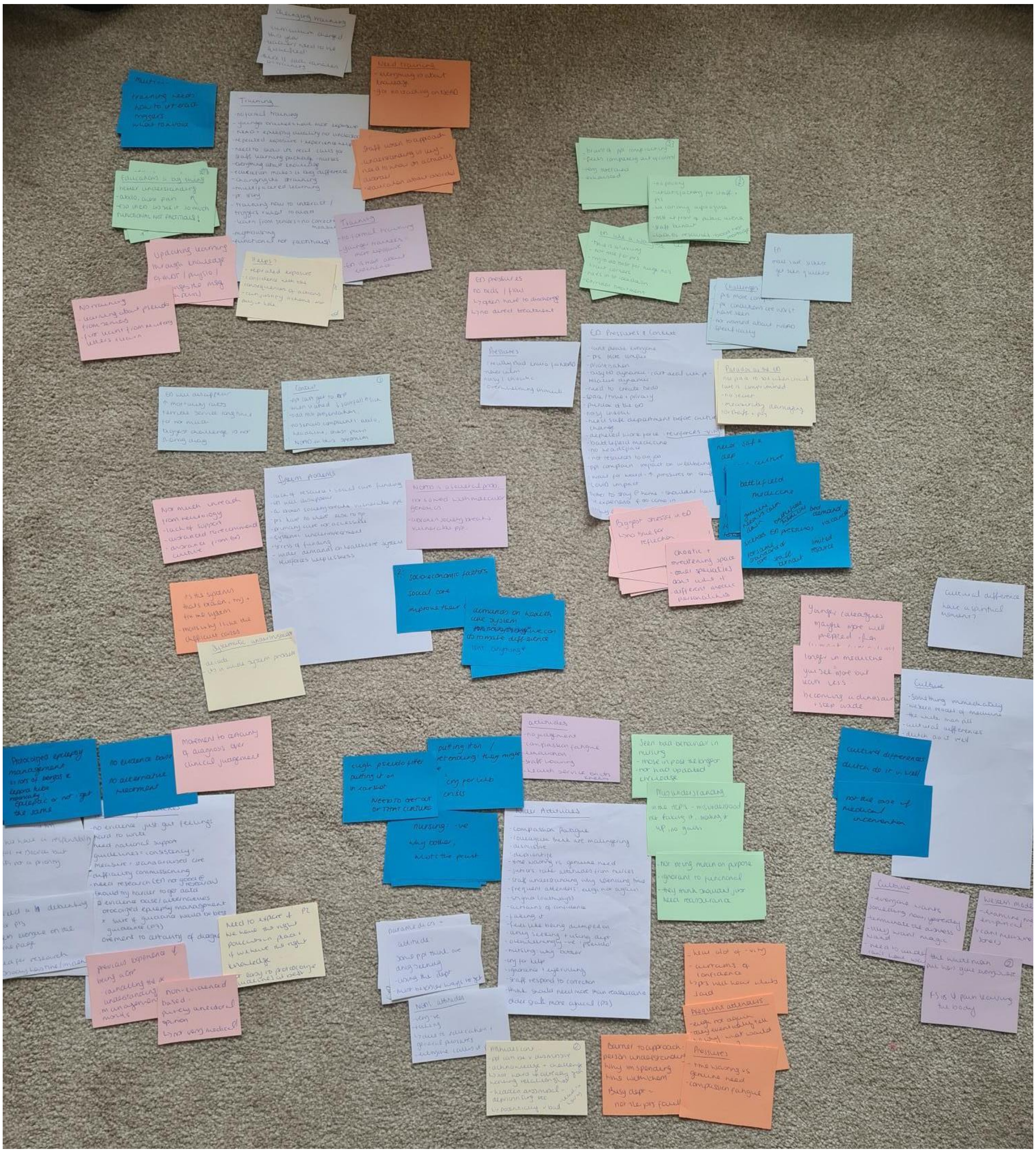


Image 7: Theme three contributions



Appendix 2-B: Statement of Contributions in Accordance with The British Journal of Health Psychology

What is already known on this subject?

- Perspectives of ED Healthcare professionals are underrepresented in functional seizure literature.
- Existing literature explores HCPs challenges

What does this study add?

- Exploring ED consultant views and experience is imperative given their leadership role
- FS can directly challenge ED professional values
- Systemic pressures restrict care the ED is able to provide for people with FS
- Improvement is needed for developing care-pathways through multi-disciplinary working
- Developing a national guidance for managing FS in the ED is imperative

Appendix 2-C: Notes for Contributors to the Authors for 'The British Journal of Health Psychology'

the british
psychological society

2. AIMS AND SCOPE

The British Journal of Health Psychology publishes original research on all aspects of psychology related to health, health-related behaviour and illness across the lifespan including:

- experimental and clinical research on aetiology
- management of acute and chronic illness
- responses to ill-health
- screening and medical procedures
- psychosocial mediators of health-related behaviours
- influence of emotion on health and health-related behaviours
- psychosocial processes relevant to disease outcomes
- psychological interventions in health and disease
- emotional and behavioural responses to ill health, screening and medical procedures
- psychological aspects of prevention

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

The types of paper invited are:

- papers reporting original empirical investigations, using either quantitative or qualitative methods, including reports of interventions in clinical and non-clinical populations;
- theoretical papers which report analyses on established theories in health psychology;
- we particularly welcome review papers, which should aim to provide systematic overviews, evaluations and interpretations of research in a given field of health psychology (narrative reviews will only be considered for editorials or important theoretical discourses); and
- methodological papers dealing with methodological issues of particular relevance to health psychology.

Authors who are interested in submitting papers that do not fit into these categories are advised to contact the editors who would be very happy to discuss the potential submission.

Papers describing quantitative research (including reviews with quantitative analyses) should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

All systematic reviews must be pre-registered. The pre-registered details should be given in the methods section but blinded for peer review (i.e., 'the review was preregistered at [BLINDED]'); the details can be added at proof stage. Registration documents should be uploaded as title page files when possible, so that they are available to the Editor but not to reviewers.

Please refer to the separate guidelines for **Registered Reports**.

COVID-19 Research
The BJHP has received an overwhelming number of COVID-19 related submissions. We can only consider papers that are providing new and novel data on COVID-19. We particularly welcome submissions of intervention studies. Furthermore, rapid peer review for COVID-19 submissions has now ended. COVID-19 papers will now be handled alongside other standard submissions.

4. PREPARING THE SUBMISSION

Free Format Submission

British Journal of Health Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at **https://www.editorialmanager.com/bjhp/default.aspx** and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; statement of contribution; main text file; figures/tables; supporting information.

Title Page

You may like to use **this template** for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Authorship

Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the **Project CRediT** website for a list of roles.

Abstract

For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. As the abstract is often the most widely visible part of your paper, it is important that it conveys succinctly all the most important features of your study. You can save words by writing short, direct sentences. Helpful hints about writing the conclusions to abstracts can be found **here**.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Statement of Contribution

All authors are required to provide a clear summary of ‘what is already known on this subject?’ and ‘what does this study add?’. Authors should identify existing research knowledge relating to the specific research question and give a summary of the new knowledge added by your study. Under each of these headings, please provide 2-3 (maximum) clear outcome statements (not process statements of what the paper does); the statements for 'what does this study add?' should be presented as bullet points of no more than 100 characters each. The Statement of Contribution should be a separate file.

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors’ names or affiliations and always refer to any previous work in the third person.
- The journal uses British spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

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Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Chapter 3: Critical Appraisal

Doctorate in Clinical Psychology

Lancaster University

2019 Cohort

Word Count: 3,982

Critical Appraisal

This critical appraisal will explore the findings from both the systematic literature review and empirical papers presented. The systematic review topic was chosen to compliment the empirical paper, given the stigmatising attitudes which are directed to both people living with functional seizures (FS) and accessing ED care for self-harm and suicidal behaviours. I felt passionate to explore the nature of ED clinicians' experiences towards both cohorts of people presenting to ED, to better understand the relational dynamics which possibly propagate the stigma experienced, in the hope to identify recommendations to improve patient care. Therefore, the findings of both papers are considered in the wider context of the literature, with thought given to the validity and relevance in this field. The decision-making process and personal reflections will also be presented here, alongside challenges faced in conducting the research, with possible future recommendations offered.

Research Findings

Three themes were constructed in this research, which illustrated the perspectives and experiences of emergency department (ED) consultants in caring for people living with functional seizures (FS): 1) Fast-paced and evidence-based: the personality of the ED and the consultant, 2) How FS are conceptualised, and 3) Systemic pressures. Such findings illustrate how the ED consultants are trained to think in the department generally, and how this impacts their perception of their role in caring for the FS patient and how they conceptualise FS. These findings also explored how their understanding had developed over time for some, but that systemic stigma is apparent and perpetuated by professionals and environmental pressures.

These findings are interesting in the context of the meta-synthesis. The meta-synthesis presented three themes which captured the perspectives of ED clinicians in caring for people who had engaged in self-harm behaviours 1) Between “frustration, futility and failure”: The clinicians’ emotional response to self-harm, 2) Attitudes on a self-harm spectrum, and 3) The ED in a challenging context. Whilst the empirical research focused solely on ED consultants and the meta-synthesis incorporated perspectives of ED clinicians (namely ED doctors and nurses); the findings of theme one in both papers indicated both difficulties (self-harm and FS) generated a sense of challenge to the ED professional’s values. Findings of both papers contributed to an emerging narrative of the personality and culture of the department, in valuing faced-paced interventions to provide physical care to the critically ill. A distinction highlighted by this research paper was of the nuanced ED consultants’ role, as a leader and manager in the ED, which impacted their direct involvement and influence of care for people living with FS. The meta-synthesis highlighted a perception that ED clinicians protect themselves from the emotional impact of caring for people with self-harm presentations, which often led them to avoid addressing the psychological distress of patients. Whereas some research participants placed themselves in charge of directly caring for people with FS, as they felt better skilled to address their individual needs. However, this was not the case for all, as some research participants also stepped back from direct care for people with FS, arguably driven by feeling inadequate and helpless to make meaningful change as identified also in the literature review findings.

Additionally, it can be argued that both FS and self-harm elicit a similar emotional response in ED staff when challenging their professional identity. In both papers, a sense of hyper-vigilance in the staff team was described. ED consultants reflected on systemic anxiety in the staff team until FS were confirmed, and similarly anxiety was reduced when a person who had engaged in self-harm behaviours was physically stable. An emotional response of frustration and helplessness was also a common experience reported in both papers. The research participants reflected on the impact of helplessness reducing job satisfaction and perpetuating negative attitudes towards people living with FS, which corroborate the meta synthesis findings (Santos et al., 2017; Fontão et al., 2018; Ngune et al., 2020; Pallikkathayil & Morgan, 1988).

A novel finding of the research paper was how FS are conceptualised by ED consultants, which proved a difficult concept for some in the absence of a unified model of FS. One participant also likened the complexity of understanding FS to mental health difficulties and attempts of suicide. However, most research participants were able to reflect on their understanding of FS and consideration of systemic factors that influence and challenge people living with FS. There was insufficient data to explore the conceptualisation of self-harm behaviours in the context of the meta-synthesis, and this did not constitute a fully developed theme. However, findings presented by Ngune (2020) reflected that understanding and awareness of the contextual factors as to why people may present with self-harm behaviours improved attitudes and offered a sense of reassurance to staff.

Conversely, limited understanding was perceived as a barrier to effective patient care, for example, in not knowing how best to approach sensitive questions regarding self-harm behaviours (Ngune, 2020). Similarly, research participants also shared apprehension in engaging in sensitive communication. This could be interpreted as contributory to the perceived helplessness of ED staff in caring for people presenting with either FS or self-harm related behaviours.

Theme three of both papers situated the findings in relation to ED staff's perceptions of systemic pressures, which could perpetuate the professional and environmental challenges, and emotions experienced. The research participants described the paradoxical nature of the ED as "not a place to be when you're unwell". Environmental stressors included lack of privacy, time, and physical space, reducing the therapeutic capacity of the ED environment, impacting on patient care and staff wellbeing. Additionally, limited community resources and follow up care was identified as perpetuating the difficulties experienced by both staff and people accessing care. These findings corroborate with those of the meta-synthesis, strengthening the current findings and highlighting the consistency of the ED crisis both in duration and location.

Moreover, the research participants also depicted experience of systemic stigma, constructed from sometimes pejorative current attitudes of other ED staff and community teams, and previous attitudes of participants. Theme two of the meta-synthesis presented ED staff attitudes towards people who engage in self-harm behaviours, illustrated on a spectrum of compassion towards first-time presentations to largely frustrated attitudes towards repeat presentations. Whilst some research participants placed people living with FS in the high-intensity user category, it was difficult to directly explore the participants' attitudes to this cohort of patients, as most reflected on their colleagues' perceived beliefs. Both papers reflected the impact of group norms on patient care.

Generally, admissions to emergency departments have tripled in the past 50 years (Kershaw, 2018). However, this predates the COVID-19 pandemic, where the significant pressures of the ED have been exacerbated and are widely reported within the media. Long wait times for admissions and accessing ED care, as well as lack of bed space and privacy are consistently reported (BBC [British Broadcasting Corporation], 2022; Flinders, 2022; Tapper & Helm, 2021). All of which have serious safety implications for both patients and staff. A Northwest ED report found people "die without the dignity of privacy" due to pressures experienced (BBC News, 2022). ED are also identified as not ideal "places of safety" (p. 1) for people accessing care for mental health difficulties, not just for section 136 requirements, but increasing longer wait times due to lack of inpatient beds, and a result of a model of care based on organisational roles rather than people's needs (Braithwaite, 2017). However, a study conducted in one ED found that people who were conceptualised within a high intensity user framework reduced their admission to the ED during the pandemic (Kyle et al., 2021). Whilst the wider impact of this change in access to care during the pandemic is still unknown, it could be reasonable to assume how this may influence staff attitudes towards this cohort of people, in considering their dependency and locus of control over their condition, rather than the contextual factors that may have influenced this change.

Quality of Findings

The findings of both the meta-synthesis and the empirical research are considered valid and highly relevant to the field of emergency medicine. Quality of the meta-synthesis was assessed through use of the CASP tool, with additional ratings by Duggleby (2010) applied. Stringent inclusion and exclusion criteria were also applied, to ensure that only findings that clearly represented ED practitioners' data were used. This is important as many studies presented data amongst allied health professionals, other specialties, and ED non-clinical staff, although relevant, was not the focus of this meta-synthesis. Furthermore, despite the variance in age of the study (1988 to 2020), all were subject to peer review and offered representation from a number of cultural backgrounds. This further complemented the research paper findings, which was solely focused on a UK population.

Furthermore, the research paper aimed to meet four quality guidelines suggested by Yardley (2000), 1) Context sensitivity, 2) Commitment and rigorous engagement with the topic, 3) Presentation of coherent and transparent narrative, and 4) Reflexivity. I engaged in a number of processes to adhere to these appraisal criteria. Supervision from both research supervisors was a critical process to facilitate reflection on my own position in the research, as well as theme construction and maintaining a rigorous analysis process. Engagement with an ED stakeholder and my field supervisor also supported sensitivity to the context. Moreover, peer supervision was utilised throughout the thesis process, which supported development of a transparent procedure through discussion and reflection with peers. These implemented processes aimed to improve the trustworthiness, validity and quality of the research presented.

Why This Research?

I was interested to explore this area of research through development of interest from a number of sources. Prior to commencing clinical psychology training, I have always been interested in the interplay between mental and physical health, through completion of a dual honours degree in psychology and human biology. From here, an interest in neuropsychology emerged and I continued to seek academic experience in exploring both quantitative and qualitative opportunities in this field. The functional neurological disorders field was new to me prior to clinical training, but seemingly fit with my interests when considering appropriate topics for the doctoral thesis.

The research question emerged through supervision and exploration of the available literature. Research supervision provided an anecdotal narrative of a clinician's experience in working in the ED. I combined this perspective with their own understanding of the literature around the diagnosis and journey through the healthcare system from the perspective of people living with FS. I felt passionate to engage with the novel opportunity to explore ED consultants' perspective of caring for people with FS. This research contributes to an already thorough exploration of other healthcare professional's perspectives towards caring for people with FS from key authors in the field (Barnett et al., 2020; Rawlings & Reuber., 2018; Reuber et al., 2020).

Reflexivity

Ultimately, I had little personal experience prior to commencing the research or engaging in the meta-synthesis. Berger (2015) argued there are both benefits and pitfalls in exploring the unfamiliar. An advantage is that the researcher can bring a fresh new perspective to the exploration of the data and previous research. However, conducting research from an outsider position can also have its drawbacks, and can lack sensitivity to appropriate language, for example (Berger, 2015). Collaboration with an ED stakeholder in developing the research materials and topic guide was invaluable to mitigate for language insensitivity. However, taking an outsider's position to the research can also mean that subtle interpretation of the data can also be lost (Berger, 2015). Therefore, seeking regular supervision to elevate interpretation was also beneficial. Arguably, my limited knowledge in the field was focused on the perspective of people accessing care, which is mainly negative. This undoubtably influenced interpretation of the data. I utilised self-reflection and supervision to achieve a balance of self-awareness and sensitivity to the dataset, in navigating this challenging patient-practitioner dynamic in the literature. The interpretation of the research data, along with meta-synthesis findings did indicate evidence of some pejorative attitudes to people accessing ED care for FS or self-harm. Interpreting causation and systemic pressures was imperative to understand the lived experience of the participants, as then it was possible to understand where challenging attitudes and conceptualisations were formed. This highlighted gaps and opportunities for future research to support this staff group and therefore ultimately meet the overall aim of the project to inform and improve patient care and staff wellbeing.

Moreover, a key assumption of Braun and Clarke's reflexive thematic analysis (RTA) is that the researcher takes an active role in analysis, with their subjectivity acknowledged as an analytic tool, as it would be impossible to take a neutral and reserved stance to the data (Braun & Clarke, 2019; Braun & Clarke 2021). RTA was applied inductively, in that themes were constructed from the data rather than generated from an existing hypothesis, driven from theoretical underpinnings. This was most appropriate, given my limited knowledge in the area outside of personal interest. However, my critical engagement with the existing literature base and own subjectivity developed throughout clinical training, inevitably influenced the final analysis of the data set (Braun & Clarke 2021). The supervisory relationship was also key to deepen interpretation throughout analysis.

Furthermore, RTA is considered autonomous from any defining epistemology, which allows for flexible application of the methodology (Campbell et al., 2021). However, its application can be aligned to phenomenological qualitative methodologies (Ho et al., 2017). In designing the research paper, I considered the appropriateness of experiential methodologies such as interpretative phenomenological approach (IPA). This is hermeneutic in its approach, aimed to explore the participants' relationship to their environment and make sense of their experiences (Larkin & Thompson, 2012). Whilst IPA with this participant cohort would have been suitable given the homogeneity and small sample size, ultimately, RTA was considered the most appropriate model. This was due to the relative flexibility afforded by RTA, allowing the opportunity to include all data presented by the participants as relevant, and not merely focusing only on experiential accounts.

Moreover, RTA was considered in line with my epistemological stance of critical realism. A critical realist standpoint aims to combine aspects of both constructivist and positivist philosophical approaches to science, in search of causal relationships to explain social phenomena (Fletcher, 2017). Alderson (2021) argues health research should not be reduced and isolated to solely epistemological or ontological exploration. Critical realism accounts for these concepts yet adds a third component to defining reality 1) the objective and intransient reality, 2) transient reality perceived through human interpretation and 3) causal unseen phenomena that exist within interactions of the observed reality (Fletcher, 2017; Alderson, 2021). This is particularly relevant to the current research, given the aims to understand the perspectives of eight ED consultants, when caring for people living with FS, whilst considering the context and possible causal factors of difficulties experienced. A critical realist approach assumes an element of objective reality across all ED consultants routines in caring for people with FS, with subjective individual experiences influenced by their knowledge, with an added critical interpretation of the causal factors within this perceived reality.

Strengths and Limitations

A key strength of this research was the novel contribution to an existing literature base which explored healthcare professionals' perspectives of caring for people with FS (Barnett et al., 2020; Rawlings & Reuber., 2018; Reuber et al., 2020). There is limited qualitative research conducted in the ED, and therefore this research, combined with the meta-synthesis aimed to offer an in-depth exploration of this staff group experience and perspectives. I welcomed the opportunity to explore a homogenous ED consultant sample and considered this as a strength of the research. The research participants offered a unique insight into their perceived role in caring for people with FS. However, as previously discussed, this was not the original design of the research, which aimed to explore the perspectives of all ED clinicians (namely ED doctors and nurses of all grades). Therefore, limitations and challenges experienced will be further explored.

The design and context of this research presented some difficulties. On reflection, the extent of the impact of the COVID-19 pandemic was problematic and significantly impacted recruitment. In designing the research, a three-phase recruitment strategy was adopted, which aimed to ensure engagement with all ED practitioners, who had highly relevant and recent experience was prioritised. This was achieved through direct collaboration and recruitment from three ED sites in the first phase. However, only three out of eight participants were recruited through these means, and from only one of the three sites, despite good working relations with all local collaborators. I considered the impact of the global pandemic as the main limiting factor. This prevented onsite visits and face-to-face opportunities, not only to promote the research, but also to answer any questions, gain leadership ‘buy-in’ to allow staff time away from their role to access the research, and maximise ad-hoc opportunistic moments to engage in data collection in the event the ED was quiet. Researcher presence in the EDs was particularly important given the unpredictable nature of the ED, which collaborators reflected meant it was hard to anticipate a good time for staff to engage with the research. I engaged in extensive work to meet site specific research and development department requirements to allow for access but was ultimately hindered by the changing landscape of the global pandemic. Recruitment in all three sites was approved by August 2021, which was also anticipated as a challenging time going into winter months for the ED and compounded by ongoing COVID-19 stressors. Replication of this research design beyond the restraints of the COVID-19 pandemic may allow for recruitment of all ED practitioners.

Moreover, this difficult context may have also contributed to the homogenous participant group of only ED consultants. Their leadership role in the ED may have afforded them more autonomy over their time, or they may have appreciated research opportunities more, or held vested interest in the topic area more so than other clinical staff. As mentioned, the majority of participants were recruited through social media, which may have also biased the participant sample towards staff who are comfortable in discussing this sensitive topic or hold a personal interest in the area. Therefore, to address this issue, for future research qualitative questionnaires could be utilised. This would provide an anonymous opportunity to express personal perspectives towards caring for people living with FS.

Furthermore, the timeline of completing this research within the requirements of clinical training may have also limited recruitment opportunities. The complex recruitment strategy required ethical clearance from the Faculty of Health and Medicine Research Ethics Committee and then research governance approvals from the NHS Health Research

Authority. This was a straightforward accessible process. However, each of the three collaborating NHS Trusts required adherence to their own research and development departmental guidelines. This proved timely and significantly impacted the recruitment trajectory of the research. This also impacted the opportunity for snowball sampling, which was the second recruitment phase which relied on professional liaison. In the interest of time, phases two and three were initiated simultaneously. Future research with more time afforded could allow for each of the recruitment stages in this design to be fully implemented independently.

Moreover, the research paper comprised of a small participant group (n = 8). Whilst Braun and Clarke (2021) reject data saturation as a term to determine sample size, guidelines to achieve data sufficiency in qualitative studies are unclear. Sandelowiski (1995) suggested that there is no analysis of power required in qualitative studies, and it is the researcher’s subjective appraisal of when a rich and diverse data set is obtained, enough to confidently address the research question and offer a new perspective, which also corroborates with Braun and Clarke’s perspective (Braun & Clarke, 2019). Given my relative inexperience with research, the supervisory relationship was supportive and offered helpful direction of when data sufficiency was achieved and to close recruitment. This was a particularly difficult point for me, given the work and time implemented in the three collaborative sites and wanting to provide the upmost opportunity to allow for data collection at thesis sites.

Ethical considerations were held with upmost importance throughout the research process. Additionally, I approached research supervisors in the event of ethical considerations, for example, when I was concerned regarding the impact of participating in the research on the participants on more than one occasion. I acknowledged that the research participants placed themselves in a potentially vulnerable position in discussion of a presentation that they may have limited understanding about. The research participants were also operating in a significantly stretched ED context, and I was empathic to the possibility of emotional impact following participation, in openly discussing their challenges. Therefore, I offered follow up emails to all participants following recruitment and signposted them to additional wellbeing resources via the participant information sheet. No participants approached me or research supervisors to express concerns with participation, and all data collected was then used to contribute to the analysis process.

Clinical Implications

In my opinion, there are numerous significant clinical implications that are identified through the meta-synthesis and the empirical paper. Each are discussed in their relative sections within this report, however, combine to highlight a need for training and education, both within the ED and across the NHS, as well as a focus on improving ED staff welfare. Improved social care funding to increase community bed availability will help to prevent blocked general hospitals, in turn improving patient flow through the department and reducing demands on ED staff (Miles, 2019). Also addressing the NHS staffing crisis would serve to reduce the pressures on current employees, last reported at 110,192 current vacancies in December 2021 (NHS Digital, 2022).

Furthermore, advocating for continuous care across the patient pathway is essential for both people with FS and self-harm behaviours. Findings of both papers indicated how these individuals are sometimes experienced as being obstructive to the work of ED practitioners. Yet, they are left with limited or no community-based options; generally, one in nine people who are on mental health wait lists access ED in crisis (Royal College of Psychiatrists, 2020). The common finding of helplessness and futility of ED intervention is understandable in consideration of the wider context of a system which isn't designed to meet the needs of these individuals, given the systemic pressures described. I have reported on possible factors which may impact ED practitioners' empathy towards these people, yet practitioners experiencing empathy in the absence of being able to provide effective care is likely to lead to difficult emotions (as reported in both papers). If the onward care doesn't exist or is too challenging for the ED practitioner to access within their remit, then reduced empathy and possibly pejorative attitudes towards these cohorts are inevitable and would serve as protection from these challenging and potentially distressing emotional experiences.

Therefore, improved communication and pathways between ED and clinical psychology could be a place to start addressing these difficulties. Presence of clinical psychology as a routine ED multi-disciplinary team member could be a direct influence, through their role of training, consultant, reflective practise, access to supervision. Also, improved access to clinical psychology in the community through increased numbers and remit of the role is required to reduce wait lists and improve accessibility in mental health services. This is a need identified within the NHS strategy, which positions clinical psychologists within liaison psychiatry services and acknowledge their role in the ED (NHS England, 2015; NHS England, 2021). These implications are key for both people accessing ED care for FS and self-harm behaviours. Addressing systemic pressures could allow ED practitioner's more time for training, education, reflection and ultimately improve their wellbeing. This also allows for access to a safer ED environment, for both the people accessing care and those working within the department.

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RUNNING HEAD: ETHICS

Section 4: Ethical Applications and Documentation

Doctorate in Clinical Psychology

Lancaster University

2019 Cohort

Word Count: 4,787

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
NEAs: The perspectives of emergency department practitioners

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
● Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

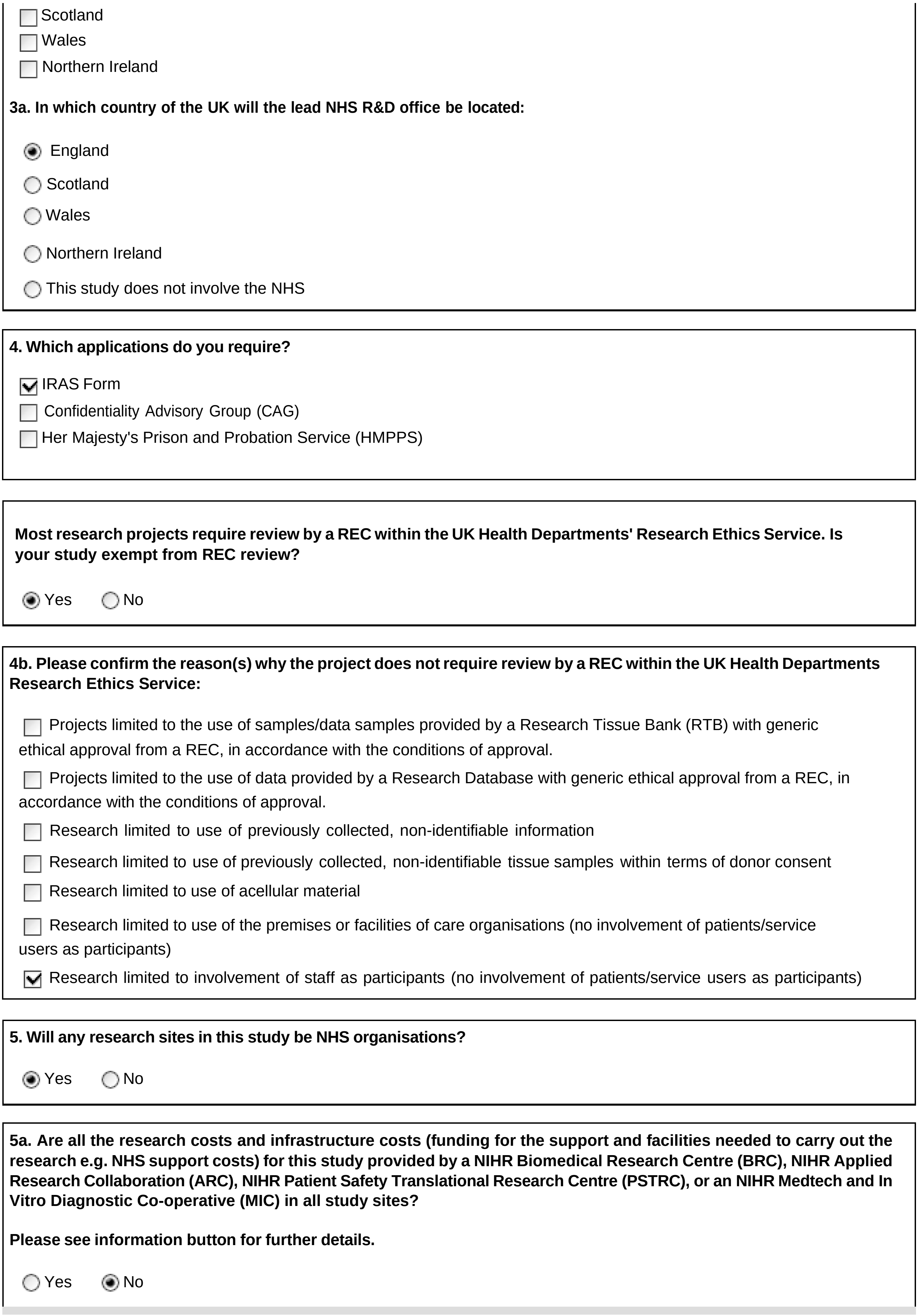
○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	Yes	● No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England



☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

● Yes ○ No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

☐ Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Research limited to use of previously collected, non-identifiable information
☐ Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
☐ Research limited to use of acellular material
☐ Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
☑ Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out the research e.g. NHS support costs) for this study provided by a NIHR Biomedical Research Centre (BRC), NIHR Applied Research Collaboration (ARC), NIHR Patient Safety Translational Research Centre (PSTRC), or an NIHR Medtech and In Vitro Diagnostic Co-operative (MIC) in all study sites?

Please see information button for further details.

○ Yes ● No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ● No

The NIHR Clinical Research Network (CRN) provides researchers with the practical support they need to make clinical studies happen in the NHS in England e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, information from your IRAS submission will automatically be shared with the NIHR CRN. ***Submission of a Portfolio Application Form (PAF) is no longer required.***

6. Do you plan to include any participants who are children?

○ Yes ● No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
This research is conducted as a requirement of the Doctorate in Clinical Psychology programme at Lancaster University.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

● Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No

Integrated Research Application System
Application Form for Research involving qualitative methods only

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
NEAs: The perspectives of emergency department practitioners

Please complete these details after you have booked the REC application for review.

REC Name:
Non-REC Studies: England

REC Reference Number:	**Submission date:**
21/HRA/1085	09/03/2021

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Non-epileptic seizures and non-epileptic attack disorder: The perspectives of emergency department practitioners

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss	Cerys	Bailey

Address
Doctorate in Clinical Psychology, Health Innovation One,
Sir John Fisher Drive, Lancaster University
Lancaster

Post Code	LA1 4AT
E-mail	c.bailey6@lancaster.ac.uk
Telephone	0000
Fax	0000

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Fiona	Eccles

Address Doctorate in Clinical Psychology, Health Innovation One,
Sir John Fisher Drive, Lancaster University
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E-mail f.eccles@lancaster.ac.uk
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Fax 000000

Academic supervisor 2

	Title	Forename/Initials	Surname
	Dr	Will	Curvis

Address Doctorate in Clinical Psychology, Health Innovation One
Sir John Fisher Drive, Lancaster University
Bailrigg, Lancaster,
Post Code LA1 4AT
E-mail w.curvis@lancaster.ac.uk
Telephone 000000
Fax 000000

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	**Academic supervisor(s)**
Student 1 Miss Cerys Bailey	☑ Dr Fiona Eccles ☑ Dr Will Curvis

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

○ Student
● Academic supervisor
○ Other

A3-1. Chief Investigator:

	Title Forename/Initials Surname Dr Fiona Eccles
Post	Research Supervisor and Lecturer
Qualifications	MPhys, DPhil, GradDipPsych, DClinPsy
ORCID ID	0000 0003 1484 2703
Employer	Lancaster University
Work Address	Doctorate in Clinical Psychology, Health Innovation One Sir John Fisher Drive, Lancaster University Bailrigg, Lancaster,
Post Code	LA1 4AT
Work E-mail	f.eccles@lancaster.ac.uk
* Personal E-mail	f.eccles@lancaster.ac.uk
Work Telephone	01524 592807
* Personal Telephone/Mobile	00000
Fax	00000

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title Forename/Initials Surname Mrs Becky Gordon
Address	Head of Research Quality and Policy Lancaster University Bailrigg, Lancaster,
Post Code	LA1 4YG
E-mail	sponsorship@lancaster.ac.uk
Telephone	+44 (0)1524 592981
Fax	0000

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	n/a
Sponsor's/protocol number:	n/a
Protocol Version:	1
Protocol Date:	30/10/2020
Funder's reference number (enter the reference number or state not applicable):	n/a
Project website:	n/a

Additional reference number(s):

Ref.Number Description	Reference Number
n/a	n/a

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open *access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.*

A5-2. Is this application linked to a previous study or another current application?

○ Yes ● No

Please give brief details and reference numbers.
N/A

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

This is a qualitative study investigating the perspectives of emergency department (ED) practitioners on supporting individuals with non-epileptic attacks (NEAs) or non-epileptic attack disorder (NEAD).

This study is important as NEAD is considered a complex disorder which has, until recently, been under researched. Nonepileptic attacks (NEAs) resemble epileptic seizures but occur in the absence of the brain misfiring which causes epilepsy. It is difficult for professionals to accurately assess and diagnose NEAs as there is not an agreed consensus about what causes it. The pathway to diagnosis of NEAD is lengthy, sometimes over 7 years. People living with NEAs report that it is difficult to manage their NEAs during this time, often feeling misunderstood and not listened to by medical professionals. This can be very distressing and can lead to more frequent attendances at ED's.

This is especially difficult to manage in an emergency department settings, as the staff are often working under highly stressful, time sensitive conditions. Emergency department practitioners can often be limited in to what support they are able to offer people living with NEAs. The common agreement is that psychological support is best placed but some people living with NEAs reject this and seek medication. It is important to understand the perspectives of emergency medical practitioners and hear about their experiences supporting people living with NEAs/NEAD. Any medical professional working in an emergency department and supported individuals with NEAs/NEAD are to be invited to take part. The participants will be invited to take part in a telephone/video call interview to hear about their perspectives on the matter. We aim to recruit up to approximately 20 participants, with each interview approximately lasting 1 hour. The data will then made in to a written transcript and analysed. This research may inform service pathways and contribute to the literature.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

We anticipate that any ethical issues relating to this research are considered as minimal. The following have been identified as considerations:

Due to the nature of this study, there is potential for emotive and distressing discussions of experiences that may arise with data collection. Participants are asked to be interviewed in their own time or in work time where appropriate and therefore safety of engaging in the research is paramount. The participant information sheet will outline appropriate support networks, including occupational health, and social media forums for professionals to connect to if needed. The interviewer will be a trainee clinical psychologist. The trainee will be sensitive to participant wellbeing and mindful of the context of the interview; offering appropriate breaks, allowing termination or reschedule of the interview may be appropriate to support participant welfare.

A PIS will be shared to allow for informed consent to engage in the study. Confidentiality will be upheld as far as reasonably possible. Given the context of interviews potentially in work time, on occasions managers may need to be informed of the participants involvement in the research. In addition, if in the workplace, confidentiality may be difficult to uphold over the phone, dependent on resources and privacy available to the participant. This will be discussed individually with each participant this may affect.

Furthermore, it may be required to breach a participant’s confidentiality agreement in the event of a safeguarding concern to the participant, the researcher or any patient or member of the general public. Safeguarding procedures will be discussed with key professionals in the relevant trust. Dependent on the presenting situation, a participant’s manager may be notified if safeguarding could impact on patient wellbeing or participant’s ability to continue working safely. Guidance with medical consultants will also be sought as to the appropriate action to take in a safeguarding event relating to risk participant, patient or public. The trainee will immediately inform Research Supervisors of any safeguarding risk relating to self.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply*:

☐ Case series/ case note review
☐ Case control
☐ Cohort observation
☐ Controlled trial without randomisation
☑ Cross-sectional study
☐ Database analysis
☐ Epidemiology
☐ Feasibility/ pilot study
☐ Laboratory study
☐ Metanalysis
☑ Qualitative research
☐ Questionnaire, interview or observation study
☐ Randomised controlled trial
☐ Other (please specify)

N/A

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

What are the experiences of emergency department practitioners working with individuals who present with possible non-epileptic attacks or non-epileptic attack disorder?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

How do medical professionals conceptualise non-epileptic attack disorder.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

Nonepileptic attacks (NEAs) resemble epileptic seizures but occur without the clear neurological indicators as seen in epilepsy. It is difficult to understand what causes NEAs, as it is considered they could be caused by many factors including but not limited to trauma, injury, existing alongside epilepsy and other neurological disorders. Many people experience depression with NEAs, as well as panic and anxiety too. It is not clear if these difficulties can cause NEAs or are a result of living with them.

Individuals with NEAs are likely to attend the emergency department (ED) in the hope of understanding their experiences. However, given the complexity of NEAs, it is difficult for ED professionals to accurately identify them. This can leave people often feeling misunderstood and rejected. Also, sometimes people experiencing NEAs often think it is epilepsy and reject a diagnosis of non-epileptic attack disorder (NEAD). Research also shows that there is a stigmatising response sometimes towards people living with NEAs as some professionals believe it is within the person's control. This can cause difficult relationships between patients and professionals.

With patients not understanding their experiences, they are more likely to attend the ED for help. ED's are known to be highly pressured and time sensitive environments to work in, which can make it hard to know how best to support people living with NEAs. It is important to understand the experiences of ED practitioners more so, as they often have a lot of interactions with people living with NEAs as described. Their views have been underrepresented in research with staff to date, which has mainly focused on other health care professionals.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

This is a qualitative study, with the intention to provide a thorough exploration of professionals' experiences. A qualitative approach for this research question is considered the most appropriate, in order to collect detailed information about individuals experiences and attitudes. Recruitment will take a three-staged approach.

Stage one aims to recruit current medical professionals directly from multiple emergency departments across NHS trusts in the United Kingdom. Stage two would allow for recruitment of professionals who have previously worked withindividuals living with NEAD/NEAs in ED, but this is no longer their current role within the NHS. The final stage would involve recruitment outside of the NHS via social media and professional bodies.

We will use semi-structured interviews, conducted by trainee Cerys Bailey, which will be expected to last for approximately an hour. However, consideration is given to the high work demands on this sample population,therefore approach to interviews will be flexible and dependent on availability of professionals. There will be opportunity to split the interviews or conduct follow-up interviews to further explore experiences.

We currently have the much-appreciated input of two emergency medicine consultants, Dr Carole Gavin and Dr Kath Morgan, to support development of the interview schedule and materials.

The participant information sheet (PIS) and consent form will be sent to all prospective participants via email. The participant will be asked to review the information and email their response. Consent to participate can be received via email in returning the consent form and electronic signature will be accepted.

Cerys Bailey will offer phone calls, video calls and face-to-face interviews (if appropriate, given the social distancing requirements and trust policy at the time). It is anticipated these will each last approximately 60 minutes but can be longer or shorter depending on the needs of the participants. Regardless of interview platform, only audio recordingsof interviews will be taken.

It is Cerys Baileys' responsibility to ensure appropriate carriage of the audio recording device between interviews and data transfer to the University's secure drive. If doing the interview remotely, then there will be no transportation of device. If the interviews are conducted in person, the recording device will be stored in a padlocked laptop carrier bag when being transported. The interview data will be transferred to the secure drive as soon as reasonably possiblein both instances.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☐ Design of the research
☐ Management of the research
☐ Undertaking the research
☐ Analysis of results
☐ Dissemination of findings
☑ None of the above

Give details of involvement, or if none please justify the absence of involvement.
The research question has been designed in part following the qualitative experiences of individuals of NEAD

reported in the literature (Rawlings & Reuber, 2016; Rawlings, Brown & Reuber, 2018). The focus of this research is on the experience of medical staff. Therefore, there has been extensive consultation with representative medical staff to ensure the design will fit with their busy schedules, the PIS is appropriate and that the interview schedule reflects their needs and experiences.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

☐ Blood
☐ Cancer
☐ Cardiovascular
☐ Congenital Disorders
☐ Dementias and Neurodegenerative Diseases
☐ Diabetes
☐ Ear
☐ Eye
☐ Generic Health Relevance
☐ Infection
☐ Inflammatory and Immune System
☐ Injuries and Accidents
☐ Mental Health
☐ Metabolic and Endocrine
☐ Musculoskeletal
☑ Neurological
☐ Oral and Gastrointestinal
☐ Paediatrics
☐ Renal and Urogenital
☐ Reproductive Health and Childbirth
☐ Respiratory
☐ Skin
☐ Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit: 120	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Inclusion Criteria enforced for eligibility of participation is as follows:
- Participants are required to be aged 18+
- To be employed in emergency departments as a doctor (all grades, including junior doctors) and nurses (all grades, including student nurses) (Stage 1).

- Any current experience of working with people presenting with NEAD or non-epileptic seizures in the emergency department (Stage 1).
- Historic experience of working with people presenting with NEAD or NEAs when working in an emergency department (Stage 2)
- Experience of working with people presenting with NEAD or NEAs when working in an emergency department, but no longer work for the NHS (Stage 3).

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Exclusion criteria:
- medical professionals that have not had any experience working with people presenting with NEAD or NEAs in an emergency department. Practitioners are asked that they have worked with suspected NEAs or a NEAD presentation in an emergency department within their career, in order to participate in the study.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Consent	1	0	10	Cerys Bailey will conduct all procedures The participant information sheet (PIS) and consent form will be sent to all prospecting participants via email. The participant will be asked to review the information and email their response. Consent to participate will be written, and electronic signatures are accepted as per the HRA NHS guidance
Interview	1	0	60	Cerys Bailey will conduct all interviews, video or telephone call, or face to face onsite at participating emergency departments

A21. How long do you expect each participant to be in the study in total?

Each participant will be asked to read and digest information from the participant information sheet (PIS) and provide informed consent. It is anticipated that interviews will each last approximately 60 minutes but can be longer or shorter depending on the needs of the participants.

Therefore overall time for each participant is approximated at 70 minutes.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Due to the nature of this study, there is potential for emotive and distressing discussions of experiences that may arise with data collection. Participants are asked to be interviewed in their own time or in work time where appropriate and therefore safety of engaging in the research is paramount. The participant information sheet will outline appropriate support networks, including occupational health, and social media forums for professionals to connect to if needed. The trainee will be sensitive to participant wellbeing and mindful of the context of the interview; offering appropriate breaks, allowing termination or reschedule of the interview may be appropriate to support participant welfare.

A PIS will be shared to allow for informed consent to engage in the study. Confidentiality will be upheld as far as reasonably possible. Given the context of interviews potentially in work time, on occasions managers may need to be informed of the participants involvement in the research. In addition, if in the workplace, confidentiality may be difficult to uphold over the phone, dependent on resources and privacy available to the participant. This will be discussed individually with each participant this may affect.

Furthermore, it may be required to breach a participant's confidentiality agreement in the event of a safeguarding concern to the participant, the researcher or any patient or member of the general public. Safeguarding procedures will be discussed with key professionals in the relevant trust. Dependent on the presenting situation, a participant's manager may be notified if safeguarding could impact on patient wellbeing or participant's ability to continue working safely. Guidance from medical consultants will also be sought as to the appropriate action to take in a safeguarding event relating to risk participant, patient or public. The trainee will immediately inform Research Tutors of any safeguarding risk relating to self.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

● Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

Due to the nature of this study, there is potential for emotive and distressing discussions of experiences that may arise with data collection.

The participant information sheet will outline appropriate support networks, including occupational health, and social media forums for professionals to connect to if needed. The trainee will be sensitive to participant wellbeing and mindful of the context of the interview; offering appropriate breaks, allowing termination or reschedule of the interview may be appropriate to support participant welfare.

A24. What is the potential for benefit to research participants?

It is unlikely that the participants will experience direct benefits from this research. Their involvement is important to inform literature around emergency department practitioners perspectives, understanding and conceptualisation of NEAs and NEAD.

A26. What are the potential risks for the researchers themselves? *(if any)*

There are no identified risks to the research team. The trainee will immediately inform Research Supervisors of any safeguarding risk relating to self arise.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Potential participants will be identified through local collaborators' connections.

Currently, we have identified the following local collaborators who have very kindly agreed to support recruitment of the study. These professionals work across 3 different NHS trusts, namely Salford Royal NHS Foundation Trust, Aintree University Hospital NHS Foundation Trust and Midlands Partnership NHS Foundation Trust:

- Dr Mary King (field supervisor) Clinical Psychologist, Salford Royal NHS Foundation Trust
- Dr Carole Gavin and Dr Kath Morgan, Consultants in Salford Royal NHS Foundation Trust

- Dr Hannah Traynor, Clinical Psychology, Aintree emergency Department.
- Dr Helen Jones, Consultant Clinical Psychologist, Liaison Mental Health with Shrewsbury Hospital and Princess Royal at Telford.

Study information will be shared with the above professionals, to promote the research within their local emergency departments. The study could be promoted at team meetings, medical handover meetings, email and information shared in key staff areas. Other emergency departments can also be recruited to widen the study if additional sites are required.

Stage 2 recruitment would require professional liaison and allow for recruitment of medical staff who have previously worked in emergency departments.

Stage 3 of the recruitment strategy use advertisement with relevant professional bodies including but not limited to The Royal College of Emergency Medicine and The Royal College of Nursing Emergency Care Association. Recruitment in this phase will also be supported using social media to advertise the recruitment poster, targeting professional platforms such as but not limited to Facebook groups: The Emergency Medicine Doctors and Faculty of Emergency Nursing. Recruitment could also be advertised and promoted via Twitter.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

● Yes ○ No

Please give details below:
The identification of participants in recruitment stages 1 and 2 may involve use of personal information, namely email addresses or contact numbers. Local collaborators may disseminate study information in this manner.

Stage 1 recruitment will focus on current colleagues in the department who may be interested. Recruitment stage 2 will allow for professional networking, for local collaborators to approach potential participants that have previously worked in the department, but this is no longer their current role. This again may be conducted via email or contact numbers. Stage 3 recruitment will be done via advertisement, and so prospective participants will contact the trainee directly via email or contact number provided on the participant information sheet.

A27-3. Describe what measures will be taken to ensure there is no breach of any duty of confidentiality owed to patients, service users or any other person in the process of identifying potential participants.*Indicate what steps have been or will be taken to inform patients and service users of the potential use of their records for this purpose. Describe the arrangements to ensure that the wishes of patients and service users regarding access to their records are respected. Please consult the guidance notes on this topic.*

Recruitment via stage 1 will use mailing lists/email addresses already available to local collaborators. Staff would not see the approach for research as a breach of use of the email. Researchers outside the trust will not have the contact details of potential participants until the potential participants make contact themselves.

If recruitment via stage 2 is used, local collaborators will check if potential participants are happy to receive the information for this purpose.

Recruitment via stage 3, no identifiable information will be used for recruitment.

A27-4. Will researchers or individuals other than the direct care team have access to identifiable personal information of any potential participants?

○ Yes ● No

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

● Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

A recruitment poster has been created to share with emergency departments. This poster could also support with Stage 2 and 3 of the recruitment strategy, in sharing between professionals no longer in the service, or via social media and with relevant professional bodies.

A copy of the poster is included in this application.

A29. How and by whom will potential participants first be approached?

Potential participants will be first approached via local collaborators, detailed below. This will be done via existing professional contacts and relationships with their associated accident and emergency department.

- Dr Mary King (field supervisor) Clinical Psychologist, Salford Royal NHS Foundation Trust.
- Dr Carole Gavin, Consultant in Salford Royal NHS Foundation Trust
- Dr Hannah Traynor, Clinical Psychology, Aintree Emergency Department.
- Dr Helen Jones, Consultant Clinical Psychologist, Liaison Mental Health with Shrewsbury Hospital and Princess Royal at Telford.

If needed, a second stage of recruitment will be employed. This will allow for recruitment of professionals whom have previous experience of supporting individuals presenting with NEAD/NEAs when working in an emergency department.

If recruitment remains challenging, stage 3 of the recruitment strategy will be employed. Prospective participants will be approached via advertisement with relevant professional bodies including but not limited to The Royal College of Emergency Medicine and The Royal College of Nursing Emergency Care Association. Recruitment in this phase will also be supported using social media to advertise the recruitment poster, targeting professional platforms such as but not limited to Facebook groups: The Emergency Medicine Doctors and Faculty of Emergency Nursing. Recruitment could also be advertised and promoted via Twitter.

A30-1. Will you obtain informed consent from or on behalf of research participants?

● Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

The participant information sheet (PIS) and consent form will be sent to all prospecting participants via email. The participant will be asked to review the information and email their response. All consent will be completed electronically prior to the interview. Consent to participate will be recorded and obtained via email, using their email address function as an electronic signature. Electronic signatures are accepted as per the HRA NHS guidance. The PIS has been shared with Consultants in Emergency medicine to help ensure appropriate language and tone is communicated.

If you are not obtaining consent, please explain why not.

n/a

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

● Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

Prospective participants will be emailed the participation information sheet and consent form, in a timely manner, prior to engaging interviews. A minimum of 24 hours will be ensured to allow for decision making.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Unfortunately, we are unable to facilitate interviews in languages other than English. Therefore, participants unable to communicate in English would not be able to participate in this study. Given all participants will be working for the NHS, this parameter is unlikely to exclude anyone.

If specific communication needs have been identified for a prospective English speaking participant, appropriate adaptations to meet their individual needs can be discussed. For example, if someone has difficulty hearing, a chat function can be used to interview instead.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

● Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

n/a

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

☐ Access to medical records by those outside the direct healthcare team
☐ Access to social care records by those outside the direct social care team
☐ Electronic transfer by magnetic or optical media, email or computer networks
☐ Sharing of personal data with other organisations
☐ Export of personal data outside the EEA
☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers
☑ Publication of direct quotations from respondents
☐ Publication of data that might allow identification of individuals
☑ Use of audio/visual recording devices
☑ Storage of personal data on any of the following:

  ☐ Manual files (includes paper or film)
  ☐ NHS computers
  ☐ Social Care Service computers

☑ Home or other personal computers

☑ University computers

☐ Private company computers

☐ Laptop computers

Further details:
All interviews will be audio recorded using a Dictaphone and pick-up recording device where needed. The files will be transferred to and then stored on Lancaster University's secure server or another secure cloud location deemed to meet the university's security requirements, e.g. One Drive. The transfer will be done in a timely manner and all recordings will then be deleted from the recording device once appropriately stored. Recordings will be held for the purpose of the thesis assignment and will be deleted once assessment is complete. Suitably anonymised research data including transcripts will be held by the University according to research standards for 10 years or 10 years from publication, whichever is the longer, and then will be deleted.

A37. Please describe the physical security arrangements for storage of personal data during the study?

The files will be transferred to and then stored on Lancaster University's secure server or another secure cloud location deemed to meet the university's security requirements, e.g. One Drive. The transfer will be done in a timely manner and all recordings will then be deleted from the recording device once appropriately stored. All files will be pseudonymised and identifiable and personal data separated. This personal data, such as names email address and telephone number will be coded and stored separately on the secure server. Consent forms will also be stored here.

It is Cerys Baileys' responsibility to ensure appropriate carriage of the audio recording device between interviews and data transfer to the University's secure drive. If doing the interview remotely, then there will be no transportation of device. If the interviews are conducted in person, the recording device will be stored in a padlocked laptop carrier bag when being transported. The interview data will be transferred to the secure drive as soon as reasonably possible in both instances.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

The trainee will transcribe all interviews, with identifiable information removed and data appropriately anonymised. Identity codes for all participants will be used in transcriptions and associated analysis, which will be stored separately to participant information.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

The chief investigator and trainee will have access to personal data, such as participant name, consent form, work email and potentially a contact number.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

The data will be analysed by the trainee, under the supervision of the chief investigator and academic supervisor. This will be conducted at the trainee's home and also at Lancaster University. The data will be held on the secure university system or secure cloud as approved by the university at all times

A42. Who will have control of and act as the custodian for the data generated by the study?

Title	Forename/Initials	Surname
Dr	Fiona	Eccles

Post	Principle Investigator and Research Supervisor
Qualifications	MPhys, DPhil, GradDipPsych, DClinPsy
Work Address	Doctorate in Clinical Psychology, Health Innovation One, Sir John Fisher Drive, Lancaster University Bailrigg, Lancaster,
Post Code	LA1 4AT
Work Email	f.eccles@lancaster.ac.uk
Work Telephone	01524 592807
Fax	0000

A43. How long will personal data be stored or accessed after the study has ended?

○ Less than 3 months
○ 3 – 6 months
○ 6 – 12 months
○ 12 months – 3 years
● Over 3 years

If longer than 12 months, please justify:
All contact details for participants will be deleted as soon as results have been provided to participants. However, consent forms will be kept electronically for 10 years or 10 years from publication, whichever is the longer

A44. For how long will you store research data generated by the study?

Years: 10
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended.*Say where data will be stored, who will have access and the arrangements to ensure security.*

Suitably anonymised research data including transcripts will be held by the University secure network. This can be accessed by the research team comprising of academic supervisor and chief investigator and administration staff from Lancaster University. This is according to research standards, and data will be stored for 10 years or 10 years from publication, whichever is longer.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ● No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ● No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants’ General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ● No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

○ Yes ● No

Please give details, or justify if not registering the research.
To support recruitment, the study may also be listed in relevant professional body networks approaching for example The Royal College of Emergency Medicine and The Royal College of Nursing Emergency Care Association. Recruitment in this third phase will also be supported using social media, targeting professional platforms such as but not limited to Facebook groups: The Emergency Medicine Doctors and Faculty of Emergency Nursing. Recruitment could also be advertised and promoted via Twitter.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study?*Tick as appropriate:*

☑ Peer reviewed scientific journals
☑ Internal report
☑ Conference presentation
☑ Publication on website
☑ Other publication
☐ Submission to regulatory authorities
☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
☐ No plans to report or disseminate the results
☐ Other (please specify)

n/a

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Pseudonyms will be used and that every effort will be made wherever possible to ensure that participants are not identifiable through the quotes in publication.

A53. How and when will you inform participants of the study results?

If there will be no arrangements in place to inform participants please justify this.
The results of the study will be offered to all participants and will be sent by email. The results will be shared once all the data has been analysed and the empirical paper of the doctoral thesis has been written, anticipated to be approximately March 2022.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed?*Tick as appropriate:*

☐ Independent external review
☐ Review within a company
☐ Review within a multi−centre research group
☑ Review within the Chief Investigator's institution or host organisationReview
☑ within the research team
☑ Review by educational supervisorOther
☐

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
This study is being conducted as a requirement of the Doctorate in Clinical Psychology programme at Lancaster University and has been reviewed by the research team. The chief investigator (CI) has initially approved the rationale and methodology of this project. Supervision is offered by the CI and Academic Supervisor, both of whom are considerably experienced in research. A field supervisor also has oversight over this study, who currently works in NEAD services. We also have stakeholder involvement by two medical consultants.

This project has been granted ethical approval by Lancaster University Faculty of Health and Medicine Research Ethics Committee.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 20
Total international sample size (including UK): 20
Total in European Economic Area: 20

Further details:
We aim to recruit approximately up to 20 emergency department medical professionals, comprising doctors (all grades) and nursing staff (all grades) with experience of working with individuals presenting with NEAs in this setting (stage 1).

If recruitment of medical professionals in their current role as emergency medicine practitioners proves problematic, we will open recruitment wider to invite those with prior experience of supporting individuals with NEAs in an emergency department (stage2). If recruitment continues to be challenging, we aim to recruit via professional bodies and relevant social media pages aforementioned (stage 3).

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Guest, Bunce & Johnson (2006) describe data saturation as exhaustive process of collection and analysis until there are no novel findings made, which is proposed to potentially occur after only 12 interviews. We will rely not on data saturation per se, but instead on theoretical sufficiency. Theoretical sufficiency is developed on the premise that exhaustion of data findings is uncommon and unpractical in its endless opportunities of subjective accounts in qualitative research (Vasileiou, Barnett, Thorpe & Young, 2018). Given the reflexive TA approach to data analysis in this research discussed below, data sufficiency is considered more appropriate given the importance of researcher's subjective interpretation of meaning in the data set. Reporting of data sufficiency is noted as a quality marker in qualitative research, despite this not being commonly adopted (Vasileiou, Barnett, Thorpe & Young, 2018). An indication of appropriate number of interviews to achieve theoretical sufficiency is dependent on variance within the participant population. Consideration of variation within this research is given to geographical differences of emergency departments to recruit from and aiming to engage with a range of medical professions.

Guest, G., Bunce, A., Johnson, L. (2006). How Many Interviews Are Enough? An Experiment with Data Saturation and Variability. Field Methods, 18 (1), 59–82. DOI: 10.1177/1525822X05279903

Vasileiou, K., Barnett, J., Thorpe, S., Young, T. (2018) Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. Medical Research Methodology, 18, 148. https://doi.org/10.1186/s12874-018-0594-7

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Reflexive thematic analysis (Reflexive TA), taking a phenomenological stance will be used to analysis data collected in the qualitative interviews. Thematic analysis is a flexible approach which permits a diverse sample and allows for identification of a wide range of pertinent issues. A thematic approach is to be employed to explore data as it will allow identification of both commonalities and differences throughout HCPs experiences of a heterogenous population (Braun & Clarke, 2006).

The stages of thematic analysis start with 'familiarisation' with the content, through transcription and immersing self within the data. The second phase of analysis is 'coding', where 'codes' aka labels are developed across the data set. Following collation of the 'codes' is development of 'themes' within the data. A theme is a pattern of codes grouped together by meaning which relates to the research question (Braun and Clarke, 2006). Themes are then tested and reviewed by examples of the data set, and particularly in reflexive TA themes will be informed by both the data and the theoretically knowledge of the researcher. Once themes are identified and reviewed, they are then established and further defined. The final phase is writing the analysis and consolidating interpretation of themes, context and connecting with the data examples (Braun & Clarke, n.d).

Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology 3: 77-101

Braun, V., Clarke, V. (n.d). Thematic Analysis: A reflexive approach. Retrieved from: https://www.psych.auckland.ac.nz/en/about/thematic-analysis.html

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co−applicants, protocol co−authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Dr	Mary	King
Post	Clinical Psychologist		
Qualifications	not yet known		
Employer	Salford Royal NHS Foundation Trust		
Work Address	Salford Royal		
	Stott Lane		
	Salford		
Post Code	M6 8HD		
Telephone	0000		
Fax	0000		

Mobile	0000
Work Email	mary.king2@srft.nhs.uk

	Title	Forename/Initials	Surname
	Dr	Hannah	Traynor
Post	Clinical Psychologist		
Qualifications	not yet known		
Employer	Aintree University Hospital		
Work Address	Aintree University Hospital Lower Lane Liverpool		
Post Code	L9 7AL		
Telephone	0000		
Fax	0000		
Mobile	0000		
Work Email	hannah.traynor@liverpoolft.nhs.uk		

	Title	Forename/Initials	Surname
	Dr	Helen	Jones
Post	Consultant Clinical Psychologist, Liaison Mental Health with Shrewsbury Hospital and Princess Royal at Telford.		
Qualifications	not yet known		
Employer	Midlands Partnership Foundation Trust		
Work Address	The Princess Royal Hospital Apley Castle, Telford		
Post Code	TF1 6TF		
Telephone	0000		
Fax	0000		
Mobile	0000		
Work Email	helenjones6@nhs.net		

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ○ NHS or HSC care organisation
- ● Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)
- ○ Other

Commercial status: Non-Commercial

If Other, please specify: n/a

Contact person

Name of organisation	Lancaster University
Given name	Becky
Family name	Gordon
Address	Head of Research Quality and Policy,
Town/city	Lancaster University, Lancaster
Post code	LA1 4YG
Country	United Kingdom
Telephone	44 (0)1524 592981
Fax	0000
E-mail	sponsorship@lancaster.ac.uk

A65. Has external funding for the research been secured?

Please tick at least one check box.

☐ Funding secured from one or more funders

☐ External funding application to one or more funders in progress

☑ No application for external funding will be made

What type of research project is this?

● Standalone project

○ Project that is part of a programme grant

○ Project that is part of a Centre grant

○ Project that is part of a fellowship/ personal award/ research training award

○ Other

Other – please state:
n/a

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ● No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ● No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title	Forename/Initials	Surname
	Ms	Katie	Doyle

Organisation Salford Royal NHS Foundation Trus
Address Summerfield House, 1st Floor
554 Eccles New Road
Salford
Post Code M5 5AP
Work Email nca.research@srft.nhs.uk
Telephone 0161 206 4734
Fax 0000
Mobile 0000

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 04/01/2021
Planned end date: 31/03/2022
Total duration:
Years: 1 Months: 2 Days: 28

A71-1. Is this study?

○ Single centre
● Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 3

Does this trial involve countries outside the EU?
○ Yes ● No

☑ NHS organisations in England	3
☐ NHS organisations in Wales	0
☐ NHS organisations in Scotland	0
☐ HSC organisations in Northern Ireland	0
☐ GP practices in England	0
☐ GP practices in Wales	0

☐ GP practices in Scotland	0
☐ GP practices in Northern Ireland	0
☐ Joint health and social care agencies (eg community mental health teams)	0
☐ Local authorities	0
☐ Phase 1 trial units	0
☐ Prison establishments	0
☐ Probation areas	0
☐ Independent (private or voluntary sector) organisations	0
☑ Educational establishments	1
☐ Independent research units	0
☐ Other (give details)	0
n/a	
Total UK sites in study:	4

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

● Yes ○ No

A73-2. If yes, will any of these organisations be NHS organisations?

○ Yes ● No

If yes, details should be given in Part C.

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

The trainee will conduct this research under supervision of the chief investigator and academic supervisor. The research team will engage in monthly supervision sessions to monitor the conduct of the research. The research team also consists of a field supervisor who will also be involved in the auditing of the research. Stakeholders have also had access to materials to be used.

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:* in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland**

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☑ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ● No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for theresearch sites. *For further information please refer to guidance.*

Investigator identifier | Research site | Investigator Name

IN1

NHS/HSC Site

Non-NHS/HSC Site

Forename	Mary
Middle name	not yet known
Family name	King
Email	mary.king2@srft.nhs.uk
Qualification (MD...)	not yet known
Country	United Kingdom

Organisation name	Salford Royal NHS Foundation Trust
Address	Salford Royal Stott Lane SALFORD GREATER MANCHESTER
Post Code	M6 8HD
Country	ENGLAND

IN2

NHS/HSC Site

Non-NHS/HSC Site

Forename	Hannah
Middle name	not yet known
Family name	Traynor
Email	hannah.traynor@liverpoolft.nhs.uk
Qualification (MD...)	not yet known
Country	United Kingdom

Organisation name Address	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST ROYAL LIVERPOOL UNIVERSITY HOSPITAL PRESCOT STREET LIVERPOOL
Post Code	L7 8XP
Country	ENGLAND

IN3

NHS/HSC Site

Non-NHS/HSC Site

Forename	Helen
Middle name	not yet known
Family name	Jones
Email	helenjones6@nhs.net

Organisation name SHREWSBURY AND TELFORD HOSPITAL

NHS TRUST

Qualification (MD...) not yet known

Address MYTTON OAK ROAD

Country United Kingdom

●
○

●
○

●
○

	SHREWSBURY
Post Code	SY3 8XQ
Country	ENGLAND

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application asapproved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by reviewbodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes ifrequired.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act2018.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.
11. I understand that information relating to this research, including the contact details on this application, may beheld on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.
12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further *information. We would be grateful if you would indicate one of the contact points below.*

● Chief Investigator

○ Sponsor

○ Study co-ordinator

○ Student

○ Other – please give details

○ None

Access to application for training purposes *(Not applicable for R&D Forms)*
Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Dr Fiona Eccles on 26/04/2021 15:29.

Job Title/Post:	Lecturer
Organisation:	Lancaster University
Email:	f.eccles@lancaster.ac.uk

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co−sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.

3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place beforethis research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

4. Arrangements will be in place before the study starts for the research team to access resources and supportto deliver the research as proposed.

5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research EthicsService (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at sponsorship@lancaster.ac.uk on 04/05/202109:11.

Job Title/Post:	Acting Head of Research Quality & Policy
Organisation:	Lancaster University
Email:	c.odonnell@lancaster.ac.uk

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Mr Will Curvis on 25/04/2021 19:17.

Job Title/Post:	Clinical tutor
Organisation:	Lancaster university
Email:	w.curvis@lancaster.ac.uk

Academic supervisor 2

This section was signed electronically by Dr Fiona Eccles on 26/04/2021 15:30.

Job Title/Post:	Lecturer
Organisation:	Lancaster University
Email:	f.eccles@lancaster.ac.uk

Appendix 4-A: HRA Approval Letter

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Dr Fiona Eccles
Research Supervisor and Lecturer
Doctorate in Clinical Psychology, Health Innovation OneSir
John Fisher Drive, Lancaster University
Bailrigg, Lancaster,
LA1 4AT

Email:
approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

04 May 2021

Dear Dr Eccles

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Non-epileptic seizures and non-epileptic attack disorder: The perspectives of emergency department practitioners**
IRAS project ID:	**290165**
Protocol number:	**Version 2**
Sponsor	**Lancaster University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the “Information to support study set up” section towardsthe end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report(including this letter) have been sent to the coordinating centre of each participating nation.
The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light ofchanges in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact detailsare below.

Your IRAS project ID is **290165**. Please quote this on all correspondence.Yours sincerely,

Michael Pate Approvals specialist

Email: approvals@hra.nhs.uk

Copy to: *Mrs Becky Gordon*
Miss Cerys Bailey

Appendix 4-B: FHMREC Approval Letter

Applicant: Cerys Bailey
Supervisor: Fiona Eccles,
Department: DHR
FHMREC Reference: FHMREC20066
18 February 2021

Re: FHMREC20066
Non-epileptic seizures and non-epileptic attack disorder in A&E: The perspectives ofA&E professionals

Dear Cerys,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirementsin order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adversereactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to theResearch Ethics Officer for approval.

Please contact me if you have any queries or require further information.Email:

fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Dr. Elisabeth Suri-Payer
Research Ethics Officer, Secretary to FHMREC

Appendix 4-C: Research Protocol

Research Protocol v2

Title: Non-epileptic seizures and non-epileptic attack disorder: The perspectives of emergency department practitioners

Principal Investigator and research supervisor: Dr Fiona Eccles, Lancaster University

Research Supervisor: Dr Will Curvis, Lancaster University

Doctoral student: Cerys Bailey, Trainee Clinical Psychologist, Lancaster University

Field Supervisor: Dr Mary King, Clinical Psychologist, Salford Royal Hospital.

This study is the research component of the doctorate in clinical psychology for Cerys Bailey.

The sponsor is Lancaster University.

Introduction

Non-epileptic attack disorder (NEAD) is currently classified as a 'Functional Neurological Disorder' (FND) or 'Conversion Disorder' on the authority of the Diagnostic and Statistical Manual of Mental Disorders V (APA, 2013). Generally, FND is where people experience neurological symptomologies without a clear medical aetiology (Lehn, et al. 2016). Non-epileptic attacks (NEAs) resemble epileptic seizures but occur in the absence of ictal brain activity (Reuber & Brown, 2017). Many conceptual models highlight psychological factors as being important in the development and maintenance of NEAD.

At present, there is no consensus on a theoretical model which characterises the mechanisms underpinning NEAs. However, many of these models do consider factors outside the control or awareness of the individual e.g. dissociative experiences. Baslet (2010) considers NEAs can be instigated from physiological events, such as head injury, co-occurring epilepsy or other neurological conditions. Additionally, Rawlings and Reuber (2016) postulate that these experiences can be as a result of a range of processes including traumatic memory, functional psychological coping skills, learned behaviour, "hard-wired reflexes" or a result of cognitive dysfunction. Individuals living with NEAs commonly experience depression, some suicidality, as well as reports of anxiety and panic (Bodde et al., 2009). It is not clear if these experiences result from living with NEAs or cause the attacks, but prevalence of this is likely to be under-reported due to a lack of accessibility of appropriate services (Bodde et al., 2009).

Undoubtedly, there is evidence for both physiological and psychological aspects that can instigate NEAs, with a sensitive and complex interplay between physical and psychological, rather than isolated and causative factors. Accurate identification of NEAs and further diagnosis can prove particularly challenging. This is often a prolonged and challenging process for both medical professionals and those accessing services. Mayor, Smith and Reuber (2011) report the process of diagnosis can be upwards of 15 years in some instances.

People experiencing NEAs often present themselves to emergency departments or are supported by family or ambulance staff. They commonly describe distressing experience of ‘blackouts’ or losing control (Mayor, Smith & Reuber, 2011). Attendance in emergency departments can be frequent given their distress regarding lack of or rejection of a diagnosis, mismanagement or misdiagnosis for other difficulties or misinterpretation of their understanding regarding NEAs (Rawlings & Reuber, 2016; Rawlings et al 2017; Rawlings, Brown & Reuber, 2018; Whitehead, Kandler & Reuber, 2013, Dunne et al, 2019).

Generally, emergency departments operate under stressful conditions as they are restricted by waiting time targets and consistently operating above occupancy, which could impact clinical decision making (Anandaciva, 2019). In suspected NEA presentation, it is the role of emergency department practitioners to distinguish NEAs from life-threatening conditions and gather evidence to support an accurate diagnosis. Some examination procedures are reported as painful and distressing. In these instances, a pejorative narrative can form, that the individual is within control of their attack as they respond to certain tests which a person with no conscious control would not be able to (Robson & Lian, 2017).

People living with NEAs report stigmatising responses, feeling misunderstood and that they are “faking” their symptoms (Rawlings & Reuber, 2016; Rawlings, Brown & Reuber, 2018; Dunne, Carolan, Swords & Fortunea, 2019). Investigative procedures often result in a ‘normal’ outcome, despite recurrent attendances and reports of difficulty (Rawlings, Brown, Stone & Reuber, 2017; Rawlings & Reuber, 2016). These experiences are likely to impact the ability to access appropriate services for people living with NEAs. It is common that individuals may leave the emergency department with no better conceptualisation or management of their problem. Yet, there are more likely to attend in the future given the distressing nature of their NEAs. A vicious cycle is perpetuated, as this frequent presentation and mismanagement contributes to service pressures in emergency departments, all the while the individual remains in a state of distress. This can be distressing and challenging for staff, who may feel helpless and possibly experience compassion fatigue

Uncertainty and fear of offending are common themes amongst professionals working with FND (Barnett, et al., 2020). Monzoni, Duncan, Grunewald & Reuber (2011) identified that HCPs are often apprehensive in communication of aetiology and suggesting psychological intervention to individuals with NEAs. This tentative approach could perpetuate misunderstanding in addition, diffusion of responsibility amongst professionals about whom was best placed to treat patients with NEAD also occurs (Rawlings & Reuber, 2018). This could also inhibit individuals with NEAs accessing appropriate services due to unconfident delivery of treatment strategy.

When considering professional backgrounds, research suggests neurologists conceptualise NEAs as psychological and perceive a higher degree of 'personal and treatment control' for those living with NEAs when compared to those with epilepsy (Whitehead, Kandler & Reuber, 2013). Interestingly, Reuber, Rawlings and Schachter (2020) recently published anecdotal experiences of HCPs, which focused mainly on perspectives of neurologists, psychiatrists and clinical psychologists. Within this research, commonalities in perspectives of clinical psychologists were of curiosity, hearing frustration from the medical team and anger from individuals with NEAs rejecting psychological considerations. This led to professionals feeling challenged and their skills tested as this population is often described as 'difficult'. Again, contributing to a blaming narrative.

Despite this recent study, there remains limited research in this area, particularly of qualitative nature. Further research could contribute to better understanding and conceptualisation of NEAs, identifying challenges within services and barriers to treatment pathways and working to resist a pejorative narrative. Although individuals with NEAD frequently encounter emergency department practitioners, to our knowledge, the experience of emergency medical professionals is yet to be qualitatively explored. The interplay between emergency department practitioners and those living with NEAs is considered key to the diagnostic and treatment pathway, but also it is an individual's first experience with HCP which can potentially contribute to the negative narrative commonly reported by people living with NEA's in such interactions. Therefore, this study aims to address the following research question: What are the experiences of emergency department practitioners working with individuals who present with possible NEAs or NEAD?

Method

Design

This is a qualitative study, with the intention to provide a thorough exploration of professionals' experiences. A qualitative approach for this research question is the most appropriate methodology in order to collect rich data focusing on experiences and attitudes. This approach will also allow for subjective accounts of an emotive subject area, without judgement.

We will employ semi-structured interviews, conducted by doctoral student and trainee clinical psychologist Cerys Bailey, which will be expected to last for approximately an hour. However, consideration is given to the high work demands on this sample population, therefore approach to interviews will be flexible and dependent on availability of professionals. There will be opportunity to split the interviews or conduct follow-up interviews to further explore experiences.

Interviews will facilitate discussion of understanding and conceptualisation of NEAD, experience of supporting individuals who are experiencing NEAs, contextual considerations of working in the department, challenges faced and suggestions for improvement. As the interviews will be semi-structured, they will allow participants to share any information that they feel is also important to help address the research question. We have shared our topic guide with Dr Carole Gavin, Dr Kath Morgan and Dr Mary King, welcoming feedback and input. It is anticipated this involvement will inform the interview schedule and materials.

Data will be analysed using reflexive thematic analysis (Braun & Clarke, 2019).

Participants

In qualitative research, there is ongoing conceptual deliberation considering at what point is the data adequately explored, using terms such as data 'saturation', 'adequacy' and 'sufficiency'.

Guest, Bunce & Johnson (2006) describe data saturation as exhaustive process of collection and analysis until there are no novel findings made, which is proposed to potentially occur after only 12 interviews. We will rely not on data saturation per se, but instead on theoretical sufficiency. Theoretical sufficiency is developed on the premise that exhaustion of data findings is uncommon and unpractical in its endless opportunities of subjective accounts in qualitative research (Vasileiou, Barnett, Thorpe & Young, 2018). Given the reflexive TA approach to data analysis in this research discussed below, data sufficiency is considered more appropriate given the importance of researcher's subjective interpretation of meaning in the data set. Reporting of data sufficiency is noted as a quality marker in qualitative research, despite this not being commonly adopted (Vasileiou, Barnett, Thorpe & Young, 2018). An indication of appropriate number of interviews to achieve theoretical sufficiency is dependent on variance within the participant population. Consideration of variation within this research is given to geographical differences of emergency departments to recruit from and aiming to engage with a range of medical professions.

Therefore, we aim to recruit up to 20 emergency medical professionals, comprising doctors (all grades) and nursing staff(all grades) with experience of working with individuals presenting with NEAs in their current role in emergency departments (stage 1). If recruitment of medical professionals in their current role as emergency department practitioners proves problematic, we will open recruitment wider to invite those with prior experience of supporting individuals with NEAs in this context also (stage 2). The final stage of recruitment involved advertisement of the research via professional bodies and social media (stage 3).

Inclusion Criteria for eligibility of participation is as follows:

- Participants are required to be aged 18+
- To be employed as a doctor (all grades, including junior doctors) and nurses (all grades, including student nurses).

- Any experience of working with people presenting with NEAD or non-epileptic seizures in an emergency department (stage 1); or have historic experience of working with people presenting with NEAD or NEAs when working in an emergency department (stage 2& 3)

Recruitment

Given the small sample required, recruitment of appropriate participant numbers is not anticipated to be problematic. However, we are aware of the current COVID-19 pandemic and the potential impact this may have. Therefore, we will conduct a three-stage recruitment strategy to optimise recruitment.

Stage one aims to recruit current medical professionals directly from multiple emergency departments across NHS trusts in the United Kingdom. With consenting trusts and departments, we intend for local contacts in the trust to advertise the project through staff emails, and/or information provided at clinical handover meetings and/or other team meetings and/or posters in staff areas. If recruitment directly from emergency departments is challenging (or indeed prevented due to COVID-19), stage 2 will include recruitment of medical professionals that have experience of supporting presentations of NEAs and/or NEAD when previously working in an emergency department, but is no longer their current role. These will be approached using the networks of local collaborators, snowball sampling and liaising with the emergency departments.

If recruitment continues to be challenging, stage 3 would be implemented which focuses recruitment from professional bodies, approaching for example The Royal College of Emergency Medicine and The Royal College of Nursing Emergency Care Association. Recruitment in this phase will also be supported using social media, targeting professional platforms such as but not limited to Facebook groups: The Emergency Medicine Doctors and Faculty of Emergency Nursing. Recruitment could also be advertised and promoted via Twitter, using the recruitment poster below. Any interest can be followed-up with the participant information sheet (PIS). In this phase, recruitment would be open to both current and previous emergency medical professionals.

Currently, we have identified the following local collaborators who have very kindly agreed to support recruitment of the study. These professionals work across 3 different NHS trusts, namely Salford Royal NHS Foundation Trust, Aintree University Hospital NHS Foundation Trust and Midlands Partnership NHS Foundation Trust:

- Dr Mary King (field supervisor) Clinical Psychologist, Salford Royal.
- Dr Carole Gavin and Dr Kath Morgan, Consultants in Salford Royal Hospital Emergency Department
- Dr Hannah Traynor, Clinical Psychology, Aintree Emergency Department.
- Dr Helen Jones, Consultant Clinical Psychologist, Liaison Mental Health with Shrewsbury Hospital and Princess Royal at Telford.

Other trusts may also be approached if recruitment is insufficient from these three. Where possible and practical, the trainee will attend the emergency department to support recruitment and discuss the study in person. However, provision will be made for virtual attendance (e.g. video calls, emails, phone calls etc) if this is not possible.

Data Collection

We will be flexible in the practicalities of data collection to meet the needs of the professionals and departments where possible. The participant information sheet (PIS) and consent form will be sent to all prospecting participants via email. The participant will be asked to review the information and contact the trainee by email for further information or if they wish to participate. Consent to participate will be recorded and obtained via email, using their email address function as an electronic signature. Electronic signatures are accepted as per the HRA NHS guidance. A hard paper copy of written consent will be obtained if interviews are able to be conducted in person. The PIS has been shared with Dr Gavin and Dr Morgan, emergency medicine consultants, to help ensure appropriate language and tone is communicated.

Interviews will be conducted by Cerys Bailey in English. She will offer phone calls, video calls and face-to-face interviews (if appropriate, given the social distancing requirements and trust policy at the time). It is anticipated these will each last approximately 60 minutes but can be longer or shorter depending on the needs of the participants. Regardless of interview platform, only audio recordings of interviews will be taken. Where possible, the trainee will use an online video platform such as Microsoft Teams. All interviews will be recorded with using a Dictaphone, with addition of a pick-up device used for telephone interviews. A follow up interview can be facilitated at a separate time if this is considered helpful and the participant is willing.

Supervision from the principal investigator and research supervisors will be sought, to ensure the trainee's interview style and appropriate questions are delivered to address the aims of the study.

Data Analysis

Analysis

Interviews will be transcribed verbatim by the trainee, using software for automatic transcription if available and suitable (e.g. video calls via teams may be able to make use of this software, with errors checked by the trainee). Otherwise, interviews will be transcribed by the trainee manually. Participants are informed it is not possible to withdraw data 2 weeks following interview, as data will be anonymised and collated.

Reflexive thematic analysis (Reflexive TA), taking a phenomenological stance will be used to analyse data collected in the qualitative interviews (Braun & Clarke, 2019). A thematic approach is to be employed to explore data as it will allow identification of both commonalities and differences throughout HCPs experiences of a heterogeneous population (Braun & Clarke, 2006).

Reflexive TA addresses assumptions of earlier TA models, acknowledging the researcher's theoretical assumptions and knowledge in their approach to analysis. The trainee in this instance will use supervision and liaison with field supervisor to critically engage with the analysis process, their theoretical knowledge and consider contextual alignment with the data set. Consensus amongst researchers is not strived for in reflexive TA, as the process is considered collaborative and scaffolded to generate a "richer, more nuanced reading of the data set"(Braun & Clarke, 2019).

Although there are clear stages still defined within reflexive TA, the process is considered recursive as mentioned above. The stages start with 'familiarisation' with the content, through transcription and frequent reading of the data to start immersing self with the data. The second phase of analysis is 'coding' of the data set, where 'codes' aka labels are developed across the data set. Following collation of the 'codes' is development of 'themes' within the data. A theme is a pattern of codes grouped together by meaning which relates to the research question (Braun and Clarke, 2006). Themes are then tested and reviewed by examples of the data set, and particularly in reflexive TA themes will be informed by both the data and the theoretically knowledge of the researcher. Once themes are identified and reviewed, they are then established and further defined. The final phase is writing the analysis and consolidating interpretation of themes, context and connecting with the data examples (Braun & Clarke, n.d).

Dissemination

This research will be written up in line of requirements for a thesis to complete a Doctorate in Clinical Psychology at Lancaster University. It is intended to submit the work to peer reviewed academic journals, relevant to the field of research. The findings and future implication of this study could be shared with relevant medical professional bodies, NEAD charities and psychology and health professionals strategic interest groups (SIGs). The trainee will present at Lancaster

University Thesis Presentation Event and could present at relevant conferences if the opportunity arises. A copy of the results will also be shared with the participants.

Practical Considerations

Research Costs

Costs for effectively conducting this research are intended to be kept at a minimum. Interviews will make use of free video calls or telephone calls via the internet where possible; dependent on participants needs and preferred method of communication. Any promotional material shall be designed and emailed to the relevant professional liaisons for dissemination amongst their relevant staff group.

Data Storage

As mentioned, all interviews will be audio recorded using a Dictaphone and pick-up recording device where needed. The files will be transferred to and then stored on Lancaster University's secure server or another secure cloud location deemed to meet the university's security requirements, e.g. One Drive. The transfer will be done in a timely manner and all recordings will then be deleted from the recording device once appropriately stored. The trainee will transcribe all interviews, with identifiable information removed and data appropriately anonymised. Identity codes for all participants will be used in transcriptions and associated analysis, which will be stored separately to participant information. Participants are informed via the consent form that it will not be possible after two weeks to remove individual sets of data, as this will have been anonymised and collated.

Recordings will be held for the purpose of the thesis assignment and will be deleted once examination is complete. Suitably anonymised research data including transcripts and consent information will be held by the University according to research standards for 10 years or 10 years from publication whichever is the longest and then will be deleted. Any paper consent forms will be scanned in and stored securely on the University secure database and original copies destroyed as soon as possible.

Stakeholder Involvement

The enthusiasm for the project from Dr Carole Gavin and Dr Kath Morgan (Consultants in emergency medicine at Salford Royal Hospital) as key liaisons has been much appreciated. Dr Carole Gavin has also agreed to work with the research team going forward, taking on an extended local collaborator role. We have shared recruitment materials with the stakeholders and took on board their feedback in relation to language used within these documents. It is anticipated that their ongoing insight in to recruitment and engagement of emergency department practitioners is invaluable.

Practicalities

It may be a challenge to gain HRA approval/individual trust approval to access an NHS workforce during the current pandemic. This is an ever-changing situation and could be manageable by the time this research is conducted. If necessary, the three-stage recruitment plan as outlined above will be employed.

Ethical Considerations

Due to the nature of this study, there is potential for emotive and distressing discussions of experiences that may arise with data collection. Participants are asked to be interviewed in their own time or in work time where appropriate and therefore safety of engaging in the research is paramount. The participant information sheet will outline appropriate support networks, including occupational health, and social media forums for professionals to connect to if needed. The trainee also must always be sensitive to participant wellbeing and mindful of the context of the interview.

To do so, offering appropriate breaks, allowing termination or reschedule of the interview, may be appropriate to support participant welfare.

A PIS will be shared to allow for informed consent to engage in the study. Confidentiality will be upheld as far as reasonably possible. Given the context of interviews potentially in work time, on occasions managers may need to be informed of the participants’ involvement in the research. In addition, if in the workplace, confidentiality may be difficult to uphold over the phone, dependent on resources and privacy available to the participant. This will be discussed individually with each participant this may affect.

Furthermore, it may be required to breach a participant’s confidentiality agreement in the event of a safeguarding concern to the participant, the researcher or any patient or member of the general public. Safeguarding procedures will be discussed with key professionals in the relevant trust. Dependent on the presenting situation, a participant’s manager may be notified if safeguarding could impact on patient wellbeing or participant’s ability to continue working safely. Consultation with the medical consultants involved in the project will also be sought as to the appropriate action to take in a safeguarding event relating to risk participant, patient or public. The trainee will immediately inform Research Tutors of any safeguarding risk relating to self.

Timescale

October 2020: Submit ethics application to faculty ethics committee at Lancaster University

November – December 2020: HRA application

March - July 2021: Recruitment and data collection

August 2021-September: Transcription and analysis

October 2021 – December 2021: First draft submission

January – February 2022: Second draft submission

March 2022: Final submission

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Appendix 4-D: Participant Information Sheet

Participant Information Sheet

Project Title: Non-epileptic seizures and non-epileptic attack disorder: The perspectives of emergency department practitioners.

IRAS ID: 290165

Version 4

Date: 19.04.2021

My name is Cerys Bailey, I am a trainee clinical psychologist and I am conducting this research as a requirement of the Doctoral Programme in Clinical Psychology at Lancaster University. Lancaster University's lawful basis for undertaking this research is that it is in the public interest and such processing is necessary for scientific research in accordance with safeguards.

What is the purpose of this study?

The interactions between accident and emergency department practitioners and those living with non-epileptic attacks (NEAs) also known as psychogenic non-epileptic seizures (PNES) is considered key to the diagnostic and treatment pathway. However, the experiences of these professionals in this context is yet to be heard.

Therefore, the purpose of this study is to investigate the experiences of medical professionals who have some experience working with NEAs or non-epileptic attack disorder (NEAD), in an emergency department.

Why have I been approached?

You have been invited to take part in this research project as we are looking for medical professionals who are currently or have previously worked in emergency departments, who have some experience in working with individuals presenting with NEAs or NEAD. We want to hear your experience of dealing with such presentations in an emergency environment.

To take part in the research, we ask the following:

That you are over 18

You are / have been employed as a medical professional working in an emergency department. This can be as a nurse (any grade including student) or doctors (also any grade including students).

Have some experience in supporting individuals with NEAs of NEAD in this context.

Do I have to take part?

No, your involvement in this study is completely voluntary. You have a right to withdraw your involvement without reason and this will not affect your legal rights. If you decide to take part, we will not be able to withdraw the data after two weeks as this will be past the point of transcription. This is because the data will have been anonymised and collated so we cannot remove individual contributions.

What will I be asked to do if I take part?

If you do decide to take part, you will be asked to provide your email address for us to send over the consent form. This will be sent in advance to allow time for any questions you may have to be answered.

If you provide consent to continue, we will arrange a suitable time to undertake an interview which we anticipate to last approximately one hour. We understand this may be difficult to navigate around work commitments and so we can be flexible with timings to suit your needs. Given the current COVID-19 climate, we anticipate all interviews will be conducted via telephone / video platform such as Microsoft Teams. It may be possible to conduct face to face interviews if the global pandemic is resolved, and contact is deemed safe. The interview will be relaxed and informal, asking questions around your perspectives of NEAs and experience of working to support individuals with this in an emergency department setting. You will be encouraged to talk about what is important to you in this context. There will be an opportunity to take part in a second interview if you feel this would be helpful for you.

Will my data be Identifiable?

The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data:

- The audio files will be transferred in a timely manner to the University approved secure cloud storage. No one other than the researchers will be able to access them. All audio files will be deleted from the recording device once securely stored.
- Audio recordings will be deleted once the project has been assessed.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. Anonymous identity codes will be utilised in transcriptions and associated analysis documents. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential. This could be your name, email address or contact number used for the purposes of contact for the interview. A unique anonymised file will be assigned to you, where this information will be stored in a password protected document. All correspondence via email will be transferred here also. This file will be kept separately from your interview responses, in the university approved secure drive. The file will then be deleted after the results of the research have been shared with participants. Only researchers will have access to this information.
- At the end of the study, anonymised versions of the data will be kept on the University Secure Cloud storage for up to ten years, or ten years from publication, whichever is the longer and only be accessible to the researchers.
- There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I must do this.

  Lancaster University will be the data controller for any personal information collected as part of this study.
- Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify

personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the research team, details below.

- For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

What will happen to the results?

The results will be summarised and reported in the form of a doctoral thesis and may be submitted for publication in an academic or professional journal. The findings could also be shared with relevant medical professional bodies, NEAD charities and strategic interest groups (SIGs). The trainee will present at Lancaster University Thesis Presentation Event and could present at relevant conferences if the opportunity arises. A copy of the results will also be shared with you as participants also if desired. As previously mentioned, every attempt will be made to ensure no identifiable data will be included in the report or any possible publication submissions.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part. We welcome your involvement to contribute to literature helping to understanding emergency department practitioners' conceptualisation and awareness of individuals living with NEAs. In understanding these perspectives, it could potentially highlight commonalities in challenges experienced by these professionals in management of NEAs and from this potential solution suggestions could be developed to support this staff group.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:

Cerys Bailey: c.bailey6@lancaster.ac.uk 07508406276

Principal Investigator - Dr Fiona Eccles: f.eccles@lancaster.ac.uk 01524 592807

Research Supervisor - Dr Will Curvis: w.curvis@lancaster.ac.uk

Doctorate in Clinical Psychology, Health Innovation One,

Sir John Fisher Drive, Lancaster University

Lancaster, LA1 4AT

What happens if I want to take part?

We would welcome any interest in taking part in the study via email to Cerys Bailey: c.bailey6@lancaster.ac.uk. Cerys will be happy to answer any questions you may have about participation in this research. If you are then happy to proceed, then we can arrange an interview via your preferred contact method.

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine, Furness Building,
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress

If you find that you are experiencing difficulties at work, we recommend that you contact your line management or occupational health. Also, your personal GP could also support you in this event. Should you feel distressed either as a result of taking part, or in the future, the following resources may also be of assistance.

Mind http://www.mind.org.uk/

Info line: 0300 123 3393

The Samaritans https://www.samaritans.org/

Info line: 116 123

Helplines Partnership

Website address: https://helplines.org/helplines/

Appendix 4-E: Consent Form

Consent Form

Project Title: Non-epileptic seizures and non-epileptic attack disorder: The perspectives of emergency department practitioners.

Name of Research contact: Cerys Bailey, Trainee Clinical Psychologist

Email: c.bailey6@lancaster.ac.uk

We are asking if you would like to take part in the above research study, looking at the perspectives of accident and emergency medical professions on working with Non-epileptic attacks, or Non-epileptic attack disorder. Before you consider consent, we ask that you read through the participant information sheet carefully (version 4, 19.04.2021). If you have any questions relating to the consent process or details about the research, then please do not hesitate to contact Cerys Bailey, on the email above. If you are happy to proceed, then please read the below statements and indicate your consent by typing your initials in each box, if you agree. We will accept your email as electronic signature of consent, when emailing the completed form back.

Please read the following carefully

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have these answered. ☐
2. I understand that my participation is voluntary and that I am free to withdraw, without giving reason. I understand that it will not be possible after two weeks to remove my data, as this will be anonymised and collated. ☐
3. I understand that my interview will be audio recorded. This will be transcribed into a written commentary and all identifiable information will be removed. ☐
4. I understand that the audio recording will be kept until after the thesis research project has been assessed. ☐
5. I consent to Lancaster University holding written transcripts of the recordings for a minimum of 10 years after the end of the study, or 10 years from publication, whichever is longer. ☐
6. Quotes I have said in the interview may be used anonymously in future reports, publications or presentations by the researchers. My personal information will not be included, and I will not be identifiable. ☐
7. I understand that my name will not appear in any reports, articles or presentation without my consent. ☐
8. I understand that any interview data I provide will be protected and kept secure. ☐
9. I understand that my personal information will remain confidential, unless in the event of a safeguarding issue where the researcher deems a risk to myself or others. In the event this occurs, the researcher may discuss this situation with other team members and may need to take action. ☐
10. I agree to take part in the above study. ☐

__________________________ _________________ __________________

Name of Participant Date Signature

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher /person taking the consent____________________________

Date ____________ Day/month/year

One copy of this form will be given to the participant and the original kept in the files of the researcher at Lancaster University.

Appendix 4-E: Recruitment Poster

Recruitment Poster

Research Opportunity

Research title: Non-epileptic seizures and non-epileptic attack disorder:

The perspectives of emergency department practitioners.

Have you worked with anyone experiencing **non-epileptic attacks** or suspected a diagnosis of non**-epileptic attack disorder** whilst working in **an emergency department?**

If so, we would love to hear from you and invite you to take part in our research.

We ask that you are over 18 to participate and have had some experience working with non-epileptic attacks in an emergency department. We invite you to take part in an interview via telephone, video or face-to-face, to hear about your experiences.

If you would like more information or have any questions, please do not hesitate to contact Cerys Bailey, doctoral student on c.bailey6@lancaster.ac.uk.

Appendix 4-F: Topic Guide

Topic Guide

This document is intended as a guide for the research team when conducting interviews and will not be shared with participants. This is to be used as an outline of the key areas that will be covered in the interviews.

Detailed below are some example questions which may support this. These questions and topics will be used flexibly and interviewing style will be adaptive in response to the participants' interests.

Opening

Rapport building & Introductions. Consent revisited

Purpose: I would like to ask you some questions about your experience in supporting individuals with NEAs / NEAD when working in the emergency department.

Timeline – We anticipate this interview may take an hour, but if at any time you need a break or wish to pause the interview for another time, please let me know.

Topic 1: Background and experience in an emergency department

Gather relevant demographics

- *Age, gender, ethnicity, role/qualifications (e.g. FY1, nurse, sister etc), length of time qualified, length of time working in an emergency department, how recent is their experience working with NEAs?*

Can you tell me what experience you have had working with individuals with NEAs?

When did you first experience this presentation?

How did you feel about supporting these individuals with NEAs/NEAD?

Did you experience any personal impact in response to your work mentioned?

- *(Holding in mind any burnout, frustrations, challenges, job satisfaction?)*

Topic 2: Understanding of NEAD

Can you tell me what you know about NEAD?

How was NEAD thought about in your emergency department?

What training or information had you received about NEAs/NEAD?

Topic 3: Strengths and Challenges in supporting individuals with NEAs/NEAD in an emergency department

What has helped you in supporting these individuals?

What challenges did you face (if any) when working with individuals with NEAs/NEAD?

Did you feel supported by the department in what support you could offer?

Do you have any ideas about what may improve service delivery in supporting these individuals?

Topic 4: General Considerations

Is there anything else you feel is important to discuss in this context?

Closing & Debrief

We really appreciate the time you have taken to be involved in this research.

Is there anything else you think it would be helpful for me to know?

How did you find participating in the interview?

We hope that there are no difficulties relating to the interview following your participation. Please do not hesitate to contact myself, or research contacts as outlined in the participant information sheet. Please also email me on c.bailey@lancaster.ac.uk if you feel there is anything you wish to further discuss following our interview today. I am happy to arrange a separate time to capture your further thoughts.

We intend to share the findings with all participants, if this is something you wish to receive.