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Walden University

College of Social and Behavioral Sciences

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Shawna Stoneking

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Walden University
2015

Abstract

The Exposure of Workplace Conflict on Residential Mental Health Clients

by

Shawna D. Stoneking

MS, Walden University, 2008

BS, New York Institute of Technology, 2006

Dissertation Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

Walden University

February 2016

Abstract

Individuals who receive residential mental health services rely on caregivers for support, supervision, and a safe living environment. Residential clients exposed to workplace conflict among staff may feel insecure and mistrust their caregivers, which in turn could negatively impact quality of life and treatment outcomes. The theory of therapeutic alliance proposed by Zetzel, emphasizing the client's perception of the therapist as a nurturing beneveolent figure, was used as the conceptual framework for this phenomenological study. Semi-structured interviews were conducted with 6 adults, recruited with homogenious sampling, who had experienced conflict among staff members and who had been discharged from residential mental health services within the last two years. Participants were asked about treatment satisfaction and perceptions of their safety while in treatment. Open-coding, categorizing, and interpretation were used to create theoretical categories for interpretation and analysis. The themes that emerged in situations involving staff conflict included reporting of increased mental health symptoms, feeling ignored by staff, feeling fear, perceiving their basic needs as unmet, and noticing staff splitting. The social change implications of this study include findings can be used to benefit the clients of these facilities and also staff through education about how relationships among staff members impact treatment; these findings may result in improved treatment outcomes that would benefit not only the clients and their families, but also the staff and facility through improved treatment outcomes and satisfaction. In turn, improved mental health outcomes benefit society in general through reduced financial costs and increased productivity.

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Chapter 1: Introduction to the Study

Individuals residing within residential mental health care facilities rely on staff (i.e. case manager, caregiver, mental health worker, and clinician) to provide life-sustaining measures and assist with daily care needs. According to the Washington State Department of Health (2012) residential mental health care facilities are designed to deliver age appropriate services within a 24-hour supervised environment, which includes evaluation, stabilization, and ongoing treatment to meet the health care needs of the residential population. As caregivers provide individualized care, support, supervision, and encouragement for a safe living environment the caregiver also develops an alliance with the residents. Such an alliance can encompass a positive need-based relationship between the resident and the caregiver, optimizing treatment adherence and success (Horvath & Luborsky, 1993). The resident's perception of safety and security may be impacted by the behaviors, workplace conflict, stress, and unprofessional conduct of the caregiving team. Residential clients exposed to workplace conflict may develop insecurity and a decrease in trust for the caregivers causing the therapeutic alliance to collapse (Dubios & Singh, 2009). Pressured timelines and increased workloads increase the potential for poor quality care and conflict within the workplace (Dubios & Singh, 2009).

Merging clinical employees into congruent caregiving teams enables optimal care for the client. One goal of this strategy is to increase effective quality-based services and supports to the service user (i.e. facility resident). When conflict within the treatment team occurs due to a breakdown in communication, responsibilities, or direction the quality of service delivered to the client may be decreased (Freeman, Miller, & Ross, 2000). Brown, Crawford and Darongkamas (2000) conducted a comprehensive study in the UK attempting to isolate the variables involved in interrelated team conflict within the mental health care setting. Brown et al. (2000) stated that roles between providers are poorly delineated when integrating working groups into team structures. Such a process imposes a potential for damage for the clinician's professional identity, which promotes isolation and aversion to service delivery (Brown et al., 2000). The consequences to such events may impact the safety, health, and services of the adult client receiving residential mental health care services.

The purpose of this study was to examine the adult residential clients' perceptions of workplace conflict, how the conflict is experienced by the adult residential clients, and how these experiences influence treatment outcomes of the adult client's residing within mental health care facilities. Failure to understand and manage workplace conflict within the team of caregivers can provoke violence, absenteeism, and neglect to job duties within the team of caregivers, which affects client care (Centers for Disease Control [CDC], 2011). According to the Washington State Department of Health (DOH) workplace conflict and stress can lead to a breakdown within the team structure and such breakdowns have the potential of leading to violence (DOH, 2011). Residents receiving care may be exposed to negative actions, behaviors, and attitudes of the caregivers. It is unclear what happens to the adult residential clients once exposed, how they perceive the conflict, if their sense of safety is altered or how the experience influences their treatment outcomes. Workplace conflict, the impact on client care, and effective treatment is discussed further in Chapter 2.

Although, a substantial amount of research is available on workplace conflict and its effects upon employees, a gap in current literature exists regarding how workplace conflict is perceived and experienced by the residential mental health client. Few researchers have specifically examined the effects of workplace conflict from those receiving services (i.e. customers, patients, or clients). The CDC (2011) and the United States Bureau of Labor Statistics (2011) reported that the consequences of unresolved workplace conflict can be life altering, forcing employees to miss work, incur psychological damage, social withdrawal, and increase the potential for fatalities. Based on the significant amount of research provided by the CDC and the United States Bureau of Labor Statistics on workplace conflict between staff, it is assumed that the conflict may impact those receiving services. Furthermore, the report made by the Centers of Disease Control (2011) on workplace conflict may aid administrators of residential health care facilities in developing stronger working teams; however, it does not provide insight or promote ideas on how to improve the relationships between the caregivers and clients who have been exposed to such conflict.

This research can help to fill the gap in literature by broadening understanding of workplace conflict as perceived by the client and promoting ideas to increase safety and health standards within mental health residential facilities. Increasing the quality of life and improving treatment adherence and successful outcomes for adult clients receiving residential mental health services must start with building collaboration and a working alliance between the client and the caregiving team (Botella et al., 2008).

Nature of the Study

A phenomenological approach was chosen as the methodology for this study. Phenomenology permits the researcher to capture the essence of the lived experience from the individual experiencing the phenomena (Creswell, Hanson, Clark-Plano, & Morales, 2007). The phenomenological approach is aimed to assist the working researcher in extracting and identifying the perception of the situation through the participants lived experience (Moustakas, 1994). For the purpose of this study I investigated the experiences of adult clients who previously lived within a residential mental health facility and focused on the influence of team conflict on treatment outcomes. The participants in this study consisted of adult clients recently discharged from a mental health residential facility. The research questions driving this study are:

1. In what way, if any, do the residents of the mental health care facility perceive conflict as interfering with their goals in treatment?
2. How do the residents of the mental health care facility experience workplace conflict when it arises amongst the team of caregivers?

The goals of this study include an examination of adult residential mental health clients reported experiences of living within mental health residential facilities, determining satisfaction of care as reported by the adult client, identifying the client’s perception of safety and health, and unfolding the client’s perception of conflict as it relates to their team of caregivers. Further discussion of the research goals and the study design is provided in the methods section, Chapter 3.

Problem Statement

Residential care facilities range from nursing homes, hospital settings, and mental health inpatient care settings. Each setting employs staff of various educational and vocational backgrounds to provide service and support to individuals in need of care and support (Dubois & Singh, 2009). The staff is assimilated into caregiving teams and assigned roles and duties necessary for the facility requirements. The caregiver to client ratio typically ranges from one caregiver to eight adult residential clients (Dubois & Singh, 2009). Stress, burnout, and an inability to cope with the demands and needs of the residential facility are risks for conflict to emerge within the caregiving team (Dubois & Singh, 2009). The conflict, should it arise, could negatively impact the outcomes for clients under the team of caregivers (Dubois & Singh, 2009). An understanding of the effects of team conflict on the therapeutic relationship between the caregiving team and the residential clients is needed.

Purpose of Study

In an attempt to increase quality of life standards for individuals residing within the structures of residential mental health, we need to know how conflict within the treatment team is experienced by the residents, how these experiences impact the resident’s perception of success and treatment outcomes, and how the residents identify the perception of these experiences. There is a need to understand how adult residents experience workplace conflict from their team of caregivers. Therefore, the purpose of this phenomenological study was to examine how residential mental health clients experience conflict within the caregiving team structure, understand the client's perception of conflict, and assess the perceived impact of workplace conflict on treatment goals of the residential mental health clients. The literature review in Chapter 2 includes information on current residential mental health care, consumer supports, and the impacts of caregiving teams on residential care.

Conceptual Framework

The theory of the therapeutic alliance has been used widely and interchangeably within psychiatry and psychoanalysis. Therapeutic alliance is the process of the clinician and client developing a collaborative relationship, utilizing reality based practices during the therapeutic process. The therapeutic alliance enables both the client and clinician to satisfy the elements of need and gratification while reflecting upon discrepancies within the relationship (Horvath & Luborsky, 1993). Due to the nature and relationships between the adult residential clients and caregivers, the therapeutic alliance was chosen as the conceptual framework of this study. In addition, the theory of the therapeutic alliance was used to guide the interview questions of this study. Through the interview questions I obtained an understanding of residential client perceptions of care and their collaborative relationships with staff. In addition, the therapeutic alliance enabled the ability to extract and code meaningful data from interviews that related specifically to transference, working alliance, and relationships between clients and staff.

For this study, therapeutic alliance is referred to as the unique relationship that progresses along a two phase continuum with the end result consisting of a decrease in patient distress (Catty, 2004). Psychiatric and therapeutic practices used the therapeutic alliance in various settings as a valued technique for collaborative work leading to positive outcomes (Safran & Muran, 2006). The presence of the alliance between adult residential mental health clients and the team of caregivers was explored in this study. Chapter 2 provides an overview of the characteristics and techniques of the therapeutic alliance.

Operational Definitions

Fraternization: The association or the development of a friendship (Lankshear, 2003).

Team based care: Assimilation of a working group who share in communication, decision making, and service delivery (Horsfall, Cleary, & Hunt, 2010).

Workplace conflict: to an aggressive interaction between people, teams, or departments due to factors involving the violation of rules, regulations, or social standards (Singleton, Toombs, Taneja, Larkin, & Pryor, 2011).

Workplace stress: the occurrence of an altered cognitive appraisal and coping mechanism in response to environmental, personal, and work related complex factors (Lazarus & Folkman, 1984).

W*orkplace violence*: is the occurrence of violence or the threat of violence against co-workers. It can occur at or outside the workplace and can range from threats and verbal abuse to physical assaults and homicide, one of the leading causes of job-related deaths (United States Bureau of Labor Statistics, 2011).

Assumptions

For the purpose of this research study, it was assumed that the residents participating in this study have experienced the phenomena of workplace conflict among the team of caregivers. Each individual would agree to participate in open-ended interviews and discuss their experiences while residing at a mental health residential care facility. It was also assumed that each participant was honest and has the ability to answer the questions posed during the interview.

Limitations

The findings from this study are subject to interpretation by the researcher. The method of sampling involved purposive and homogenous sampling, which limited the sample population to those who recently lived in one facility and may had experienced the phenomena, and who shared distinctive characteristics (Creswell & Plano-Clark, 2006). The small sample size does not imply generalized results for all individuals who have received mental health residential services. Limited data were ontained due to a low response rate. Results from this research study are not a generalization of all individuals living in or who have lived within mental health residential facilities.

Delimitations

For the purpose of this study only those participants who recently discharged from the designated residential mental health facility were invited to participate.

Significance

The influence of workplace conflict on the perception of safety, wellbeing, and treatment success of the facility client is unknown due to the gap in current literature. This study explored the lived experiences of adult clients who recently resided at a mental health residential care facility and their perspective of safety, health, and treatment outcomes. The findings of this study may help promote a better quality of life and a safer living environment for the residents living within residential mental health care facilities.

Implications for Social Change

The impact of workplace conflict on client care was addressed by obtaining direct accounts from the adult clients who recently resided within a mental health care facility. The implications for positive social change can be accomplished from this study by using the lived experiences of the adult participants to understand their perception of safety, care, and mental health treatment success. An understanding of how conflict among caregivers is experienced by residents will help to refine communication amongst caregivers and between caregivers and the clients. The results of this study may improve human and social conditions for residential clients through refining communication, increasing safety and health care standards, and promoting a higher quality of life for the individuals receiving care. The implications of increased health care standards will create a safer workplace atmosphere for healthcare providers as well as improved self-care among the healthcare team. Healthcare providers can also utilize the findings from this study to develop strategies to increase continuity of care, care delivery, and client satisfaction. Benefits may also extend to the families of individuals with mental illness who may need higher levels of care. Families may take proactive approaches to the health care and safety needs of their loved ones and seek residential treatment.

Summary

This study was intended to expand awareness of the impact that workplace conflict may have on client's residing in mental health facilities. Client exposure to conflict among the team of caregivers within the residential mental health care facility is an ongoing social problem with the potential to lead to altered treatment success and reduced quality of life. This study was needed in order to expand awareness of this problem.

Chapter 1 introduced the topic of this study and explained the organization to frame this study. Chapter 2 discusses the search strategy used in gaining the literature on the topic of interest and review relevant literature to support the study. Chapter 3 provides the methodology and study design.

Chapter 2: Literature Review

Introduction

Adult residential mental health care facilities are designed to enrich the lives of the population served by providing support, safety, and ongoing care (Department of Social and Health Services, 2011). Recovery and resiliency of chronic mental illness can be altered by various factors including environment, stimuli, acceptance, treatment modality, and appropriate care settings (Gaumond & Witter, 2009). By understanding the lived experience from the point of view of the adult client receiving residential mental health services, we may be able to increase client success and prevent relapse. Client satisfaction surveys have been utilized to capture quantitative data for client satisfaction of services provided. However, little has been reported on the perception of the residential client's experiences as it relates to the exposure of conflict within the team of caregivers. To understand more about adult clients receiving mental health residential services, I first examined origins of residential care, where it is today, and support networks available to aid in the process of recovery. Following this examination, I reviewed challenges that may pose an impact to the clients receiving residential services. Finally, I will discuss a popular model of care.

Organization of the Review

Upon commencement of the literature review, an analysis of research strategies is presented. The remaining content of this literature review will focus on influential research pertaining to the origins of residential care, residential care today, consumer supports, and the impacts of caregiving teams on client care services. This will provide a better understanding of client care and services offered to individuals living within the structure of residential mental health care facilities.

I will begin this review of literature with a historical background of residential care settings for individuals with mental illness, touching upon the roles of service providers and the modalities of treatment. Next, I will discuss current models of residential care settings and the tools used to increase recovery and resiliency within the residential population. Thirdly, I will present a discussion on available consumer support networks and the impacts of the caregiving team on residential services. I will provide an overview of therapeutic alliance, encompassing the benefits and challenges involved in the development of the therapeutic relationships between the residential client and the service provider. In addition, I will also identify gaps in current literature.

In order to prepare for this research study, available literature was reviewed to establish a background for the study. The sources used for the literature search include the libraries of Walden University; databases such as ERIC, EBSCO, and Pro Quest were utilized. Key search words were community mental health, residential care facilities, patient care, mental health teams, perceptions of care, and mental health staff. In addition to the Walden library, government Web sites such as Joint Commission (JACHO), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Alliance for Mental Illness (NAMI), and the Department of Social and Health Services (DSHS) provided additional resources. There was little research literature that directly referred to mental health residential care facilities and the perception of residential client experiences, or conflict within caregiving teams. For this reason, literature related to residential facilities, nursing homes, and health care facilities became favorable in the Walden Library search. Therefore, the available information made a minimal contribution toward understanding the perceptions and experiences of individuals receiving mental health services in a residential care setting as it relates to exposure to workplace conflict.

Residential Mental Health

Origins of Residential Care

Residential care for acute and chronic clients with mental illness dates back to services made available in the late 1700s, which were considered long term care or institutionalization. The first hospital designed to provide care for patients with mental illness opened in Williamsburg, Virginia (“The History of Eastern,” 2011). At the time the staffing pattern consisted of a physician, a keeper, a matron, and random care providers, which often included slaves (Virginia.gov., 2011, “Treatment: 18th Century vs. 19th Century”). Aside from the physician, the providers had no medical or mental health training (Centalaza, 2009). Residential settings were developed to provide safety and housing for individuals with mental illness as well as to keep the community safe from unpredictable behaviors and symptoms brought on by the illness (“The History of Eastern,”2011). At the time, mental illness was considered to be either a state of mania or melancholia (Centalaza, 2009). Individuals identified as disruptive to society were often diagnosed with mental illness. These individuals were often removed from the community and restrained within the confines of the hospital until disruptive behavior ceased or until family was able to retrieve and provide safe housing for the individual (Centalaza, 2009). The idea of reintegrating the patients back into the community was dependent on the patient's ability to become normalized. Treatment modality often included seclusion to small rooms or cells containing a mattress and shackles or the use of leeches and restraining chairs (Centalaza, 2009). Bed space was sparse: patients were allowed to stay for only a few weeks prior returning to family or to jails. It quickly became apparent that these individuals were not able to manage independently and the creation of long term housing or institutionalization became a favorable way to treat the highly acute (The History of Eastern," 2011). Once the practice of long term housing was accomplished, its success of providing safety for both patients and the local community prompted other communities to open and enlarge current housing units for people diagnosed with chronic mental illness who were believed to lack the ability to live independently. The expansion of such structured settings was not without difficulty, areas of concern during the early development consisted of funding, available staffing, medical providers, inhuman treatment modalities, and acceptance of the community members ("The History of Eastern," 2011).

For more than forty years, continued efforts by mental health service providers have enabled a great number of patients with mental illness to transfer from institutional models of care to community based models (Manderscheild, Atay, & Crider 2009). These changes have occurred in order to provide proactive solutions to the challenges found within the long-term institutions as well as enrich the lives of those with mental illness. Commonly reported challenges consisted of inhumane treatment, limitations on therapeutic practices, high cost causing financial burden, and widespread overcrowding (Lamb & Bachrach, 2001; Thornicroft & Tansella, 2002). As a means to overcome these challenges, community models were introduced such as long-term residential care, short-term residential care, outpatient care with community support, and case management. Additional features to community-based models are patient-centered care, structured housing, mental health treatment options, assistance in developing real life skills, assistance in accessing community resources, opportunities to integrate back into independent living, and re-establishing relationships with family (Thornicroft & Tansella, 2002). Current literature provides ample evidence for the changes to environmental and mental health treatment program options, but little is published on how challenges within the care teams were overcome. Challenges within the care teams ranged from inadequate training, inadequate staffing to provide appropriate care to the patient population, the presence of abuse and neglect toward vulnerable patients, and violence or bullying within the care team (Thornicroft & Tansella, 2002).

Residential Care Today

Residential settings for individuals diagnosed with chronic and persistent mental illness have been a unique approach to prevent repeated hospitalization and homelessness. Residential settings are designed to provide continuous and round the clock supervision by trained mental health care providers within a community based housing structure (DSHS, 2012). These structures are often not locked, providing access to community supports and resources. Residential settings were designed to prepare individuals with the tools needed to be safe and successful before returning to independently living. Residential settings differ in areas of programing, education, size, target population, and community involvement.

Areas addressed in these treatment settings may include medication management, diagnosis and symptom management, cooking, household cleaning, personal hygiene, relationship building, shopping, finance and budgeting, and self-awareness. Treatment modalities encompass individualized strength based treatment plans and the inclusion of education and therapeutic groups, individualized therapeutic sessions, and hands on skill building. The number of staff varies, as it is based on shift needs and acuity within the milieu (Ireys, Achman, & Takyi, 2006). The staff structure may be composed of the division director, team leader, therapist, psychiatrist, mental health nurse, reception, case managers and line staff. The line staff is scheduled to provide 24 hours day supervision with a ratio of no less than one staff member to eight residents during daytime hours (Ireys et al., 2006).

The introduction of community mental health has brought with it programs and treatment centers geared to improve the lives of people who suffer from innumerable forms of mental illness within the community. Many mental health treatment and services may provide a wide gamut of services which may include dependency health, victim's advocacy, children and adolescents, adult, geriatrics, family planning and family counseling, and homeless prevention programs (NAMI, 2011). The need to provide increased services and diverse treatment modality to individuals with acute and chronic mental illness continues to grow each year. Some agencies provide both inpatient and outpatient service options to those diagnosed with acute and chronic mental illness. An estimated 40.5 % of seriously mentally ill adult patients received outpatient services and an estimated 7.5% of seriously mentally ill adult patients received inpatient services during 2008 in the United States (NAMI, 2011).

Many individuals with mental illness successfully live independently within their communities (NAMI, 2011). For some, living independently has presented with challenges and barriers compromising success and in some cases leading to homelessness. In a 2008 annual homelessness review, an estimated 26% of all homeless adults receiving temporary shelter had a serious mental illness (Paquette, 2010). Such barriers include poor judgment, poor insight, treatment nonadherence, alcohol and drug abuse, decompensating, and homelessness (Lamb & Bachrach, 2001).

Support, Caregivers, and Care Models

Consumer Support

Individuals with acute and chronic mental illness make up a considerably high population (Catty, 2004). National Alliance for Mental Illness (2010) estimated the current population of individuals with a diagnosable or diagnosed serious mental illness to be comprised of nearly 60 million Americans. This population of men, women, and children are faced with obstacles that may interfere with quality of life including but not limited to health care, employment, housing, and food. Furthermore, this population may be stricken with symptoms of decompensation, placing them at risk for neglect, abuse, and coercion. Community leaders have assembled housing projects and treatment centers to assist individuals with mental illness to overcome the hurdles hampering their quality of life. Additional standardizing, credentialing, and regulatory organizations have been developed to provide further support.

The onset of consumer support organizations emerged in the late 1960s as a method to ensure patient safety and care. Organizations such as the Joint Commission (JACHO), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Alliance for Mental Illness (NAMI) have become proactive leaders and consumer support networks. The continued efforts of these consumer support networks aids in the development and utilization of best practices used within community mental health agencies. National Alliance for Mental Illness has provided services to improve the lives of individuals and families suffering from mental illness since 1979 (NAMI, 2010). NAMI has used innovative evidence-based practices to ensure successful outcomes such as support, education, advocacy, and research.

In 1992, SAMSHA developed a block grant to fund community mental health agencies that serve individuals with chemical dependency disorders (SAMSHA, 2010). Federal legislation required all agencies providing services within this range to develop an operational definition of serious mental illness. Agencies providing services to individuals with functional impairments related to mental, behavioral, or emotional disorders are advised to encompass strategic initiatives in the following eight areas: prevention of substance abuse and mental illness, trauma and justice, military families, health reform, housing and homelessness, health information technology for behavioral health providers, public awareness, support, data, outcomes, and quality (SAMSHA, 2012).

Joint Commission has been actively working within the mental health field since 1969 (JACHO, 2012a). During the early years, JACHO's involvement was primarily restricted to developmental disability services. It has since grown with the inclusion of hospitals, mental health hospitals, and community mental health agencies. The purpose of including JACHO standards is to ensure that programs and care facilities are providing the best quality of health care services possible (JACHO, 2012b).

Community mental health agencies utilize the services of JACHO, NAMI, and SAMSHA as these organizations can provide the latest research information on successful patient care and evidence based outcomes. Mental Health agencies have incorporated standards and guidelines developed by these innovative leaders into working policies. The primary goal of such integration of standards, guidelines, and policy is to promote mental health recovery and resiliency within the population served.

With the aid of organizations as SAMSHA and NAMI, the stigma attached to mental illness has declined. As community awareness increases, so does the need for community mental health agencies to provide adequate support and care. Community mental health has identified the urgency for increased services in recent years and has embedded comprehensive services available to community members. Such services include medical services, outpatient services, inpatient or residential care settings, urgent or acute care services, and outreach case management.

Challenges Impacting care

While providing various opportunities for care appears to provide a manageable continuum of standards for individuals with mental illness it also presents challenges and barriers for some service providers. Cost, space, resources, and skilled staff are necessary components in the development and maintenance of residential care facilities (Lamb & Bachrach, 2001). Communities that lack in funding, resources, and skilled staff may marginally meet the demands of the patient population. Caregivers may be faced with increased caseloads, increased stress, and decreased flexibility in offering individualized treatment options. Potential barriers and challenges faced by health care delivery teams can include larger caseloads assigned to individual providers, increased responsibilities with little or no compensation, poor communication, longer work hours, and staff burnout (Gilbody, Barkham, Bee, & Glanville, 2006; Hunslicker, 2010). These barriers and challenges within the team of caregivers may further lead to avoidance and hostility ultimately decreasing safety and security for the residential clients (Gilbody et al. 2006). Consequently, the clients receiving mental health services may be exposed to the workplace conflict amongst the team of caregivers potentially impacting care and treatment success. Literature on the effects of workplace conflict on residential clients residing within residential mental health care facilities is limited, showing that there has been little research conducted to date.

Caregiving Team

Teams are comprised of individuals working together to accomplish a common goal. Grumbach and Bodenheimer (2010, p. 1246) provided a working definition of the grouping of individuals into a team context as “a group of diverse clinicians who communicate with each other regularly about the care of a defined group of patients and participate in that care.” The use of primary care teams dates back to 1915, at which time a team of multidisciplinary professionals composed of physicians, health educators, and social workers assembled to work together at Massachusetts General Hospital (Grumbach & Bodenheimer, 2010). The innovation of such structures took on a culture of its own, encompassing New York Montefiore Hospital in 1948 and Yale in 1951 (Grumbach & Bodenheimer, 2010).

While the team approach continued to gain popularity, the need to implement regulatory provisions became apparent. Barriers in disciplinary measures and territoriality emerged, causing a breakdown in structure (Grumbach & Bodenheimer, 2010). Grumbach and Bodenheimer (2010) presented the following as the most recognized variables acting as barriers within the team structure:

- Ratio of patients to clinicians
- Unclear goals
- Fractured systems

- Unclear designation of role
- Lack of training
- Poor communication
- Team dynamics
- Team size
- Funding

These barriers continue to exist within team structured organizations. Debate on the cost effectiveness and prosperity of such structures has been on going both within the United States and the United Kingdom. According to Brown et al. (2000) integrating working groups into team structures erodes the clinician’s professional identity as well as promotes isolation from collegial department’s further depleting support and empowerment.

Task-oriented workloads offer timelines and direction for employees to complete routine tasks assigned daily. They also may offer the staff an opportunity to gain responsibility, growth, and acceptance amongst peers and agency hierarchy. The team atmosphere tends to turn away from innovative theory based practices and more toward what has worked in the past; the working environment becomes stagnant and ritualistic. Although this might appear to aid the team to reach productivity goals, it fails to provide the best services to consumers and the team members. From a systems perspective, maintaining a systemic routine approach enables workloads to be completed timely, costs to be minimized, and expectations to be understood (Horsfall, Cleary, and Hunt, 2010).

The task-oriented approach may be beneficial to fast paced business, but it fails to provide optimal care in areas of mental health care delivery.

The existing barriers found within mental health are also existent within the health care arena. Lingard (2004) reviewed interprofessional collaboration within intensive care settings whose structure is team centered. The study explored the team members and their ability to interact within a high demand complex structure. The study points to three areas of interest including daily clinical goals, delineate professional boundaries, and negotiated systems issues. Lingard (2004) presented a level of collaboration and conflict within the team structure that was composed of six key areas: authority, education, patient needs, knowledge, resources and time. Furthermore, the attitudes of the members within the ICU teams were found to be deviant of the term team as roles and power interfered with decision-making and flexibility.

Blurred professional identities often result from different beliefs regarding care modalities, skill building, economics, and political agendas (Bown, et al., 2000). In addition to blurred professional identities, ownership and trade become optimal forces within the team constructs creating tension within the team, which distracts from collaboration (Lingard, 2004). The conflict between the team members may cause irreversible damage such as anger and resentment to both the team and patients long before intervention is sought (Lankshear, 2003). The team members may engage in such behavior as isolation, homogenization, fraternization, negotiation, demarcation, and manipulation (Lankshear, 2003). Personal identities can be damaged reinforcing gaps in systems, communication, and productivity.

Team Breakdown

Community mental health residential care settings often utilize a team approach that is composed of a complex structure of professionals educated and trained in areas of community resources, mental health, diagnosis and treatment, crises management, and group facilitation. Due to the similarities in training and work responsibilities, roles of the team members can be blurred. (Brown et al., 2000) Blurring roles leaves team members feeling stressed, lacking direction, leadership, and support (Brown et al., 2000). The workplace atmosphere becomes encumbered with splitting, blaming, isolating, and poor communication (Brown et al., 2000). Unresolved conflict amongst team members may have the ability to alter the success of the team as an integral and congruent body further eroding the team structure (Brown et al., 2000) The consequences of such erosive events may compromise client care and subsequent treatment gains such as neglecting the immediate needs of the clients, transference of unsettled or negative emotions onto clients, or demonstrating unprofessional behavior in front of the clients (i.e. name calling, gossiping, swearing), potentially triggering traumatic memories for the client (Hunsicker, 2010).

Brown et al. (2000) hypothesized optimal team function can be obtained once an understanding of the interactions between team members and service users, professionals, specialties, and work environments are reached. Furthermore, improving the quality of care and protecting patient safety can be met once the current barriers imposed within the team structure are rectified including but not limited to communication, congruence and equality (Lingard, 2004). In order to ascertain and overcome these barriers, the team of caregivers must develop an understanding of the potential impact their behavior has on the residential client.

Client exposure

The barriers possessed by team conflict can become toxic, filtering into patient care and service outcomes. Patients are exposed to gossiping, name-calling, and negative comments between team members (Hunsicker, 2010). In a Gallup telephone poll survey evaluating honesty and ethics of people in health careers, 85% of respondents reported exposure to health care staff using degrading comments between each other (Hunsicker, 2012). Discriminate attitudes may be imposed on decision making and horizontal violence altering perceptions between staff and patients thus creating splitting behavior. Patient care may be pushed aside as team members are engrossed in personal agendas preventing patient growth and appropriate treatment (Heginbotham, 1999).

Individuals living within such structures may be faced with barriers interfering with their ability to understand, identify, or report observed potential conflict situations within the milieu. Assumed consequences including punitive treatment may also be a barrier to the residential clients. To decrease unsafe conflict driven situations from developing within the workplace, prevention and proactive planning is needed.

Care Model

The Sanctuary model symbolizes "a theory-based, trauma-informed, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an organizational culture (Bloom, 2012, "What is Sanctuary," para 1)." This organizational cultural intervention was designed to enable individuals to engage in cohesive healing from both psychological and socially traumatic experiences. The model designed by Bloom is structured to

> Facilitate the development of structures, processes, and behaviors on the part of staff, clients and the community-as-a-whole that can counteract the biological, effective, cognitive, social, and existential wounds suffered by the victims of traumatic experience and extended exposure to adversity. (Bloom, 2012, "What is Sanctuary," para 1).

The principles of the Sanctuary model are assimilated as seven commitments, to empower individuals in the community, and to embrace corrective, emotional, relational, and environmental experiences. The Seven Sanctuary Commitments include a commitment to nonviolence, a commitment to emotional intelligence, a commitment to social learning, a commitment to open communication, a commitment to democracy, a commitment to social responsibility, and a commitment to growth and change (Bloom, 2012, "The Seven Sanctuary Commitments," para 2). Each of commitment provides the elements for a living operating system, which supports trauma-invoked goals for clients and staff.

The Sanctuary Model is a trauma-informed, theory based, evidence-supported structured methodology designed for creating and/or changing organizational culture (Bloom, 2012, “Organizational Stress,” para. 2). This complex structure utilizes integrated theories to educate and enhance organizational systems in competency, quality, and effectiveness. The model aims to teach individuals and organizations the necessary skills to create and sustain nonviolent lives, nonviolent systems, and to believe in the unexplored possibilities of peace (Bloom, 2012, “Trauma-informed Framework,” para 2). The idea behind the Sanctuary Model comes from the belief that people working in human service delivery share a coherent framework also referred to as the parallel process for understanding the influences of chronic stress within an organization known as workplace stress (Bloom, 2012, “Trauma-informed Framework,” para 5). The concept of the parallel process is to provide organizational leaders and staff the tools needed in order to think outside the box. To consider what has occurred and what is occurring within the service delivery as it relates to the complex interactions between traumatized clients, stressed staff, pressured organizations, and social and economic environments (Bloom, 2012, “Parallel Process, ”para. 3).

The philosophy of this model includes client and staff experiences, perspectives, and safety as important factors in the development of the model and maintenance of a healthy culture (Bloom, 2012, “Sanctuary as a Living Philosophy,” para 1).

Theories, ideologies, models, and programs have been developed and implemented in various mental health organizations seeking to provide better services to individuals with mental illness. Today, agencies are building a client centered culture which offers a wide array of services including but not limited to health care, pharmaceuticals, and mental health. Such services depend on the inclusion of multidisciplinary professionals working together within a single team structure. Bennington-Davis (2009) reported the philosophy of a healthy team includes acknowledgement and validation of experiences, perspectives, and safety. These attributes are believed to be important in the development of a multidisciplinary team as well as the maintenance of a healthy culture. Although staff perspectives are emphasized in this process, little emphasis is placed on developing partnerships between team members, partnerships between team members and clients, alternative forms of communication, prevention of conflict between team members, tackling conflict within the workplace or protecting clients from experiencing workplace conflict.

Presently, a gap exists in the literature on the impact or the experiences of workplace conflict on mental health residential clients. In order to fill this gap, qualitative studies and data analysis focused on the impact and the nature of the impact of workplace conflict on mental health clients is needed.

Conceptual framework

For the purpose of this study, the therapeutic alliance was used as the conceptual framework. Lived experiences and perceptions of those experiences are unique from person to person. The lived experience and the perception of those experiences aid the client in decision-making, acceptance, resiliency, and relationship building. Individuals receiving residential mental health care may use their lived experiences and perceptions of safety and health to guide them in their adherence to treatment and interactions with their caregivers. Therapeutic alliance can be applied to the process of increasing treatment adherence and enhancing positive perceptions of safety and health. This process is done by including the resident as part of the therapeutic practice while optimizing the positive need rewarding relationships with the caregiver (Horvath & Luborsky, 1993).

Therapeutic Alliance

The theories and components of the therapeutic alliance have been investigated and argued by various schools of thought dating back to Freud in 1912. Initially, Freud wrote on the concept of collaboration between patient and doctor as a vehicle for success in the realm of psychoanalysis (Catty, 2004). As with many of Freud's works, he received ambitious followers who would in time alter his original concept. Zetzel originally coined the term therapeutic alliance, intrigued by Freud's ideas of patient doctor collaboration (Catty, 2004). Zetzel focused heavily on the perception of therapeutic alliance between the British Object Relations School and classical analysis (Catty, 2004). Zetzel identified distinguishing differences in the perception of transference neurosis between the two schools. Following Zetzel's investigations of the therapeutic alliance and transference, Greenson proposed the reality-based collaboration between therapist and client or working alliance. According to Greenson, therapeutic alliance is a therapeutic model containing three modules: transference, working alliance, and real-relationship (Horvath & Luborsky, 1993). This concept specifically includes the client as part of the therapeutic process. Further, therapeutic situations enables the therapist to perform in a positive, reality grounded format which enable the client to identify the inconsistencies between the delusional and reality of the therapeutic relationships (Horvath & Luborsky, 1993). The flexibility of the practitioner in providing care and services as a partnership with the client increases the adherence for treatment as the client develops a sense of value in the relationship thus an alliance can be formulated (Botella, Corbella, Belles, Pacheco, Gomez, Herrero, Ribas, and Pedro, 2008).

Summary

It is unclear how workplace conflict between caregivers impacts the residents, the therapeutic relationship, the residents' ability to meet treatment goals, and their successful recovery. The available research fails to provide answers. This research study proposes that residents of a mental health residential facility may be impacted by the exposure of workplace conflict from the caregivers. The literature on the effects of workplace conflict on residential clients residing within residential mental health care facilities and the impact of the exposure is limited, showing that there has been little research conducted to date. Data needs to be gathered to determine if there is an impact, and what the nature of that impact is.

A phenomenological approach has been used to probe this previously unexplored topic. Gaining a personal account of the residential clients' experiences and perceptions may provide the direction and guidance needed for leadership and administration to develop trainings to better equip caregiver teams with the tools needed to increase quality of life for the individuals served in the residential care settings.

This section included a review of the literature related to individuals living within residential mental health care facilities. The origins of residential care were examined to provide background knowledge of mental health residential care settings. An overview of current residential care settings was provided, followed by a discussion of consumer supports as it relates to individuals with mental illness. This section also reviewed challenges that impact care, the caregiving team, team breakdowns, client exposure to team breakdowns and a discussion on one current care module used within residential care settings today. In addition, an explanation of the conceptual framework utilized for this study was provided. Chapter 3 describes the approach or methodology used for the study and outlines the role of this researcher.

Chapter 3: Research Method

Introduction

Chapter 3 presents the data gathering methods for the study. First, the research design and questions guiding the research are discussed. The context of the study is defined; ethical considerations for the proposed participants are addressed. The role of the researcher and how the participants were selected is explained. The methods for the proposed data collection are reviewed. Finally, the proposed analysis and validity of the study is addressed.

Combining practitioners into treatment teams has been in common practice since the opening of the first mental health hospital in Williamsburg Virginia in the 1700s. The unification of practitioners has enabled clients to receive multiple services from one comprehensive team. As the teams merge to provide optimal care the roles and functions of team members often blur. The blurring of roles has the potential of leading teams to decrease communication, increase stress, and the development of disgruntle feelings within the group. Understanding how the effects of workplace conflict amongst the team of caregivers influences and impacts services is an important component to ensuring positive responsiveness to treatment and safety within the residential setting. The study questions guiding this research are:

1. In what way, if any do the residents of the mental health care facility perceive conflict as interfering with their goals in treatment?

2. How do the residents of the mental health care facility experience workplace conflict when it arises amongst the team of caregivers?

Research Design

For the purpose of this study, a qualitative phenomenological research method as the research design was selected. This method was chosen because I sought to understand the effects of workplace conflict on individuals in residential mental health facilities. The approach elected for this study is an inductive process that allows the researcher to collect and examine described experiences or phenomena from the individual's perspective (Maxwell, 2005, p. 22). An inductive study provides an opportunity for the researcher to collect data from participants who have experienced the phenomena under investigation and examine the phenomena using developed concepts and identified themes (Creswell & Plano-Clark, 2007, "Analyzing the Data," para. 4.).

Contemporary Qualitative methods

The purpose of this qualitative phenomenological study was to identify how conflict within the team is experienced by residential mental health clients, how these experiences impact the perception of success and treatment for clients and identify the perception of these experiences and influence the outcomes for relapse, challenging behaviors, and violence within the milieu. This phenomenological study was completed by (a) exploring the experiences of clients living within a mental health residential treatment setting; (b) determining if workplace conflict influences their treatment outcomes; and (c) gaining the perceptions of workplace conflict from the clients' point of view.

Qualitative research, as noted by Creswell et al. (2007), has five main approaches to data collection: narrative research, phenomenology, grounded theory, participatory action research, and case studies. These qualitative research approaches are currently widespread and noted to be the most frequently used approaches in contemporary social science research (Rudestam and Newton, 2007). Each method varies in both approach and data collection processes while maintaining the tradition of using the researcher as a tool in the research practices. Each approach has a unique pattern to identify commonalities that are used to draw conclusions (Maxwell, 2005).

Narrative research is a qualitative methodology used to derive natural conversations using interviews or field work in order to capture events, actions, or series of events in a chronological order (Rudestam and Newton, 2007). A narrative approach is especially useful when a research study consists of one or two participants. The data may be collected through interviews, field observation, or extended conversations; this process gathers the participant’s stories and experiences chronologically in order to ascertain the meaning of those experiences (Rudestam and Newton, 2007; Creswell & Plano-Clark, 2007, “Analyzing the Data,” para. 5). The narrative approach was not chosen for this study, as this study is not attempting to collect the experiences of the participants’ life in a chronological order.

The grounded theory approach is a research methodology used to identify similarities in experiences of a large population to generate a broad explanation, process, and/or action (Rudestam and Newton, 2007). The data must be grounded in data extracted through the means of field research driven by the populations' actions, interactions, and social processes (Creswell et al., 2007). Considerations involved in grounding theory research begin by identifying which approach is best, systemic or constructivist. Once identified, the researcher will utilize a discovery-oriented approach to the research, which suggests fixed actions for data collection and theory building (Rudestam and Newton). Grounded theory relies on clearly framed sequences of measures for theory development disabling the researcher's flexibility with perception. The grounded theory was not chosen for this study because of the constraints on participation of the researcher, additionally this study does not aim to develop a generalized explanation for the process under study.

Participatory action research is a method of exploration that requires the researcher and the participants to collaborate on all levels in the research process in order to find a suitable solution for a social problem that significantly affects underserved (Creswell et al., 2007). Creswell emphasizes the need to incorporate both research and participants in the process and to take ownership of research in order to develop action. The participants were expected to be involved and engaged in the process of examination of their understanding, skills, values, and interpretation of their world view. Participatory action research is especially useful in research projects that focus on liberation of social constraints in order to produce change and solve a social problem (Creswell & Plano-Clark, 2007, “Studies in the Gray Areas,” para. 6; Creswell et al., 2007). Participatory action research was not chosen for the method of inquiry because the study does not aim to create change but to identify areas that change is needed. This process may be ideal for follow up studies.

A case study design is used with one or more participants, organization, event, program, or process within a bound system that focuses on an issue specific to the selected case (Rudestam and Newton, 2007). This design differs from the narrative because it does not focus on the individuals’ lived experience in chronological order to capture the meaning of the experience but instead on the specific issue with the individual case selected to understand the issue sources for the purpose of generalization to the population (Rudestam and Newton, 2007). The method of case study was not chosen for this study, as this study will focus on the lived experiences of more the then two participants: additionally, this study does not aim to pull case specific data. The study attempted to identify if an issue exists based on the essence of the experience.

This qualitative study was conducted following the phenomenological approach in qualitative design. Of the approaches discussed, the phenomenological approach best fit the intent of the study, as it allows flexibility for the researcher and the sample population to derive the essence of the experience while allowing room for interpretation. The research study I conducted did not focus on the participant’s life experiences but rather on the lived experiences since admittance to a mental health residential setting.

Phenomenological research focuses on revealing and describing the lived human experiences of the participants in order to identify commonality (Rudestam and Newton, 2007, p. 39). This study investigated the personal experiences of clients recently discharged from a residential mental health facility who may have been exposed to workplace conflict. The individuals who participated in this study have recently discharged from a mental health residential facility. All participants in the study lived at the residential mental health treatment facility for three months or longer.

The phenomenological approach to research enables the researcher to be both a researcher and an instrument in the process of seeking information of the situation and the event through the lived experiences of the participant (Maxwell, 2005). The event under consideration for this study was exposure to workplace conflict within the treatment team while residing at a residential mental health facility. The goal was to obtain detailed descriptions from the participants on their experiences while residing at the facility. I identified the following the phenomenological approach to analyze data and identify themes based on the participants' experiences.

Research tools and procedures

Data Collection

Data was collected from individuals who recently discharged from one residential mental health facility located in a Northeastern state. The interview data collected was obtained using a semi-structured open-ended question interview. Questions asked during the interview sessions were geared toward the sample population. More specifically, the questions asked of participants during the interview were in relation to their experiences while residing at a mental health residential care facility. Appendix A includes the questions that was used to guide the interviews. An attempt to use audio recording for each interview was made, audio recording ensures accuracy of the data collection, two participants elected to allow the audio recording of the interview. The audio recording began after the participant read, discussed, and signed the consent to participant document. All recordings were transcribed by the researcher immediately following each interview. List notes were completed for those interviews with participants who declined the audio recording, notes were immediately typed into word document when the interview concluded.

Context of the Study

The data collected was obtained from individuals who once resided at one location. The location chosen for this study is a transitional mental health residential care facility that provides 24-hour care, support, and treatment for individuals with acute and chronic mental illness. The facility is located in the Northeastern portion of Washington State. Prior to interviewing the volunteer participants, I obtained authorization from the mental health organizations Quality Improvement Board (QIB) following their policy for research involving clients (see Appendix B). Once approval was granted by both QIB and the Walden University IRB (02-26-14-0018535), I began purposive sampling following the completion of interviews.

As part of the mental health agency policy, the Quality Improvement Board (QIB) monitored the progress of the research study involving research participants. The participants' identity of any statements made was not identified to the agency in the review process. The progress was documented using the QIB Implementation follow up report (see Appendix C), this document was made available to the QIB monthly to ensure client safety was maintained.

Criteria for Selecting Participants

The participants in this study were limited to six individuals who had discharged from the mental health residential care facility within the last two years. The mental health residential facility provides 24-hours a day supervision and support to both male and female adults over the age of 18. There were no restrictions or limitations in areas of ethnicity and educational backgrounds. The residential facility is authorized to provide care and support to individuals who have acute and chronic mental health illness, who need to acquire safe living skills in order to return to independent living within the community, and who demonstrate the ability to leave the facility grounds in order to participate in community events without supervision of staff. Although, a sample of this size does not represent the total population it is recommended as qualitative research studies are typically comprised of smaller sample sizes (Rudestam and Newton, 2007). Rudestam and Newton (2007) further note using smaller sample sizes for phenomenological interviews, samples of no more than ten, provides richer research data. For this reason, I sought to obtain a sample size of 14 participants, with the plan to stop collecting data when saturation was reached. Although the participant pool was limited to six, rich data was obtained. Saturation was achieved from the rich data allowing the resulting theory to emerge easily. Weiss (As cited in Maxwell, 2005) explain the essential construct of maintaining a working relationship with the participant is by framing the interaction of the interview into a research partnership. A smaller sample size allowed me to develop a partnership-based relationship with the participants chosen for this study. This study was limited to one residential mental health facility located in Northeast portion of Washington State: I was willing to travel up to two hours from home to collect the research data.

Purposive sampling was used in the selection of interview participants. Purposive sampling according to Creswell and Plano (as stated by Maxwell, 2005) is the process of selecting participants who may have experienced the phenomena or key concept under investigation. The strategy used was homogeneous sampling, which is the process of choosing individuals who have distinctive characteristics. The distinctive characteristics used for selection of study participants include individuals who had lived at a residential mental health care facility within the last two years, resided at the facility for at least three months, who spoke and read English fluently, were aged 18 or older, and were willing to volunteer as participants. As the study progressed, the data developed a theoretical relevance further leading toward the saturation of discovered concepts assimilated from the sample (Rudestam and Newton, 2007). For the purpose of this research study, prescreening questions were included in the invitation to participate letter.

In an effort to obtain the sample needed for this study, I provided invitation letters (see Appendix D) to the Contract Compliance Specialist of the agency. The Contract Compliance Specialist from the agency sent invitation letters on my behalf to individuals who had discharged from the mental health residential care facility. I had no involvement or knowledge of the individuals who received the invitations. Each invitation letter discussed the request for volunteer participation, critiera to particiate, and explaination of steps if the individual volunteered to participate. In addition to the invitation letter, the informed consent (see Appendix E), and a self addressed stamped envelope was included.

Upon receiving participant responses, I contacted by phone each volunteer who met the distinctive criteria outlined, and scheduled the research study interview.

Interview Procedures

After receiving each response, I called and scheduled the individual interviews. Each interview was scheduled for one hour. Each participant was given the opportunity to identify a location for the purpose of the interview. If the participant was unable to provide a designated location a private meeting room in a local coffee shop was reserved for the interview. Interviews were spaced out over the course of two weeks. The interviews began with a discussion and explanation of the participant’s ethical protection. Each participant received a copy of the signed consent document. The participant was encouraged to ask questions about the consent and reminded of the right to refuse to answer any question or to withdraw from the study. The participant was given the opportunity to stop the interview at any time without question. Had the interview been stopped by either the researcher or the participant, an offer to reschedule would have been made.

Establish rapport with participants

During this study, I interviewed each participant. I asked questions related to their experiences and perceptions of conflict within the treatment team, safety and support. A request to audiotape each interview was made, but declined by all but two participants. In addition to audio recording the interview I took field notes on statements and observations during interview sessions. For those who declined the audio recording, I took detailed list notes. I took notes on all interviews and actively listened to all participants, reflectively rephrasing their responses to make certain I clearly understood them.

In an attempt to provide privacy to the interview participants, two hour time blocks were made available between interviews. This enabled me to have a one hour gap between participant arrivals during which I was able to review interview notes. Once the participant arrived at the designed meeting place, I introduced myself to the participant and thanked the participant for volunteering in the interview. I followed this with a review of the informed consent form, discussed the participants right to end or reschedule the interview, ability to skip questions, as well as identified the IRB faculty contact information if the participant had concerns or additional questions to address. The identified IRB faculty information is located on the informed consent. The participants were given the opportunity to state concerns and ask questions prior to the start of the interview. An informal conversation, or small talk followed. The informal discussion aided me in developing rapport with each participant and decreasing any anxiety the participant may have had related to the interview. Interviews followed the semi-structured open-ended questions interview format (see Appendix A) with questions such as, “Please describe your perception of safety?” and, “Please discuss how conflict can impact your recovery.” If needed, probes or subsequent questions were presented in a conversational tone following each open-ended question.

Debriefing procedure

At the close of the interview, debriefing was conducted with each research participant. The purpose of debriefing at the end of a research interview is to ensure the research participant has as much information about the study as possible in order to prevent confusion or embarrassment, and to allow the participant to ask questions prior to exiting the interview. The debriefing procedure included a statement thanking the individual for their participation in the study, a brief discussion of the purpose of the study, and a reiteration of the individual’s right to and assurances of confidentiality in the study. To close, the participant was given the opportunity to ask any unanswered questions. Each participant was asked if he or she would like to be mailed a copy of the results of the study.

Role of the Researcher

The role of the researcher includes acknowledgement of personal bias and a prevention plan that restricts the bias from interfering with the study. My personal bias begins with my belief that workplace conflict between the residential staff negatively impacts patient care. My personal bias might have influenced me to ask leading questions or interpret the data in a biased fashion. Ways of dealing with personal bias involve the recruitment of an expert to review the interview questions, the request of another researcher to code the data, bracketing, and/or using a semi-structured interview format with each participant. In addition, the role of the researcher also includes recruiting participants for the study, conducting interviews with the participants, ensuring safety guidelines are in place for the participants, transcribing tapes, reviewing data collection procedures, and analyzing the data.

I believe that interviewer bias did not pose a direct threat to the participants in this study as I do not have a relationship with the individual's sought for this study; I was not nor had I ever been an employee of the mental health care facility the participants discharged from, at the time of the interview I had no authority over the day to day operations or decision making for the facility or the residents, and I am restricted from medical records of those for whom I do not provide direct service. Although the limitation to my role may prevent a direct threat to the participants, my opinion and expectations of the outcome could create bias in this study. It is in my opinion that the residents of the mental health facility have been exposed to conflict and the conflict has impacted or interfered with their treatment goals and success. In an effort to prevent my opinion and bias from interfering with the study, I conducted semi-structured interviews with open ended questions, I followed safety guidelines to protect each research participant, transcribed all audiotapes, typed all notes into a secured word document, reviewed and analyzed the data collected immediately after each interview, and I used bracketing to prevent my opinions and experiences during the data collection, analysis, and reporting from interfering with the results. I honestly and realistically probed my bias and beliefs at the beginning and during the study. Throughout the data collection and analysis I maintained an awareness of biases and bracketed those biases. I used journaling throughout the study. I treated all data equally during the data collection, analysis, and reporting.

My role in the research process was a combination of observer and participant. As the observer, I assessed and documented all observable characteristics during the interview process including but not limited to body language, verbal language, behavior changes, and environmental stimuli. As a participant to the research I conducted each interview, engaged in conversation, and pulled the essence of the lived experience from the participant's explanations as it related to experience and perceptions of those experiences. My role included recruiting the participants for this study. I ensured safety guidelines were met by providing a private meeting place, when applicable, for the purpose of interviewing. I provided and discussed with each participant the consent to participate documentation. In addition, participant confidentiality was increased with the use of numerical coding in place of participant names. All data obtained from each interview was immediately transcribed and stored in password protected files with the N-

Vivo 10 operating system on my home computer. All data will be kept secure for no less than five years, at which point the data will be destroyed.

At the time of the interviews I was employed as a Mental Health Therapist and Team Leader for two mental health residential facilities. I have fifteen years' experience working within various residential settings designed to provide services to a wide range of individuals with mental and developmental disabilities. My experience and training gained from working within various residential settings aided in my ability to establish a rapport with each participant interviewed. The volunteer participants had been discharged from a mental health residential facility within the last two years and are now living independently within the community. I had no direct or active role with the staff or the individuals residing at the residential mental health care facility.

Ethical Protection:

Consent to participate in a research study is an essential tool used for ethical protection of the participant (see Appendix E). The consent to participate in the research document typically contains the following components; assurance of confidentiality, securing of data, interviews are conducted in a safe and private environment, and request for permission to audiotape. In addition, the consent to participate in research form includes the title, purpose, risks, benefits, and confidentiality of the study. For ease of reading the consent to participate was written at the 11th grade reading level, the reading level was established by using the Flesch-Kincaid analysis. The purpose of this document is to ensure the participant is fully aware of all risks, confidentially, and participant rights.

Approval of this research study was obtained by Walden University Institutional Review Board (IRB) prior to execution of its methods or procedures. After the IRB approval had been granted additional approval from the mental health agency was requested. Once approval of the study had been established, data collection began. In order to ensure that all participants' privacy was protected, no names or other identifying factors were included. Each participant was given the consent to participate in research document, requesting their participation in the research. The consent to participate in research document included a request for permission to audio record each interview (See Appendix E). The participant was asked to read and discuss the consent to participate in research document prior to signing. Once the participant acknowledged an understanding and agreed to participate in the research, the participant was asked to sign. This process take place prior to the start of the interview.

The voluntary participants chose to participate in this study without threat of force or coercion. Each participant was informed of their right to withdraw from the study at any time, refusal to answer any question they felt was too personal, and encouraged to ask any questions as they arose prior to, during, or after the interview session. I explained the participants' rights and informed the participant of their option to obtain a copy of the research results.

All data retrieved for the purpose of this research study will be maintained and secured using confidentiality as the level of security. Confidentiality is a classification used in securing data, allowing only the persons authorized by the owner of the data to have access to the data. The protection of confidential data includes storage procedures, data dissemination, who will have access to the data, and when data will be destroyed. The data obtained in this research study will be stored in a secured location only retrievable by researcher. More specifically, all data will be stored in electronic files (files will be password protected) on my home computer. The data will be kept in this secure location for no less than 5 years, at which time the data will be destroyed. The process for destroying the data will include, shredding and burning all documents, deleting and crushing all audiotapes and USB devices.

In order to protect the confidentiality of the participants, numerical coding was assigned in place of participant names and stored in password protected electronic files. The key that associates the participant's identifying information with the numerical codes is only accessible to the primary researcher. The key was destroyed after the data set was complete, and the data is kept for an additional five years at which time the data will be destroyed.

As part of the mental health agency policy, the Quality Improvement Board (QIB) monitors the research study progress. Study progress was reviewed by QIB monthly (see Appendix C). In addition, the findings from the research study is co-owned by the mental health agency as per agency policy. Each participant was informed of the co-ownership of this study and assured that no identifying information would be released to the mental health agency during the review process. This requirement is included in the consent to participate to ensure each participant has full knowledge of the co-ownership and the review process.

Data Analysis and Interpretation

The data obtained for this study include audio-taped recording, observational notes written at the time of the semi-structured interview, and list notes. The auto-taped recordings and list notes contained the precise responses and statements made during each interview. NVivo 10 software (2014) was used for all data transcriptions, storage and analysis. After each interview, the data was transcribed verbatim. Prior to analysis, the data was carefully reviewed for accuracy, comparing researcher transcription to audio recording and list notes. As a means of checking the reliability of the data, a second coder was recruited. The second coder is a former Walden student who recently obtained her MS in Forensic Psychology. Interceder comparison helps ensure reliability of the data. The phenomenological data retrieved from the participants was analyzed using the following steps: coding, categorizing, verification of coded data, and interpretation.

Data was reduced via NVivo, a qualitative data software package used to provide in-depth analysis of qualitative data. NVivo software is designed to assist the researcher with the organization of unstructured data for the purpose of classification and sorting. After completion of all interviews and data was imported into NVivo, the final coding of data involved the construction of nodes, which are references gathered regarding particular themes, individuals, or other areas of interest; nodes were then grouped into matrix cells, which will allow the creation of hierarchical structures (i.e., categories and sub-categories) used to further explore data (QSR International 2010).

The imported data was reviewed, and chunked into broad topic segments *nodes* based on similar or relevant data. This process is Broad-brush coding, which is a coding style that enables the researcher to identify the following: what has been covered and if additional information is needed, identify text that is particularly relevant to the area of focus, set aside text that might not be relevant at this time but may be needed at another point in the analysis process or in subsequent research, identify sequences from within the context, complete preliminary analysis as a guide to where and how you will proceed, sort answers according to questions from the interview, and code the contextual circumstances (Bazeley, 2007, “Broad-brush or ‘Bucket’ coding,”). One benefit of developing nodes with the Broad-brush style is the freedom to recode data as needed. Once all nodes are created, matrix coding queries are used to locate relationships with the collected nodes.

The data examination included asking questions, making comparisons, and identifying similarities and differences between comments. The identified similarities are used to create the theoretical categories. As noted by (Creswell & Plano-Clark, 2007, “Representing the Data,”), themes and significant statements are reoccurring statements offered by participants during an interview that are directly related to the experiences. These themes serve to demonstrate the participant’s perception of care in the areas of satisfaction, safety, and if successful outcomes were made by the individual while a resident at the residential mental health care facility. The themes identified aided in the interpretation of the data, which is the transformation of the data into general descriptions of experience.

Validity

Special consideration for trustworthiness and potential threats to validity is essential in qualitative research. Although qualitative research does not require the same statistical inferences as quantitative research, it is still best to become both knowledgeable and prepared for potential threats that may deem the study invalid. Maxwell (2005) suggests using a checklist to ensure potential threats and strategies have been considered. Maxwell suggests using all or some of the following checklist for this purpose: (a) involvement, (b) rich data, (c) respondent validation, (d) intervention, (e) discrepant evidence, (f) triangulation, (g) quasi-statistics, and (h) comparison. After careful review of this checklist, I was able to identify the areas that ensure trustworthy data; including involvement, rich data, and comparison.

The proposed strategies have been used with each identified checklist item for describing, understanding, and bracketing personal bias or potential bias. Involvement with the participants as an agency employee has a potential to impose threat to the validity of the participants’ responses during the interview process. I am knowledgeable on the topic and am an experienced mental health treatment team member. I also had preconceptions about the topic that I contained in order to prevent an influence on the data interpretation. It was equally important for me to utilize bracketing of my personal feelings and judgment while examining the data. Creswell and Plano-Clark (2007) suggested the researcher identifies experiences with the phenomena under investigation followed by putting the personal feelings, judgment, or personal bias aside during the research process. Another way to combat my personal bias: my physical presence was restricted from the residential mental health facility as my role as a team member within the agency may have influenced the participants' responses.

Rich data as explained by Maxwell (2005) is the quality of the raw data obtained during the interview and observational process. This study faces threat if the data is weak, incomplete, or lacks detail. In an attempt to minimize such threats I used audiotapes or list notes during each interview, used a paper copy questionnaire, took notes of each conversation, transcribed all data verbatim immediately after each interview, and provided all data to a second coder for review. Each of these techniques allowed me to capture quality details from each interview.

Summary

Chapter three of this research study was developed to present the study design. This study used phenomenological approach to capture the essence of the lived experiences and perceptions of clients receiving residential mental health services. In this section, I provided the questions guiding the research, defined the context of the study, explained ethical considerations for the participants, the role of the researcher, and the selection procedure. Finally, the analysis and validity of the study are discussed.

Chapter 4 Results

Introduction

The purpose of this study was to examine the adult residential clients' perceptions of workplace conflict, how the conflict is experienced by the adult residential clients, and how these experiences influence treatment outcomes of the adult clients residing within mental health care facilities. The phenomenological approach was the methodology used to assist the working researcher in extracting and identifying the perception of the situation through the participants' lived experience (Moustakas, 1994).

The participants in this study consisted of adult clients resently discharged from a mental health residential facility. The research questions driving this study are:

1. In what way, if any, do the residents of the mental health care facility perceive conflict as interfering with their goals in treatment?
2. How do the residents of the mental health care facility experience workplace conflict when it arises amongst the team of caregivers?

The purpose of this study was to investigate the lived experiences of adult clients who lived within a residential mental health facility within the last two years, and the influence of team conflict on their treatment outcomes. Chapter 4 presents the detailed analysis of interviews from six volunteer. Each volunteer participant was a residential client whow recently discharged from a mental health residential treatment facility within the last two years.

Data Gathering and Storage

The interviews were scheduled to last no longer than 60 minutes, each participant had the option of conducting the interview in their home or at a designated local coffee shop. Of the six who participated, only one requested the interview be conducted in his home. The mailing address for the five who agreed to conduct the interview at the designated coffee shop was obtained, each was mailed a paid bus pass and bus route instructions. The home address of the one who requested the interview take place in his home was obtained. The interviews were scheduled within a week of receiving responses, the timeline of six weeks to receive all responses allowed additional time to schedule the interviews without overlap. Each interview began with an introduction of interviewer followed by discussion and explanation of the participant's ethical protection. Each participant received a copy of the before signed consent to participate document. The participant was encouraged to ask questions about the consent and reminded of the participant rights to withdraw from the study at any time. The participant was given the opportunity to stop the interview at any time without question.

An attempt to audio record each interview was made, of the six who participated four declined the audio recording of the interview. Observational notes accompanied each audio recorded interview, the notes highlighted any emphasis placed on specific questions, statements, and notable behavioral changes of the participant during the interview. Data collection of the four participants who declined the audio recording was completed using list note format. The list note format is completed by writing out the entire statement made by the participant with immediate review reciting each statement back to the participant for accuracy. Interviews requiring the list note format required additional time then the planned 60 minutes, the average time of each of the four non-audio recorded interviews was 85 minutes.

Upon completion of each interview, the two audio recordings were uploaded into the NVIVO 10 software, and all observational notes immediately typed into NVIVO document storage. NVIVO 10 software provides storage for audio and video data as well as documents related to a study. The two audio recorded interviews were uploaded into the NVIVO 10 software and transcribed using the NVIVO 10 software transcription program tools and deleted from mobile audio recording device. The remaining four interviews were loaded manually, and reviewed twice for accuracy. All data is stored on researchers password protected home computer.

Population Demographics

To respect the anonymity of the participants, each was assigned a number. For example, P1 was used to identify Participant 1. The following is specific information on each of the individuals volunteering to participate in this study (see Table 1).

Table 1.
Participant Demographics

Participant	Treatment duration	Age	Sex
P1	6 months	47	Male
P2	4 months	41	Female
P3	3 months	58	Female
P4	3 months	32	Female
P5	5 months	49	Male
P6	3 months	59	Female

P1 is a 47 year old man who was a resident of a mental health care facility for six months within the last two years. P1 left treatment three times during the six months against program advice then was readmitted to the residential facility three times during six months of residency.

P2 is a 41 year old woman who was a resident of a mental health care facility for four months. P2 left treatment against program advice 13 months prior to interview.

P3 was is a 58 year old woman who was a resident of a mental health care facility for three months. P3 was discharged from the residential facility 21 months prior to the interview.

P4 is a 32 old woman who was a resident of a mental health care facility for three months. P4 was discharged from the residential facility 12 months prior to the interview.

P5 is a 49 year old man who was a resident of a mental health care facility for five months. P5 was discharged 20 months prior to the interview.

P6 is a 59 year old woman who was a resident of a mental health care facility for three months. P6 was discharged 18 months prior to the interview.

Data Analysis: Identifying Themes

An analysis of the data was performed using NVIVO 10 software, which revealed emerging themes. In an effort to prevent researcher opinion and bias from interfering with the study, semi-structured interviews with open ended questions was used, all data was entered into the NVIVO 10 software immediately after each interview, and researcher opinion of interview responses or experiences as they may relate to responses were bracketed and entered in separate journal.

Initial coding occurred with importing data into the NVIVO 10 software. Each participant was assigned a numerical code in place of the participant name. After each interview was uploaded, the data was analyzed by researcher for emerging themes. NVivo software is designed to enable the researcher to organize unstructured data for the purpose of classification, sorting, and the final coding of data. Themes were not identified prior to the analysis, themes were expected to emerge from the participants responses. To better organize the data, the process of Broad-brush coding was used.

Once all data was imported into NVIVO 10 software, a word frequency query was completed. The word frequency query is a form of coding that identifies the frequency of words or phrases used most often within a data set or the entire data collection. Nodes were then created based on the word frequency query. Adjectives and adverbs used commonly to describe perception, emotion, and experience was filtered from the entire list. Key terms identified from the word frequency query included understaffed, argue, afraid, anxious, fight, loud, nervous, sucked, stop, tension, confusing, hated, unsafe, yelling, fighting, and leave. The key terms were then ran using a text search query. The text search query revealed the context of the terms allowing for organization of the data to begin. The data was organized into thirteen nodes: satisfaction of care, staff rumors, staff involvement, safety, noise, nervous, hiding, argument, fear, trust, comfortable talking with staff, understaffed, support from facility supervisor.

In order to complete the coding to reveal themes, additional coding was needed. The following questions evolved while reviewing the initial thirteen nodes: did the participants state if conflict was experienced, did the participants state frequency of experiences, were the experiences positive, negative, or neutral, did the participant feel safe within treatment, did the experience impact interaction between the client and the caregiver, did the participant have a positive, negative, neutral response to treatment, and did the caregiver provide adequate support? After review of the node contents, these nodes were then organized by manually coding the nodes into three primary nodes: satisfaction of care, level of safety, available support.

The identified similarities are used to create the theoretical categories. As noted by (Creswell & Plano-Clark, 2007, “Representing the Data,”), themes and significant statements are reoccurring statements offered by participants during an interview that are directly related to the experiences. These themes serve to demonstrate the participant's perception of care in the areas of satisfaction, safety, and if successful outcomes were made by the individual while a resident at the residential mental health care facility. The themes identified aided in the interpretation of the data, which is the transformation of the data into general descriptions of experience.

Evidence of Trustworthiness

Credibility

Distinct consideration for trustworthiness and potential threats to validity is essential in qualitative research. Although qualitative research does not require the same statistical inferences as quantitative research, it is still best to become both knowledgeable and prepared for potential threats that may deem the study as invalid. Strategies suggested by Maxwell (2005) guided the steps used to decrease potential threats to trustworthiness. The steps taken throughout this research process to ensure the quality of this study include identifying researcher involvement, preparation for rich data as it was revealed, respondent validation, peer debriefing, and comparison of ideas or perceptions as they emerged.

The actions taken for selecting volunteer participants initially involved developing a participant protocol. The protocol followed a rigid course which limited access to the name and identifying information related to the individuals invited to participate in the study. Acquisition of potential participant information was made available only when the individual responded to the invitation to participate. Prior to recruitment of volunteer participants, the approval from Walden University Dissertation Committee and IRB was acquired.

Dependability

In order to ensure dependability of the research, the data collection and interpretation of findings must be clear and free from research bias. Researcher bias can ultimately mislead the interpretation of findings and alter the conceptualization of the study. For the purpose of this study, journaling of opinions, impressions, and ideas was maintained. Journal entries were completed throughout the development of the study, between interviews, while categorizing data into nodes, and as the final coding led to themes. Comparison between journal entries and the interpretation of findings was completed by researcher as well was a second party coder. The second coder reviewed the data for accuracy, completeness, and to ensure research bias was bracketed from interpretation of findings. Leading statements or researcher opinion were identified and removed from interpretation of finding.

Confirmability

Rich data as explained by Maxwell (2005) is the quality of the raw data obtained during the interview and observational process. This study faced threat if the data was weak, incomplete, or lacked detail. In an attempt to minimize such threats, audio recorded interviews, list notes, and field notes were used to capture data during each interview. Field notes were written on the questionnaire developed for the interview and list notes were documented on separate sheets of lined paper. All data was imported and transcribed verbatim immediately after each interview. A second coder reviewed all hand written field notes, interview responses, and audio recordings for accuracy. Limitations of the current literature prevents comparison with the findings obtained from this study. In order to close the gap in the literature, additional research is needed. As a final note, I adhered to all of the research procedures previously outlined in this study.

Results

This section presents the results obtained from the data collected during each participant interview. In an attempt to extract each participant's perception of conflict among the staff while residing within a residential treatment facility, semi-structured interview questions were developed prior to the interview. The questions developed were used as cues to enable each participant to openly discuss their perception as experienced while residing in a mental health care facility. The data obtained from the semi-structured interview questions was used to answer the two primary research questions.

Research Question One

In what way, if any, do the residents of the mental health care facility perceive conflict as interfering with their goals in treatment?

Table 2.
Research Question One: Evolving Themes

Participant	Fear	Increased Mental Health symptoms	Neglect from staff
P1	1		
P2	3	2	5
P3	2	2	4
P4	1	3	4
P5	2	1	3
P6	2	2	2

Note. All numerical entries represent the frequency of each participant endorsement to the identified themes obtained from Research Question one.

The results obtained from the interview questions associated with this research question indicated that conflict within the team of caregivers was perceived to interfere with the participants' ability to meet treatment goals while in residential treatment facility. Of the six participants, five indicated difficulty in adhering to treatment goals due to fear derived from situations on the unit, fear of retaliation from the caregiving staff if concerns were reported, an increase in mental health symptoms (i.e. paranioa and anxiety) caused by situations or actions from the caregiving staff, and neglect due to the lack of support from the caregivers (see Table 2). Of the six participants, one participant left the facility three times against program advice but returned after each unauthorized leave. Of the six participants, one left the facility against program advice without returning for readmission. P1 indicated the reasons for his multiple leaves was due to the lack of staff available to meet basic needs while P2 indicated the reasons for leaving was directly related to the degree of fear felt while a resident and the lack of support. P2 stated. “This impacted my recovery, very much. I was afraid to come out of my room, and I refused my bedtime medication since they were the ones handing them out. Since I didn’t take my medication I couldn’t sleep. All I wanted to do all night was hide.” When asked if the participant was exposed to conflict between the caregiving team, P2 stated:

> While in the dining room having evening snack two male staff were talking very loudly and kept getting louder. I am unsure of the reason for what seemed to be an argument but I recall something about mopping and laundry. The event seemed to last for a long time but I am sure it was only a few minutes. The other residents took their snacks to their rooms, but I couldn’t. The only way to my room was to walk through the two of them and I was too afraid to move from my seat let alone walk near the two staff. So I stayed in the dining room until the both of them left the area. When I was able to leave the room, I went straight to my room and refused to leave it for the rest of the night.

P4 stated:

> Well I have already stated what I saw with the caregivers, but I would like to note that I think the caregiver’s frustration was often taken out on us. Not me exactly, but us as a group and I guess a couple other residents. See, when the caregivers argued our meals were late or medication was given late. Sometimes, I wouldn’t see the staff for long periods of time because they were in the kitchen arguing. Sometimes the caregivers would argue with some of the residents about things

> that didn’t seem to need an argument. I cannot be specific, but it happened enough. My overall perception was that the caregivers didn’t always think of the resident’s safety.

When asked to identify barriers that may have impacted goal achievements P3 stated:

> Yes definitely, I don’t really like to leave my room when I hear arguing it makes me feel anxious and brings back trauma from my childhood. I especially hated asking the staff questions because it just seemed like I was wasting their time. I also feel that set me back from achieving my goals.

Research Question Two

How do the residents of the mental health care facility experience workplace conflict when it arises amongst the team of caregivers?

Table 3.
Research Question: Two Evolving Themes

Participant	Staff Splitting	Understaffed	Basic Needs not met	Feeling Ignored by staff
P1		2		
P2	2	1	2	2
P3	1	1	1	3
P4	2	1	1	3
P5	1	2	3	
P6	2	1	1	3

Note. All numerical entries represent the frequency of each participant endorsement to the identified themes obtained from Research Question one.

The results obtained from the interview questions associated with this research question indicated conflict within the team of caregivers was experienced on more than one occasion. Of the six participants, five indicated the presence of conflict between the caregivers was observable and it impacted the daily routine for the individuals. Most participants indicated splitting between the staff, understaffed, inabiltity to have basic needs met, and feeling ignored by the caregivers (see Table 3). Particiants were asked to describe their level of comfort with discussing problems with the staff. P2 stated:

> It depended on who was working. I was comfortable when my case manager was working, when the day staff were working, and one of the fill-ins. He was a nice guy. Always telling jokes and making me laugh.
>
> I recall one time-one day- they changed my medication and I felt very nervous about the change. I knew I was moving soon and I needed reassurance that all was ok. I also forgot details due to my medications, and sometimes just because. Anyhow, I went to the staff asking for information about the medication and about my move. I was suddenly stopped in my tracks and told "you have asked the same questions six times, why don't you write it down so you can stop bothering me!" I felt so ashamed. I did write it down, but that caused me to have another question. I did not go and ask however…I didn't want to be a bother any longer.

P3 Stated:

> I felt uncomfortable most of the time, talking with the staff about my problems was hard. I just didn’t trust them. I often heard the staff argue about tasks, about the schedule, and sometimes about who was going to help some of the other residents. It sucked. Customer services was never really given!
>
> Once, I was standing in the day room talking with one of the staff and any other staff person came into the room. He began to shout of both the staff and me about the wet floor sign in the hallway. I tried to go to my room but was frozen as I didn’t know what to do. I wanted to tell the supervisor but she was really difficult to talk to. She always said…go to your case manager with issues. I am very busy and cannot help you right now.

The two research questions driving this study were accompanied by specific interview questions, used as cues to engage the participant in the interview process. The interview questions provided the opportunity for the story to develop as perceived and experienced by the participant. The first research question was designed to draw the participant perception of conflict interfering with achieving goals while in treatment. The second research question sought to draw the participants’ experience of workplace conflict as it emerged amongst the team of caregivers. Participants’ direct statements were used to identify common themes. Common themes that emerged from Research question one include fear, increased mental health symptoms, and neglect from staff (see Table 2). Common themes that emerged from research question two include staff splitting, understaffed shifts, basic needs not met by caregiving staff, and neglect (see

Table 3). Each table includes the common themes along with frequency theme endorcement by each participant.

As the themes from both interviews were further reviewed it was found that the common elements rest in lack of support and safety, communication barriers with the caregiving team, the perception of neglect and rejection. For example P2 discussed her level of safety as it related to her current mental health symptoms and how her symptoms were increased due to stress and fear:

> When I feel safe I feel comfortable and I am able to sleep. I have nightmares, which I take medication to help with. When I feel unsafe the nightmares are worse and I cannot sleep even if I take a ton of medication. I also laugh, joke, and talk with others when I feel safe. When I feel unsafe, I just want to hide. I also get stomach pains…oh they suck!
>
> I remember hiding a lot when I was at the facility because I felt unsafe. This was mostly during the evening when the two male staff were the only staff working. Don't get me wrong, the staff didn't fight everyday but it was often. I think one of the hardest things to deal with was the way the other residents dealt with it. See I know it impacted me, and I can only imagine that it also impacted them. Sometimes the residents would start to argue and get loud as well. It was a nasty pattern of disruption.

P3 discussed an example that related to the perception of neglect and rejection:

> I remember not long ago two staff were in their office arguing so long that they forgot to make dinner. When they finally called us down for dinner it was so late in the evening that they didn't even finish cooking the food. I mean…the staff actually poured spaghetti sauce right out of the can on our plates of noodles and gave that to us to eat. It was terrible!

P1 discussed an example that related to communication barriers that directly effected the residents of the facility:

> I don't know if it is conflict more than a lack of proper communication. So many people being given one example then they break it down into the way they perceive their example, and its gets convoluted. The purpose of our treatment shifted, organization of the program was not good.

Each of the participants provided direct accounts of their experiences while at the residential mental health care facility. All participants openly discussed their experiences including fear and perception of safety, increased stress, lack of support, limited staff available to provide for the resident needs, impact of conflict on recovery, communication deficits between residents and staff and between the working staff. Of the six participants, five participants provided negative statements indicating decreased satisfaction of care, level of safety, and available staff support.

Discrepant Findings

Analysis of the data showed that the participants experienced some level of conflict while receiving treatment at the residential mental health care treatment facility.

Of the six volunteer participants, one participant provided positive feedback on the program and the team of caregivers. P1 Stated, “I don’t think it [conflict] affected my perception of safety because even though there was a lot of changes going on, the guidelines for the whole facility stayed the same. The staff were doing their job and that’s was just safe.” With the exception of one participant, all provided detailed explanations of situations and experiences related to exposure of conflict while in residential treatment.

The statement from P1 does not indicate he was exposed to conflict but he does reference confusion, limited staffing, and decreased communication between the caregivers and the residential clients. P1 stated, “I don’t know if it is conflict more than a lack of proper communication. So many people being given one example then they break it down into the way they [staff] perceive the example, and its gets convoluted.”

Summary

Chapter four of this research study was developed to present the study results. This study used phenomenological approach to capture the essence of the lived experiences and perceptions of clients receiving residential mental health services. In this section, I provided the demographics, data gathering and storage, data collection, data analysis, evidence of trustworthiness, and results obtained from the participant interviews. Chapter 5 will briefly present the purpose and nature of the study and summarize key findings, describe limitations, ad provide recommendations for further research and implications for social change.

Chapter 5 Conclusion and Recommendations

Introduction

The last chapter is a discussion of the findings, implications for social change, and recommendations for future research as well as an opportunity for the reader to draw from personal experiences as it relates to customer service and compare those experiences with the stories told by the clients receiving residential mental health care services. The purpose of this study was to examine the adult residential clients' perceptions of workplace conflict, how the conflict is experienced by the adult residential clients, and how these experiences influence treatment outcomes of the adult client's residing within mental health care facilities. The narratives of the clients' accounts and the analysis revealed how the clients adapted to the environment and used the experience to enable them to endure what each was exposed to while in admittance at the residential mental health treatment facility.

This phenomenological study explored the perception of conflict from the point of view of the clients who receieved residential mental health services. I used semi-structured interviews as the method of inquiry and interpretation. Influencing the study was my point of view as a researcher, my personal experiences relating to residential care settings, and the conceptual model of the Therapeutic alliance. Therapeutic alliance is the process of the clinician and client developing a collaborative relationship, utilizing reality based practices during the therapeutic process (Horvath and Luborsky, 1993).

The key findings of this study, acquired through semi-structured interviews, data review, and nodes has shown the breakdown in communication between staff members impeded the overall care and support of the residential clients. This breakdown interfered with the relationship process of the therapeutic alliance which impacted the expected evolution of the treatment process. The three key themes identified include clients' satisfaction with care, perceived level of safety, and perceived availability of support from the caregiving team.

Interpretation of findings

Two research questions guided the review of the literature and assisted in the development of semi-structured open ended interview questions. The two research questions were as follows:

1. In what way, if any, do the residents of the mental health care facility perceive conflict as interfering with their goals in treatment?
2. How do the residents of the mental health care facility experience workplace conflict when it arises amongst the team of caregivers?

Research Question one asked, in what way, if any, do the residents of the mental health care facility perceive conflict as interfering with their goals in treatment? The data presented in Chapter 4 indicated conflict within the team of caregivers has been observed by most participants during residential treatment. This is reflected by the responses received from interview questions and prompts. Participants were initially asked to define, based on own perception, the term conflict. Each was then engaged in subsequent questions designed to pull direct experiences as it related to their residential treatment care. These questions focused on exposure of conflict within the caregiving team, how this impacted recovery, level of caregiver involvement in the residents' course of treatment, as well as the perception of safety while in treatment.

Therapeutic alliance is referred to as the unique relationship that progresses along a two phase continuum with the end result consisting of a decrease in patient distress (Catty, 2004). This continuum includes the development of trust, agreement, and cohesive understanding to the therapeutic course. The clinician's ability to grasp the client's worldview is essential to the process, without this understanding the relationship will not follow a healthy treatment course. The development of the alliance includes the clinician's ability to listen to the client without judgement, ability to provide the client with a clear rationale for the therapeutic approach, ability to identify gaps in client understanding for the rationale, and find alternative approaches to explain the rationale. It is also necessary for the clinician to be open to client opinion, concerns, and demonstrate the ability to articulate goals as related to the approach. The responses to question one provide little indication of the beginning of such a relationship between the caregiving staff and the client receiving care.

Of the six participants interviewed, five related negative experiences, meaning the impact of conflict induced fear, increased mental health symptoms, and perception of neglect while a resident of the facility. The data revealed a breakdown in the initial development of the alliance between the caregiving staff and the client which ultimately hindered the long-term benefits of the therapeutic alliance. Each participant was able to recall the events of each situation and discuss the events freely. The participants ability to freely discuss the events allowed the themes to easily unfold.

The experiences as, described by the participants, was obtained using semi-structured open ended interview questions. Each participant response provided opportunity for the participant to reveal thoughts and opinions based on their ability to recall the events while in residential care facility. The question set included asking the participant to recall specific times when conflict was observed, how the event directly impacted their perception of safety, and if it impacted specific treatment goals. Each participant was also asked to discuss their opinion as it related to the caregivers engagement in care, interaction between each other, and interaction between the caregivers and the clients.

While research question one was guided by the factors inclusive to the development of the alliance between caregiving staff and the client, question two focused on the capacity to maintain the alliance. Based on the initial responses pulled from question one, the ability to pull meaningful data indicating the alliance was maintained during the therapeutic relationship was insufficient. This is due to the initial breakdown within the alliance between caregiving staff and the client followed by the inability of the evolution of the relationship. Maintaining the alliance is essential to the continuance of the treatment course, factors included in the maintenance of the alliance are the ability to recognize threats to the progress of the therapeutic course, ability to provide alternative goals when appropriate, as well as the ability to provide alternative interventions when appropriate.

Of the six participants interviewed, five participants openly discussed their opinions and provided detailed events each perceived to involve conflict within the caregiving team. Although the participant pool was limited, rich data was obtained from each interview. Saturation was achieved from the rich data allowing the resulting themes to emerge easily. The data obtained from the narratives indicated an insufficient level of care, limited support, barriers in communication and collaboration, and an exclusion to the development of alternative goal and intervention opportunities.

Limitations

The findings from this study were subject to interpretation by me as the researcher. The method of sampling involved purposive and homogenous sampling, which limited the sample population to those who had recently lived in one facility and may have experienced the phenomena, and who shared distinctive characteristics (Creswell & Plano-Clark, 2006). The sample size sought for this study was 14 male or female individuals who received residential mental health treatment within the last two years for at least three months, over the age 18, currently living independently in the community, literate in English, and agreed to participate voluntarily. A total of 36 invitations were sent, with a response of eight. Of the eight responses, six volunteered to participate in the study. Of the six participants, two agreed to an audio recorded interview. The limited participant pool was due to the limited enrollment of volunteer participants.

Recommendations

Future research should explore factors such as the differences related to gender of caregiver and gender of client, if length of stay in residential treatment impacts perceptions, and if caregivers have the same perception as clients about treatment outcomes as related to client perception of workplace conflict. Additionally, the limited sample in terms of those who perceived conflict: is this a common issue among residents or not, and exactly how common it is. It is without question that the context of the experiences described in which the client identifies an inability to meet treatment goals is dependent on the interaction and support of the caregiving team. Current and recent research on the impact of workplace conflict within the workplace provides a glimpse of the harmful outcomes that may result from unresolved conflict. Unfortunately, little has been published on the harmful effects of indirect exposure of workplace conflict to clients, patients, customers. This gap in current research, effects of conflict among caregivers on clients, needs further investigation.

Current research, as discussed in the literature review, has shown that team members may develop resentment, become hostile, or fail to complete assigned tasks, when conflict between the team members is present. The literature review aids to validate the data obtained from this research as participants provided direct accounts of caregivers failing to complete tasks and the indication of hostility toward each other. The literature did not provide an indication of the impact conflict may have on the client receiving services from the caregiving teams. The findings from this research identified themes which indicate the likelihood of impact on the clients receiving services furthermore the impact was shown as a decrease in the perception satisfaction of care, level of safety, and support of the caregivers and the clients enrolled in treatment.

A number of important conclusions were drawn from this study. Specifically, the findings of this study opened a door to the gap in current literature in the areas of workplace conflict and the impact it may have on individuals receiving residential mental health care. My recommendations for future studies include more in-depth research and the inclusion of additional research tools such as surveys, exit interviews, and follow up interviews. It is suggested to obtain data from residents enrolled in long term mental health residential care services and obtain the caregivers perception on the impact of workplace conflict. In addition, I recommend future studies to help determine if there is an association between the client responses and staff satisfaction with employment. Staff satisfaction surveys and interviews can be obtained without harm to the population served while providing the organization with rich data for future project improvements.

Implications for Social Change

Findings from this study could result in positive social change by first, the discovery of a problem that has an impact to individuals, communities, organization, institutions, cultures, or societies. Second, eliciting future research and data gathering globally. Third, with a better understanding of how workplace conflict impacts the lives of clients or patients receiving caregiving services, organizations can develop solution focused strategies for implementation in the workplace.

Currently, research focused specifically on the impact upon the client or patient populations exposed to workplace conflict within caregiving structures is sparse. While research data targeting the impact of workplace conflict upon the staff (i.e. nurses, caregivers, case managers) is expansive. This research study did identify the presence of a problem that impacted a group of individuals receiving residential mental health care services. Additional research is needed to understand the depth and breadth of this impact on a wider scale. Once the extent of the problem is clearly known appropriate strategies can be implemented to improve workplace conditions. Strategies such as better reporting procedures for staff when conflict arises, better policies to deal with conflict, and improved support for caregivers from facility administration can make a positive change for caregivers and the clients receiving care.

This research study was necessary because the population of individuals requiring caregiving services, either in their homes or institutions, should receive care that promotes dignity, safety, and increased quality of life. Evidence from this study indicated conflict between the caregiving staff negatively impacted the clients' ability to adhere or complete treatment goals while receiving residential mental health services. The evidence from this study was obtained through individualized interviews with previously enrolled clients in a residential mental health facility. The participants in this study discussed experiences and emotions specific to situations that occurred while in treatment. All participants reported feeling fear; and most reported neglect from the staff, increased mental health symptoms, a decrease in treatment adherence, not having basic needs met, and feeling ignored. The lived experiences of the participants in this study indicates the presence of a problem that has impacted the clients' lives, this problem clearly deserves future research.

The impact of workplace conflict on client care was addressed by obtaining direct accounts from the adult clients' who recently resided within a mental health care facility. While this study provides a glimpse of one group, in one location, with distinctive characteristics it is not plausible to believe that this one group is the only group to have been exposed to workplace conflict amongst caregivers. To consider or compare with varying groups, treatment centers, additional residential care centers, and hospitals is outside the scope of this paper. Although not discussed here, the findings from this study does encourage inquiry that can only be addressed with thorough investigation, research, and the acquisition of additional data. Positive social change can be accomplished, even if we change only one group at time.

Conclusion

For some individuals with chronic and persistent mental health disorders living independently within the community is an uphill climb with little opportunity for rest. For others, it is manageable with appropriate natural supports. Those who struggle to climb the hill may benefit from enrollment to a residential mental health care facility, one that provides care and support as well as education and training in areas of independent living skills. To provide the care, support, education, and training needed a team of trained caregivers in various specialties is required. Each is assigned specific roles and all are given the same expectation and goal to provide high quality care, dignity and support that promotes recovery.

Chapter 5 included findings of the research, limitations of the study, and recommendations for further research. The research findings indicate clients residing within residential treatment facilities are both exposed to and impacted by conflict within the treatment team. Additional research is recommended along with the development of training programs to prevent and eradicate conflict from the team level as well as educational programing to support the clients to recognize when conflict is present and how to report concerns. In addition, Chapter 5 provided a discussion on the impact of this study on social change, "the improvement of human or social conditions by promoting the worth, dignity, and development of individuals, communities, organization, institutions, cultures, or societies." The worth and dignity of individuals receiving residential mental health services as well as the caregiving staff must be recognized and the emphasis on improving the lives of individuals in need of residential care services must be made. Social change can be accomplished with a team approach.

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Appendix A: Interview Questions and Possible Probes

1. In what way, if any, do the residents of the mental health care facility perceive conflict as interfering with their goals in treatment?
2. Please describe your perception of term conflict?
3. While residing at the mental health residential care facility, were you exposed to conflict? between the caregivers? If yes, Please discuss your perception of this event.
4. Please discuss how conflict can impact your recovery.
5. While residing at the mental health residential care facility, did you observe situations of conflict? Please discuss your perception of the event?
6. Please discuss your role in the treatment recovery process while residing at a mental health residential care facility. Please discuss the level of staff involvement in your treatment recovery. Were you satisfied with this level of involvement? Why or Why not?
7. Did you feel there were barriers preventing you from achieving your goals? If yes, Please discuss these barriers.
8. Please describe your perception of safety? Can you discuss your perception of safety (safe or unsafe) while residing at the mental health residential facility?

9. Please describe your level of comfort with discussing problems with the staff. Has there ever been a time when you felt uncomfortable discussing your problem with the staff? Can you describe the event?

10. How do the residents of the mental health care facility experience workplace conflict when it arises amongst the team of caregivers?

11. Can you recall a time when staff spoke to you about issues involving other staff or announcing the facility was understaffed and unable to assist you with completing a goal? If yes, please discuss how this event impacted your progress. Did this event change your view of safety?

12. What are your experiences of workplace conflict?

13. While residing at the mental health residential care facility, did you witness workplace conflict within the caregiving team? If yes, please explain your experience.

14. In your opinion, how did the staff get along with each other? How did the staff interact with each other? Did the way in which staff interacted with each other change the way you interacted with the staff? With other residents?

15. Have you ever overheard or witnessed the staff engage in an argument? If yes, Please discuss your experience of this event.

16. Is there anything that I haven’t asked you about concerning your care,

17. Treatment goals or your impression of staff that you would like to share with me?

Appendix B: Agency Policy

CENTRAL WASHINGTON COMPREHENSIVE MENTAL HEALTH POLICIES AND PROCEDURES

Title: Research Involving Clients	**Policy #: RI-002**	
	Creation Date: June 30, 2000	
Chapter: Rights, Responsibilities, Ethics	**Revision Date(s):** *6/22/05; 4/23/07;*	
References: 45 CFR, Part 46, RCW 70.02.010, 71.05.390, 71.05.630, WAC 275-57-340 & 275-57-370, RI.2.180	**Attachments:**	
Affected Parties: All Staff		
Approval Signature:	**Title:**	**Date:**

Policy: When CWCMH conducts research, investigations or clinical trials involving human subjects, its first responsibility is to the health and well-being of the individuals served. To protect and respect the rights of individuals served, the QIB shall ensure that the following are always adhered to:

- Review all research, investigations or clinical trials relative to the organization's mission statement, the project's values, and other organizational guidelines. Exception to this is research being conducted by the State of Washington or by Federal Government. However in such cases the State of Washington or the Federal Government agencies must submit verification that the research meets human subject standards consistent with State and Federal requirements.
- Weigh the relative risk and benefits to the subjects.
- Obtain the subjects' consent as applicable.

Valid written client consent must be obtained before participation in a research, investigation or clinical trials project unless it is demographic data collection, no treatment is being provided to the client as part of the data collection and the client is not identifiable. Informed consent becomes possible when the client is given full information and can make a rational decision about whether or not to participate. Clients have the right to refuse to participate in any research, investigation or clinical trials without compromising their access to ongoing treatment services.

Because the client's participation in research, investigation or clinical trials needs to be based upon their having sound information and making a rational decision, the following items are documented in the client's medical record:

- The name of the person who provided information.

- The date the form for participation in research, investigation or clinical trials was signed.

CWCMH shall ensure clients are knowledgeable of and protected by established rights when conducting research, investigations or clinical trials in which they may be asked to participate. In all such cases, written informed consent of the client (or of the person legally responsible for the client) shall be obtained prior to the client serving as a subject in research, investigations or clinical trials.

Definition: Adequate information includes an explanation of the purpose of the research and expected duration of the subject's participation; a description of expected benefits, potential discomforts, and risks; alternative services that might prove advantageous to the individual; and a full explanation of the procedures to be followed. *(4/23/07)*

**Site Listed By Exception, Only*

CENTRAL WASHINGTON COMPREHENSIVE MENTAL HEALTH POLICIES AND PROCEDURES

Policy: Research Involving Clients

Procedure:

Responsible Party	Site*	Action Required
Researcher/Investigators		1. Submit Request for Research Proposal to the Quality Improvement Board (QIB) for review. In the case of the State of Washington or Federal Government agencies requesting to conduction research. The respective State or Federal agencies will submit verification of meeting human subject standards consistent with State and Federal regulations. If research is part of a regionally approved accredited higher educational institution and part of a thesis or doctorial research project, the institution most first have reviewed and approved the project before it can be approved by QIB.
QIB		2. Reviews proposal according to established review process and accepts or rejects proposal.
		3. a) If proposal is accepted it is forwarded to CEO for final approval. b) If proposal is rejected, QIB notifies researchers or investigators of rejection. Rejection at this level is final.
CEO		4. Reviews QIB recommendation for acceptance of proposal and makes final approval.
		5. If approved, project proposal is submitted back to QIB for coordination.
		6. Disapproval by CEO is final.
QIB or designee		7. Notifies researchers or investigators of Leadership Committee's approval or disapproval.
		8. If project is approved, QIB monitors project for compliance with RCW, WAC, DSHS and JCAHO guidelines and standards.
		9. Coordinates all ongoing research projects to prevent interference from one project with another, interference with clinical program, and over-utilization of certain client groups for research.
		10. Controls the access to the organization's client population for research.
		11. Co-owns the data and can veto the use of data if deemed

		inappropriate.

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mental health

Quality Improvement Implementation Follow-Up Report

Project Chairperson: Date:

Project Title:

Project Start Date: Initial Project: Redesign Phase:

The project is currently in the phase of: ☐ Plan ☐ Do
☐ Study ☐ Act
☐ Demonstrating Sustained Improvement
☐ Re-Design ☐ Project Termination

Expected Outcome (Hypothesis):

Project Summary to Date/Update:

Question for Committee Considerations:

Committee Response: ☐ Report Accepted With No Recommendations
☐ Report Accepted and Recommendations Submitted to Group
☐ Report Not Accepted & Returned to Committee with Feedback

QIB Recommendations:

____ ______________________

Committee Chair Signature Committee Review Date

These reports can serve as attachments to the Leadership Quarterly Reports submitted by the chairperson of the QIB.

Appendix D: Invitation to Participate

To whom it may concern:
You are invited to take part in a doctoral research study of people who lived within a mental health residential care facility for three months or longer within the last two years. Criteria to participate in this research study include: each participant will have discharged from a mental health residential care facility within the last two years, resided at the mental health residential care facility for three months or longer, is currently living independently in the community, over the age of 18, and agrees to volunteer as a participant.
As part of this research study you will be asked to take part in a confidential interview with the doctoral student researcher. Along with this invitation you will find a copy of the informed consent form for your review along with a self-addressed pre-stamped envelope. If you agree to take part in this study please answer the questions below, review and sign the informed consent. Please return both this letter and the informed consent to student researcher using the self-addressed pre-stamped envelope no later than (date).

Sincerely,

Shawna Stoneking
Student Researcher

[ ] I am interested in joining in this research study.

[ ] I was a resident of a mental health residential care facility for three months or longer.

[ ] I have discharged from a mental health residential care facility within the last two years.

[ ] I am over the age of 18.

Please indicate best phone number to contact you: ______________________________

Please indicate the best time of day to contact you: ______________________________