The Relationships of Hospitalized Persons with Acute Mental Illness and Their Nurses: An Interpretive Inquiry

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IN LOVING MEMORY OF CAROLYN THIBEAULT
(1922-2008)

Abstract

The nurse-patient relationship is prominently featured in nursing discourse, particularly in the literature and practices of psychiatric-mental health (PMH) nurses. PMH nurses have found it challenging to focus on their relational work in the face of pressure to provide efficient, technological, and biomedical care, especially in hospital settings. The purpose of this inquiry was to explore the relational experiences of patients with acute mental illness and their nurses in inpatient psychiatric settings. The researcher engaged in conversations with ten PMH nurses and six patients hospitalized with acute episodes of severe mental illness. Interpretation of transcribed accounts yielded four dominant themes: engagement, withdrawal, mindful approach, and keeping safe. The author discusses the relational practices of nurses and their patients as experienced in the day-to-day world of an acute psychiatric inpatient unit. The author explores relational experiences in brief encounters, as patients and nurses move toward the other in order to understand the other; in psychological work, as they attempt to achieve a shared understanding about future directions; and in practices related to caring for patients with physical needs related to activities of daily living. The author discusses the state of unknowing that some patients and nurses experience as they withdraw from the other. The author concludes that relational practices are a prominent feature of the work of psychiatric-mental health nurses in acute inpatient psychiatric units, but that the nature of these practices may be changing. The author also suggests that despite their occasional experiences of nurses' withdrawal and absence, patients highly value the experience of working with nurses in supportive, health-promoting relationships.

Résumé

La relation personnel infirmier-patient a été un élément important du discours en sciences infirmières, particulièrement dans la documentation et la pratique du personnel infirmier en psychiatrie-santé mentale. Les infirmières/infirmiers en psychiatrie-santé mentale rencontrent des difficultés à se concentrer sur leur travail relationnel face à la nécessité de fournir des soins efficaces, technologiques et biomédicaux, particulièrement en milieu hospitalier. L'objectif de cette enquête était d'explorer les expériences relationnelles des patients atteints de maladies mentales aiguës et de leurs infirmières/infirmiers en milieu hospitalier psychiatrique. La chercheuse a engagé des conversations avec dix infirmières/infirmiers psychiatriques et six patientes/patients hospitalisés dans des unités de soins psychiatriques intensifs. L'interprétation de la transcription des conversations a révélé quatre thèmes dominants : engagement, repli sur soi, approche attentive et sentiment de sécurité. L'auteure discute des pratiques relationnelles du personnel infirmier et de leurs patients telles quelles sont vécues dans l'univers quotidien d'une unité de soins psychiatriques intensifs. L'auteure explore ces expériences relationnelles lors de rencontres brèves, lorsque les patients et le personnel infirmier vont l'un vers l'autre afin de mieux se comprendre; lors du travail psychologique, lorsqu'ils tentent de parvenir à une compréhension commune de l'orientation future; et lors des pratiques liées aux soins des patients présentant des besoins physiques en liaison avec les activités de la vie quotidienne. L'auteur discute du sentiment d'ignorance éprouvé par les patients et le personnel infirmier lorsqu'ils s'éloignent l'un de l'autre. L'auteur conclut que les pratiques relationnelles sont un élément important du travail des infirmières/infirmiers d'unités de soins psychiatriques

qui ont participé à cette enquête, mais que la nature de ces pratiques pourrait être en train de changer. L'auteur suggère également qu'en dépit des expériences occasionnelles de retrait et d'absence du personnel infirmier, les patients interrogés dans cette enquête accordent une grande importance à la collaboration avec le personnel infirmier dans le cadre de relations de soutien et de promotion de la santé.

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CHAPTER ONE

Orientation to the Topic of Interest

The purpose of this inquiry is to explore the experiences of psychiatric-mental health (PMH) nurses and their patients as they relate to each other during the patient's hospitalization in an acute inpatient psychiatry unit. Why is it important to understand these experiences? Why study persons with severe and persistent mental illness and their nurses? What experiences are left to uncover? To answer these questions, I will discuss the concept of nurse patient relationship as it exists in nursing theory and practice in general and mental health nursing in particular. I will contend that the concept of nurse patient relationship has been an important focus of interest in mental health nursing theory and practice, but that researchers, theorists and clinicians have tended to focus on narrow aspects of the nurse patient relationship and failed to uncover its essence. I will suggest that nurses' preoccupation with understanding the characteristics of beneficial, health promoting relationships has minimized the significance of understanding other aspects of relationship such as interpersonal discord, power imbalance and moral distress, and that there has been little exploration of relationship in its fullest and most intricate meaning.

A Personal Narrative

In order to situate myself, the researcher, in this inquiry, I will describe experiences that first led me to ask questions about the relationships of mental health nurses and their patients. The first of these occurred at the beginning of my career as a Registered Nurse. I worked on a 32-bed gynecology unit in a tertiary care hospital. I recall it clearly: participating in the ebb and flow of shift report, meeting new patients,

monitoring dressings, drains, catheter bags and intravenous drips, assessing vital signs, and scheduling hygiene care.

There were many times when my patients experienced feelings of anger, fear, or sadness. When patients' physical needs were superseded, at least temporarily, by psychological needs, I learned that I needed to be with patients in a very different way, although I was not at all sure what that meant. Why would patients want to tell me about their feelings? How would patients know that I would respond in a helpful manner? How would I know how to be helpful? How would I know what to say? I had some formal knowledge of the matter. The concept of therapeutic relationship was not new to me, but I was not sure what it meant to be in a therapeutic relationship. What constituted therapeutic relationship? I recognized the human value of helping people to ease their psychological distress, but I wondered whether helping people express and cope with painful feelings really made a difference in their recovery.

I had an experience that helped provide some answers to my questions. A woman who had given birth seven days earlier was hospitalized with a post-partum infection. A day after the initiation of intravenous antibiotic therapy, the woman became distraught. She had been breastfeeding her newborn, and now she feared that she was no longer producing milk. I spent a mere 20 minutes at her side. We talked about her child, and about what it meant to be a mother. We talked about how much she loved the intimacy of holding her baby to her breast. At the end of our time together, she looked down at her hospital gown. Milk had started to flow, and she asked for a breast pump. For the first time as Registered Nurse, I understood the potential of the nurse-patient relationship.

I have experienced many positive relational moments with patients, but I have also experienced many challenging moments. I am sure that my patients experienced these latter experiences as less than helpful. I remember a specific situation that took place on a day when I was feeling very overwhelmed by the demands of my work. Once, during a particularly harried workday in a small northern hospital, a patient stopped me in the hall and told me (in a rather angry tone, I remember thinking) that she needed new glasses, and that it was her right to get a new pair of glasses. I was in the middle of preparing to do a particularly challenging wound dressing—a patient's large abdominal incision had dehisced, and surgical repair had yet to take place. The patient with the wound had recently and only barely recovered from peritonitis secondary to a ruptured appendix. I was very concerned about performing the procedure correctly, and the last thing I wanted to do was worry about another patient's new glasses. With irritation in my voice, I said to the patient in the hall, "You already have glasses. You are only entitled to new glasses once a year. I worked in the community, I know how this works, so please don't try to tell me any differently". Although I was her nurse for many more days, never again did she ask me for anything. I had responded coldly to a patient who was making a request of me. It was a request I considered frivolous and unnecessary; moreover, the request demanded an action of me that I had neither the time nor the inclination to carry out. My answer was truthful but unhelpful; worse, I offered no options, no empathy. After the incident, I was wracked with guilt. I felt that I had let my patient down. Of the two of us, she was the one in the more vulnerable position, yet I was the one who had acted defensively.

Several years ago, a very good friend developed terminal cancer and within five weeks of learning her diagnosis, lay in a hospital bed, living the last days of her life. One evening, her husband said to me, "I am so tired…I haven't been able to sleep". I replied, "Why don't you go home and get some real rest? I don't have to work tomorrow. I can stay with her all night." He considered my offer for a few moments and said, "Do you think you could?" I nodded, and after saying good-bye to his wife, who was drifting in and out of awareness, he left the room. Throughout the evening, I sat in the chair beside my friend's bed. At about midnight, she opened her eyes and said "Cathie? Where's Evan?" I told her that he had gone home to rest, and that he would be back in the morning. She gave a half smile and drifted out of conscious awareness. As the night wore on, I moved my chair so that I could sit as closely as possible. At times, I touched her hand. When she became restless, I asked her nurse to give her pain medication. I talked to her while the nurse bathed and turned her. I watched as her skin colour changed, and her respirations slowed. By 6 a.m., it became apparent to her nurse and to me that this had been the last night of her life, and we decided that it was time to call her husband.

What did this last story tell me about the relationships of nurses and patients? It told me that nursing is more than a series of actions—it is a *way of being*. As I spent the night watching my friend, I experienced the intense feelings of a nurse keeping vigil. Even though I had not directly cared for her body, my watchful presence was not just an act of friendship, it was an act of observing, connecting, and *being with*, arising out of my sense of duty to those who need comfort. Moreover, it was not only my presence which

created this way of being, it was the meeting of our *presences*, those of myself and my friend, in a common understanding of what was wanted and what was required.

I have continued to explore and experience what it means to be in relationship with a person who is ill, and try to understand what it means for a person who is ill to be in relationship with a person giving care. I now work exclusively with people with severe mental illness, where much nursing work is focused on engaging with and understanding the person's life-world. In my experience, people with mental illness, particularly if hospitalized, seek an affirming environment where they can feel safe and at ease. Unlike people whose primary problem is physical disease, persons with mental illness have no wounds or disability to clothe their emotions. In an acute inpatient psychiatric unit, nurses protect, support, and attempt to heal these souls-laid-bare. Patients with severe mental illness can be fearful, withdrawn, isolative, impulsive, disinhibited, agitated or angry, especially in the very acute phase of illness. As many patients reject comforting overtures as seek them. I have witnessed a person with extreme paranoia heed the gentle and kind direction of his nurse and enter a room, where only moments before the person insisted that the devil's signature "666" was on the door. I have also listened to a very sad patient describe an intense longing for meaningful conversation with her nurse, whom the patient described as "nice, but in a distant sort of way".

I have had thousands of interactions with patients, but I am not sure which, if any of those interactions constitute relationship. I have had many discussions with patients about their illness, their anxieties, and their hopes for recovery. In my mind, these are moments of significance, but this is my perspective only. What is the difference between

interaction and relationship? What has to happen in order for relationship to be helpful to the person in need? What does it mean to be helped? In my long experience as a Registered Nurse, it has become clear to me that being in relationship with a patient means many, many things; when the patient is a person with acute symptoms of mental illness, there is a particular meaning to being relationship and this meaning can be revealed. This is the focus of my inquiry.

The Nurse-Patient Relationship

It is difficult to understand the development of the discipline of nursing unless one pays significant attention to the relationship between nurse and patient. The concept of relationship in nursing practice has been a subject of keen interest in nursing since 1952 when Hildegard Peplau published her seminal work *Interpersonal Relationships in Nursing Practice* (Peplau, 1952). Peplau was recognized by Meleis (1991) as the first of the "interaction theorists" (p.105); Meleis asserted that "interaction is the major tool by which nurses assess clients' needs and resources…a central tool in providing nursing therapeutics" (p.105). Peplau, whose theory of nursing emanated from direct observation and personal experience, "produced the first articulated concept of nursing as an interpersonal relationships with components of interpersonal processes central to nursing needing to be elucidated and analyzed" (Meleis, 1991, p.35). Travelbee (1971), another interaction theorist, suggested that "communication is a process which can enable the nurse to establish a human-to-human relationship and fulfill the purpose of nursing…to assist individuals and families to prevent and cope with the experience of illness… assist them to find meaning in these experiences" (p.93). It has been over fifty years since Peplau's work first sparked significant development in research on the nurse-patient

relationship, and the concept has remained at the centre of nursing practice paradigms, regardless of patient situation or nursing specialty (Fawcett, 1995). Indeed, Kim (1987) suggested that the concept of nurse patient interaction is a separate component of the nursing metaparadigm, in addition to the critical elements of nurse and patient (Fawcett, 1995).

According to Benner (2000), relationship is embedded in engaged nursing practices that "meet, comfort, empower, and advocate for vulnerable others" (p.11). It has been argued that engagement is an "essential aspect of responsible caregiving" (Schultz & Carnevale, 1996, p.189). The practice of "engaged caregiving" (Schultz & Carnevale, 1996, p.193) brings the clinician to a place of understanding the person; the clinician gains knowledge of the other through interpretation of the experience of the person. There is a complication, however: the act of nursing does not take place in a vacuum. The nurse patient relationship exists within environments "shaped by prevailing social, cultural and ethical norms", and "changes in the milieu in which nursing is practiced…demand close scrutiny and potential modification of practice paradigms" (Hagerty & Patusky, 2003, p.145). In our contemporary Canadian health care system, one of the most significant "prevailing norms" is sustainability, which is challenged by "a health care system under considerable stress as a result of financial cutbacks, workforce deficits…. and changing demographics such as aging and cultural diversity" (Canadian Nurses Association, 2001, p.6). As Western health care delivery systems bend and groan under the weight of current expectations and limited resources, a chronic gap in nursing workforce supply may lead nurses to lose interest in "the emotional work of attunement and engagement" (Peter & Liaschenko, 2004, p.220).

It has been suggested that a modern ideology of medicine contests the value of an engaged caregiving relationship and suggests the relationship between caregiver and patient should be one of distance and objectivity (Schultz & Carnevale, 1996). Providers are asked to deliver more cost effective, evidenced-based care; further, what constitutes evidence is often defined so restrictively it can only be commensurate with a natural science point of view. It has been suggested that nurses are being forced to abandon a caring relation with patients in favour of "fast-paced, fast-talking health care provision" and that there is a "rising momentum of evidence-based practice developed around procedural approaches to the management of patients' bodily functions, in which the patient is treated as a pathophysiological object" (Jonsdottir, Litchfield, & Pharris, 2004, p.243). Nursing has been overwhelmed by a trend to medicalization:

> The unmet needs of concern to nursing that are commonly categorized as psychological, social, spiritual and existential are likely to be approached in a similar way to bodily needs (i.e. from a task oriented notion of solving problems) to achieve specified outcomes. This emphasis on a rational and linear thinking approach to solving problems in a standardized, prescriptive manner has insidiously become the approach driving nursing practice. (Jonsdottir et al., p.243).

Given the current environment in which the majority of nurses deliver care, and the hegemony of a natural science perspective, is the relationship between patient and nurse an irrelevant component of nursing practice? It is true that the exigencies of health care exert a powerful influence on nursing practice, but it is also true that the nature of that influence is yet to be fully understood. Relational values in nursing practice, nursing

theory, and nursing knowledge will not evaporate in the face of a technological imperative; indeed, it is because of the pressure to technologize nursing practice that the nurse-patient relationship is an important topic for study.

The Nurse-Patient Relationship in Psychiatric Mental Health Nursing

As much as the nurse patient relationship is a significant aspect of nursing practice in general, it holds an even more prominent place in mental health nursing discourse. According to Welch (2005), "hardly a single textbook in recent years will fail to mention the therapeutic relationship and its key role in mental health nursing" (p.161). Historically, psychiatric mental health nurses have operated within a paradigm that holds in high esteem values such as "human to human connection" (Mohr, 1995a, p.365), "purposeful use of self as its art" (American Nurses Association, 1982, p.5), and the critical role of the nurse patient relationship (Barker, 2000, Forchuk, 1992; Peplau, 1952). Peplau's (1952) work had a significant impact on the discipline of nursing as a whole, but her influence on the specialty of psychiatric mental health nursing was monumental. Peplau described the nurse patient relationship as "a significant, therapeutic, interpersonal process…that makes health possible" (p.205) and clearly suggested that the relationship between the psychiatric mental health nurse and patient is not merely important, but therapeutic in and of itself.

Despite the strength of Peplau's work and the influence of her work on generations of mental health nurses, it has been suggested that psychiatric mental health nurses have "uncritically absorbed…the materialist medical epistemology", which has become "assumed psychiatric nursing knowledge" (Horsfall, 1997, p.58). Focus on DSM IV (American Psychological Association, 2000) diagnosis and pharmaceutical treatment

has led to "the distancing of the nurse from the patient" and "discourages the acknowledgement of patient strengths" (Horsfall, 1997, p.59). In others words, when psychiatric mental health nurses narrow their focus to medication administration and observation of side effects, monitoring patients in seclusion and conducting mental status assessments, they are in fact practicing their own technologized and "utilitarian" (Horsfall, 1997, p.59) version of nursing. This version of nursing is consistent "with an epistemology that posits the dysfunctional body as the basic cause of psychiatric distress" (Horsfall, 1997, p.60). It has also been suggested that a "renaissance of interest with nursing in….biological determinism" (Barker, Reynolds & Stevenson, 1997, p.666) is "a potential threat to the traditional value base of psychiatric nursing, which has favored an interest in persons above that of patients" (Barker et al., 1997, p.666). Ross and Alvin (1995) suggested that biological psychiatry, with its emphasis on identifying the somatic determinants of mental illness in order to target treatment approaches, is a form of reductionist thinking which "projects a world view that biology is destiny" (p.8). Mohr and Mohr (2001) pointed toward how this renaissance in biological determinism in psychiatry is affecting PMH nursing:

> Although the concepts of therapeutic communication, self-esteem…. and other scientifically unsubstantiated notions have informed our practice in the past, it is clear that practice and research in psychiatric nursing requires conceptual models that go beyond…interpersonal relations. Although we do not propose doing away with the therapeutic alliance, we are saying that a narrow focus on the one to one relationship may hold us back, much as it served to hold back psychiatry in the past (p.178).

Although Mohr and Mohr hold the view that the therapeutic alliance should remain a component of practice, their endorsement is less than enthusiastic. To characterize concepts such as therapeutic communication and self-esteem as "not scientifically substantiated" suggests allegiance to a particularistic, reductionist paradigm in psychiatric mental health nursing practice. While this does not constitute evidence of psychiatric nursing's materialist medical epistemology, it is certainly congruent with such a viewpoint. In contrast, Horsfall (1997) stated, "Psychiatric nurses need to decrease distance, increase connection, and work with consumers in egalitarian ways" (p.63). In effect, Horsfall is saying that psychiatric mental health nurses need to reclaim their humanistic roots and focus more directly on relational practice that "values the patient as a person, is more empowering for both psychiatric nurses and psychiatric patients, and…decrease the focus on diagnosis" (p.64).

Despite the fact that the nurse-patient relationship or aspects of it is pre-eminent in mental health nursing literature, "its identity and practice are still somewhat undefined" (Welch, 2005, p.162). There are numerous studies which have focused on various aspects of the nurse patient relationship in mental health nursing (Altschul, 1971; Breeze & Repper, 1998; Forchuk and Reynolds, 2001; Heifner, 1993; Hummelvol & Severinsson, 2001; Martin and Street, 2003; Müller & Poggenpoel, 1996; Richmond & Roberson, 1995), but research has tended to focus on either the nurse's perspective (Martin & Street, 2003) or the perspective of persons with mental illness (Moyle, 2003, Forchuk & Reynolds, 2001); rarely have the two groups been included in the same study. Researchers have tended to center their inquiry on determining that aspect of the relationship perceived to be helpful, or therapeutic, rather than on understanding the

essence of the relationship in all of its dimensions. Researchers have attempted to measure the therapeutic relationship (McCabe & Priebe, 2004) but such measures are often more appropriate for use in psychotherapy than in PMH nursing (Welch, 2005).

Of the many conclusions drawn by researchers, one of the most important is that there is a disconnection between nurses' perceptions of the therapeutic value of the relationship and observed behaviour of these nurses (Martin & Street, 2003; Hummelvoll & Severinsson, 2001). In a qualitative descriptive study, O'Donovan (2007) identified that PMH nurses attempted to enact patient-centered care, but in the same study, PMH nurses also identified that they used coercive practices. In a survey of inpatient PMH nurses, Cleary, Walter, and Hunt (2005) identified that 35% of PMH nurses considered the reality of inpatient mental health nursing to be different from their original expectations of the work. Many participants were concerned about the "limited time that nurses have to assess and establish relationships with their patients" (Cleary et al., 2005, p.76); the authors concluded that there were "discrepancies between the ideals of mental health practice and the realities of the clinical setting" (p.76). The hypothesized gap between the notion of the ideal therapeutic relationship and actual nursing practice, particularly in acute inpatient psychiatric mental health nursing, is further evidence that the experience of relationship in that practice environment is poorly understood. When do persons with mental illness experience care, comfort, growth, and health in relationships with their nurses? When do they experience fear, isolation, and rejection?

Caring for persons with mental illness in inpatient settings. Despite the fact that most mental health care takes place in the community at large, "no community service is likely to succeed if it does not count on the provision of an effective, well-

structured and readily available acute inpatient service" (Dratcu, 2002, p.82). Approximately 5% of admissions to general hospitals relate to the presence of a mental disorder (Canadian Institute of Health Information, 1996-2002). Hospital treatment of the mentally ill has changed significantly in the past 50 years; asylums have been largely replaced by smaller acute care psychiatric units (Baker, 2000) and prolonged periods of hospitalization are no longer considered appropriate in the treatment of the vast majority of mental illnesses.

The principal function of acute inpatient programs is "the provision of a safe, structured and supportive environment where assessment and stabilization of the person with mental illness can occur" (Cleary, 2003, p.139). In these units, people are admitted for treatment of severe mental illnesses such as schizophrenia, bipolar disorder, and major depression, and "face persistent and pervasive dysfunction in self care for socialization, to neurocognition to self care" (Iyer, Rothman, Vogles, & Spaulding, 2005, p.43). Given that relatively short-term interventions form the foundation for longer-term community intervention (Dratcu, 2002), acute inpatient programs have "a daunting and complex job" (Dratcu, p.81). Patients are discharged as quickly as possible to community-based care to continue biomedical and psychosocial treatment.

All patients who are hospitalized with severe mental illness will receive nursing care, and nurses are the largest group of professionals who provide care from day to day. A psychiatric nursing paradigm that focuses on the healing value of the therapeutic nurse-patient relationship may be at odds with brain-based psychiatry. In spite of this, approaches to hospital care are "dominated by biological psychiatry" (Walton, 2000, p.86), and "there is no logical reason to prioritize communication approaches" (Walton,

2000, p.86). The nurse-patient relationship may be most valued as a vehicle for delivering biomedical treatment. For example, when a person is hospitalized with severe mental illness, pharmacotherapy is commonly the first line of treatment. It is not unusual to hear nurses and physicians say, "We are waiting for the drugs to kick in". Treatment not only includes drug therapy, it relies on drug therapy. While there is no question that pharmacotherapy is an important component of the treatment of mental illness, it assumes a very limited view of the person and the illness. Nurses who provide care according to "biomedical orthodoxy" (Barker, Reynolds & Stevenson, 1998, p.663) are actually foregoing their ability to help people with mental illness satisfy their basic human needs, which only occurs within an "engaged relationship of mutual influence" (Barker et al., 1998, p.664), concerned with "the future development of the person" (Barker et al., 1998, p.663). In the words of Barker and his colleagues (1998), "Nursing needs to acknowledge that the phenomena dealt with by nurses are human responses to various life problems. Nurses do not deal with now, and have never dealt with mental illness per se" (p.660).

The tension plays out every day in acute care psychiatric units. Nurses have a rich knowledge of one to one relationship, therapeutic communication, group therapy, milieu therapy and crisis intervention, and state that they value individualized and humanistic care; however, the psychiatric mental health nurse who understands mental illness to be wholly brain-based will emphasize interventions that are rooted in biology (Lego, 1992). A biological orientation does not dismiss any consideration of the relational, but it does not require it. If relationship is the core of nursing practice, and psychiatric mental health nursing practice is rooted in the interpersonal paradigm, then it

is critical to understand how psychiatric mental health nurses and patients create meaningful relationships while situated in a background of meaning which assumes that reductionist explanations of mental illness are the best explanations.

The concept of nurse-patient relationship is related to popular health care values such as partnership, mutuality, power-sharing, and patient autonomy (McQueen, 2004), which are challenging to express in a clinical care setting where the formal knowledge possessed by health care providers (including nurses), invests them with significant power. It has been suggested that even though nurses articulate their allegiance to the notion of patient involvement in treatment decisions, they also believe that there are circumstances in which patients' opinions can be legitimately ignored (Anthony & Crawford, 2000). One such circumstance may be the presence of mental health legislation, which often permits patients with severe mental illness to be medicated and detained against their will. In acute inpatient psychiatric settings, nurses are in relationship with patients whom they may have physically restrained or otherwise controlled. Johansson and colleagues (Johansson, Skärsäter, & Danielson, 2006) found that in a locked psychiatric unit, "for the most part, staff were in control because of their duties and legal mandate" (p.247). Barker and Barker (2005) stated that the tradition of observation "might be viewed as the metaphorical original sin of psychiatric-mental health nursing" (p.546), building on Horsfall and Cleary's (2000) view that observation reinforced a "traditional medical hierarchy of power relations" (p.1295). In reporting the findings of a qualitative descriptive inquiry to understand nursing practice in an acute psychiatric admission unit, O'Donovan (2007) stated that, "the nature of the units … prevented (nurses) from practicing in a patient-centered way" (p.547). Cleary (2003)

reported that although psychiatric mental health nurses believe that it is important to collaborate with patients, there is often no possibility of real partnership, because the stated goals of the patient and those of the clinicians may be vastly different, and "tension therefore exists between the role of therapy and the role of control" (p.144). Buchanan-Barker and Barker (2005) hold the view that it is possible for nurses to create engaged relationships by reaching out to those for whom they care and gaining "access to the person's lived experience" (p.546). Clearly, there are multiple and persistent tensions in PMH nursing, especially in the acute inpatient setting, and the presence of these tensions provides further support to the notion that the nurse patient relation in mental health is a complex one, not yet fully understood.

A Need for Further Inquiry

There are several reasons why the relationship between nurses and hospitalized patients with mental illness should be studied. Firstly, the concept of nurse patient relationship has been pre-eminent in nursing discourse for the past fifty years but the current environment in which nurses practice exerts considerable pressure to practice technologically driven interventions that directly support medical treatment rather than exploit positive, health promoting aspects of the nurse-patient relation. Nursing theory and nursing practice have struggled to yield a sufficiently rich body of knowledge about all relational aspects of practice in a rapidly changing care environment. Secondly, psychiatric mental health nurses, whose very specialty has operated within a paradigm of nurse-patient relation for at least 50 years, are struggling to see how the relational fits the biological (McCabe, 2002, p.55). Now more than ever, it can be argued, psychiatric mental health nurses need to have a clear understanding of what it means to be in

relationship with people in their care, and how relational knowledge of the patient links with other, emerging knowledge structures which form the context of psychiatric mental health nursing practice. Further, researchers have focused too strongly on only one dimension of the nurse patient relationship, that of the therapeutic relationship. Given that the nurse patient relationship is a central concept in the psychiatric mental health nursing paradigm, and that nurses working with the acutely mentally ill experience challenges, it is critical that the essence of relationship be explored and uncovered, and that the exploration be undertaken from the perspective of both the nurse and the person with mental illness.

A Phenomenological Inquiry

In order to explore and uncover the essence of nurse patient relationship in an acute inpatient psychiatry unit, I engaged in a phenomenological inquiry. Phenomenology is an appropriate form of inquiry when phenomena have remained "covered up" so that they are "visible only through a semblance", or when they have been "understood in an empty way, and loses its character" (Heidegger, 1962, p.60). The phenomenon of interest in this inquiry, nurse patient relationship, has frequently been studied in ways that separate the experience from the person and which focus on selected aspects only; I suggest that the nurse patient relationship is understood as Heidegger would say, "in an empty way" (p.60). In this inquiry, it is important to recognize that the experience of relationship was not studied so that its instrumental purposes could be defined, or its inherent value as a caring action could be asserted. I studied the nurse patient relationship as an experience to be amplified or knowledge to be uncovered, and

the significance of the experience, and thus the knowledge, was revealed to me as I engaged with nurses and persons with mental illness.

In this inquiry, I sought to uncover answers to these two principle questions:

- What are the relational experiences of hospitalized persons with severe mental illness with their nurses in acute inpatient settings?
- What are the relational experiences of nurses with hospitalized persons with severe mental illness in acute inpatient psychiatric settings?

These questions can be framed in other ways:

- What does it mean to be a hospitalized person with severe mental illness in relationship with a nurse?
- What does it mean to be a nurse in relationship with a hospitalized person with severe mental illness?
- What are the relational practices experienced by patients in acute inpatient psychiatric units and their nurses?
- What relational experiences are of concern to the nurse and the hospitalized person with severe mental illness?
- What aspects of these relationships are strongly valued or not strongly valued by the persons involved?

As patients and nurses shared their experiences with me, the phenomenon of nurse-patient relationship showed itself in participants' actions and stories. My experiences in this inquiry created an interpretive process that yielded a rich understanding of a remarkable way of being for patients and nurses on an acute inpatient psychiatric unit: being in relationship.

CHAPTER TWO

Literature Review

In order to illustrate the philosophical and theoretical context of this inquiry, I will first describe the philosophical framework that informed this work. After discussing the philosophical framework, I will shift focus and review literature related to the discipline and practice of psychiatric-mental health nursing, with particular emphasis on the evolution of acute inpatient psychiatric treatment and the treatment milieu, inpatient psychiatric-mental health nursing and the nurse-patient relationship in the inpatient setting.

Philosophical Framework

The framework of this inquiry is interpretive phenomenology. In this section, I will describe the key elements of hermeneutic phenomenology. In addition, I will outline selected and related works on relational ethics. In order to provide a meaningful backdrop for this discussion, I will first highlight selected aspects of the philosophy of Descartes.

The Cartesian view of the world. The central tenet of Cartesian philosophy is that the ego is divorced from the physical world. The self is disengaged, experiencing the world through sense organs, and through which representations of the world are lodged in the mind. The Cartesian self holds private, personal meanings, which are not a perfect representation of the external world; in order to know what is real, one must have a correct representation of the external world. Further, in order to see the distinction between the soul and the material world, it is necessary to "disengage ourselves from our usually embodied perspective…objectify the world (Taylor, 1989, p. 145)". In this view

of the world, it is not possible for those in the external world to access the personal meaning of the other, as only the behaviour of the object is accessible. The personal, private knowledge of the self does not define what is true; the procedure by which truth is determined defines what that truth is.

Hermeneutic phenomenology. Phenomenology, as developed by Edmund Husserl, is the "culmination of the Cartesian tradition", stated Koch (1995, p. 828). According to Husserl, "pure phenomenology analyzes and describes in their essential generality…the experience of presentation, judgment and knowledge" (Husserl, 1970, p.249). Husserl suggested that phenomenology describes sources from which specific ideas flow, so that the basic concepts can be understood clearly. Husserl emphasized the analysis of meanings, which come from *the things themselves* and not "remote intuitions". Husserl's perspective was that phenomenological analysis is descriptive and inexorably linked with epistemology. According to Koch (1995), Husserl's phenomenology highlighted three major ideas: essences, intentionality, and bracketing. Husserl hoped to "come face to face with the ultimate structures of consciousness" (Koch, 1995, p. 828); the concept of *essences* derived from this line of thinking. Husserl attempted to establish specific essential meanings of concepts by establishing clear boundaries, in a distinctly Aristotelian manner. *Intentionality* refers to the idea that the mind is directed toward objects and that an action must have a "single objective correlate" (Husserl, 1970, p. 579). Husserl wanted to find the meaning of structures and concepts of consciousness that are constructed by our actions (Moran & Mooney, 2002). In this respect, Husserlian phenomenology is consistent with the notion of Cartesian mind-body split. The concept of *bracketing* emerged from the notion that "an

epistemological investigation that can seriously claim to be scientific must, it has often been emphasized, satisfy the principle of freedom from supposition" (Husserl, 1970, p.264). Husserl stated that in order to do this, it is necessary to identify and abandon all preconceived notions, in order to disconnect from them. The process of bracketing was considered a crucial aspect of phenomenology as a research methodology, in order to "defend the validity or objectivity of interpretation against the self-interest of the researcher" (Koch, 1995, p.829).

The phenomenology of Heidegger, a student of Husserl, was a response to Husserl's neo-Cartesianism and its focus on epistemology (Leonard, 1989). Heidegger (1962) defined a phenomenon as "that which shows itself in itself" (p.50), and phenomenology as "our way of access to what is to be the theme of ontology" (p.60). In other words, a science of phenomena means that every aspect of a phenomenon must be shown and demonstrated. Phenomenon may be hidden, undiscovered, or "veiled in their indigenous character", visible "only through a semblance" (Heidegger, 1962, p.60). Hidden phenomena are sometimes bound together in a nexus of experience, leaving open the possibility of staying hidden. In this way, hidden phenomena may be deceptive or misleading, or merely understood in a superficial way.

Heidegger's phenomenology marked a move from epistemology to ontology—"the science of the Being of entities" (1962, p.62). Heidegger used the term *Dasein* to indicate the being who exists in the world, is concerned with its existence in the environment and "the situated meaning of the human in the world" (Annells, 1996, p. 707). Mackey (2005) commented on Heideggerian phenomenology, stating, "Human beings exist in the framework of an encompassing world" (p.181). According to

Heidegger (1962), "the Being of Dasein lies existentially in understanding" (1962, p.116) and "understanding always presses forward to possibilities" (1962, p. 117); the self is limited by being situated in a world that allows possibilities for what the self can become and with which the self is inextricably linked. Interpretive phenomenology allows for the development of understanding by revealing an account of Dasein revealing essential structures of *Being-in-the-world*.

Heidegger's view of intentionality was slightly different than that of Husserl. Heidegger (1985) emphasized that there is a difference between being aware of a structure and "understanding inherent sense and implications" (1985, p.28). Intentionality is a metaphysical process—it "comes out of itself toward something physical" (1985, p.28). Perception is "intrinsically intentional, regardless of whether the perceived is in reality on hand or not" (1985, p.31). Even if a person is perceiving something not "real", it is "directing itself toward" something (1985, p.31). Both of these propositions are incommensurate with Cartesianism.

Two of Heidegger's important ideas were "historicality of understanding and the hermeneutic circle" (Koch, 1995, p. 830). Key elements of both these ideas are the notions of background, pre-understanding and *co-constitution* (Koch, 1995). Background understanding is the understanding given from culture and birth, those cultural practices that exist in the world before we understand the world; it determines what the person experiences as real. Unlike Husserl, Heidegger's position was that it is impossible to make all background meanings and practices completely explicit, thus, the notion of bracketing does not exist in Heideggerian phenomenology. Co-constitution refers to the unity of the person and the world, with no division between the two. Personal existence

in the pre-understood, co-constituted world is expressed through culture, history, and social contexts (Koch, 1995). The term *hermeneutic circle*, first coined by Shleiermacher (Ormiston & Schrift, 1990), refers in its most basic sense to the back and forth movement between partial understanding and understanding of the whole. Dreyfus (1991) stated that Heidegger's circle is more complex than Schleiermacher's; a simple explanation of the hermeneutic circle does not differentiate hermeneutic disciplines, which study humans situated in the world, from natural science disciplines, which study humans as if they were separate from the world. Dreyfus (1991) suggested, "We must show that studying human beings as self-interpreting beings requires interpretation within the full hermeneutic circle of shared significance" (p.203). The hermeneutic circle is a circle of shared meaning, not a circle of theoretical projection.

Gadamer, who was influenced by Heidegger, emphasized the importance of "language as the fundamental mode of operation of being in the world (Leonard, 1996, p.707)." Thus understanding experience through text is a fundamental activity of hermeneutics. An important Gadamerian idea is the expansion of the notion of a *fusion of horizons*. The horizon is the wide field of vision of the interpreter who is seeking to understand; the fusion of horizons is a merging of the historical field of vision with the present field of vision. According to Gadamer (1975), "every finite present has its limitations…the standpoint that limits the possibility of vision" (p.269). The essential part of the concept of situation is the concept of horizon, or "everything that can be seen from that particular vantage point" (Gadamer, 1975, p.269). Further, "the working out of the hermeneutical situation means the achievement of the right horizon of enquiry for the questions evoked by the encounter…" (Gadamer, 1975, p.269). Gadamer added to the

idea of the hermeneutic circle, as "anticipatory movement of fore-understanding…the circle of whole and part is not dissolved in perfect understanding, but, on the contrary, most fully realized"; the circle of understanding possesses a "fore-conception of completeness" (p.298). Gadamer assumed that the meaning of the text is complete until it is unintelligible, and because the goal is to understand the text and the story, the reader moves back and forth from part to whole, until the text is intelligible. In Gadamer's words, "it is the anticipation of completion that guides all our understanding", which "is always specific in content," and "cannot be detached from the understanding of the textual content" (p. 261).

Interpretation in human sciences. Taylor (1985) maintained that interpretation is a necessary element of the human sciences, because it is "an ontological issue which has been argued in epistemological terms" (1985, p.17). Taylor suggested that rationalism, "where no higher grade of certainty is conceivable," and empiricism, "in which knowledge is reconstructed so that there is no need to appeal to judgment" (p.18), created the understanding that all components of knowledge are brute data, subject to verification and "beyond the challenge of a rival interpretation" (p.19).

The problem for the human sciences, said Taylor (1985), is that "man is a self-interpreting animal….there is no such thing as the structure of meanings, independently of his interpretation of them" (p.26). What is the meaning of meaning? Taylor stated that meaning is "for a subject," "of something," and "only in relation to other things" (p.21). Events do not exist in isolation, unrelated to each other. If human behaviour comes out of "a background of desire, feeling, emotion, then we are looking at a reality which must be characterized in terms of understanding" (Taylor, 1985, p.24), not a reality

comprised of a collection of brute data whose meaning cannot be disputed, and where intersubjective meanings do not exist.

Taylor's perspectives were not unopposed. Geertz (1994) accused Taylor of polemicizing against natural science in order to allow for the possibility of hermeneutic approaches to explanation. Taylor looked to create "an uncrossable gulf" (Geertz, 1994, p.83) between the human and natural sciences, and Geertz (1994) attacked Taylor's perspective that natural sciences have evolved directly from Enlightenment ideology. Rorty (1994) asserted that there is a difference between naturalism and reductionism, the latter being the real enemy of the human sciences. On the other hand, Benner (1994) praised Taylor for "articulating the good embedded in practices and broad institutional and cultural frameworks of self-understanding" (p.138). Benner reflected on the value of Taylor's work in the phenomenology of nursing, stating, "His view of practices as socially embedded and dialogical allows the observer-participant to uncover the notions of the good inherent in the skills of involvement, responsibility, and skills of preserving the world and personhood of extremely ill persons" (p.154).

Relationship as moral practice. In order to accept and amplify the concept of relational ethics, it is necessary to have a certain understanding of the self in the world and in relation. I return to the work of Taylor (1989) who referred to certain "inescapable frameworks" (p.3) through which we experience the world. One particular framework of interest here is the notion of moral intuition, which is broader than our typical ideas of what is moral, such as respect, dignity, and justice. While respect for the life and well-being of others reflects moral concern, Taylor held that our basic reaction of the moral does not seem to be created by our culture and upbringing. Rather, moral reaction is "an

assent to the given ontology of the human" (Taylor, 1989, p.5); that is, moral reactions are "implicit acknowledgements of some independent property". Further, it is the articulation of what matters to us, what commands our respect, what is worth doing, which helps the orient the self in moral space (Taylor, 1989, p.28). In other words, individual identity orients us, gives us a frame of meaning: "the horizons within which we live our lives and which make sense of them have to include these strong qualitative discriminants….Living with these strongly qualified horizons is constitutive of human agency" (Taylor, 1989, p.27). Further, Taylor stated, "human agency must exist in a space of questions about strongly valued goods" (1989, p.31). It has been said that the moral horizon reflects the direction toward which nurses navigate in relationship with patients; in reporting on a naturalistic inquiry on nurses' ethical decision-making, Rodney and colleagues (2002) stated that this direction "emerged as a context of treatment and care" (p.81). Therefore to understand relational space, it is necessary to understand the self as a human agent and to understand those "defining orientations", uncovered in the "narratives of human life" (Taylor, 1989, p.34), which encircle the self's belief that a particular action is to be taken.

It is useful to take note of James' (1994) view of Taylor's position. James (1994) challenged Taylor's view of human agency. James criticized Taylor's anti-Cartesian stance, stating that he dismissed "the complexities surrounding Descartes' conception of moral value" (1994, p.18). Taylor, stated James (1994) understood Descartes to say that "nothing in the external, natural world has any moral meaning" and that moral value "resides specifically in our capacity to subject our passion to the dictates of reason by the use of will…to be virtuous is to be rational" (James, 1994, p.10). James stated that

Descartes does not equate the procedure of reasoning with rationality, as rationality is closely intertwined with the substantive notion of a "non-deceiving God…who is the source of certainty" (1994, p.11). James (1994) also stated that Taylor has misread Descartes as rigidly dichotomizing the internal and external world. James (1994) held that Descartes' "clear and distinct ideas" are not so easily dichotomized. Descartes said that the will does not work alone, said James (1994); it depends on certain understandings of the world, which transcend the boundary between inner and outer existence.

Notwithstanding James' (1994) criticism, by linking human agency with moral intuition, Taylor (1989) has provided an anchor for moral values and commitment. As a moral agent, a person is connected to moral sources that frame "what is good, worthwhile, or admirable, or of value" (Taylor, 1989, p.27). I now explore the notion of "what is good" in the relational practices of nurses.

The nurse-patient relationship as a moral practice. It is difficult to articulate that which constitutes being "good in nursing" (Benner, 2005, p.152). Benner (2005) linked the nurse's moral agency to the larger community of practice, stating that "as this particular relationship is lodged in a social tradition of schooling, science and education, those engaging in practice can recognize strong instances of excellent or poor practice" (p.153). Van der Zalm and Bergum (2000) stated that ethical knowledge is "discovered in relationship" (p.215); similarly, Peter and Liaschenko (2004) stated that the "central moral understandings of nurses are grounded in the nurse-patient relationship" (p.219). Rodney et al. (2002) suggested that working with patients in relationship is a moral practice, and values and beliefs about the nurse-patient relationship shape nurses' moral agency. Bergum (2004) stated that relational space is "the space where nurses and

patients make connection" (p.486), and that it is the "location of enacting morality" (p.487). According to Bergum, that relational space is intersubjective, interconnected, and moral. In order for nurses to understand what is right, they cannot rely on knowing ethical principles; they must understand themselves and those with who they are interconnected.

Bergum (2004) identified four themes for relational ethics in nursing: environment, embodiment, mutual respect, and engagement. The first theme, environment, is the place where "the action we take affects the whole system" (p.489). The second theme is embodiment; the body and the mind are integrated and inseparable. The ethical imperative is that nurses are committed to "who the patient is, and not just how she" is existing (Bergum, 2004, p.494). Bergum's third theme is mutual respect. Respect is "interactive and reciprocal" (2004, p.495). Mutual respect, said Bergum, is "expressed in a space or moment that gives equal attention to needs, wishes, expertise or experience of both parties" (2002, p.10). The last of Bergum's themes is engagement. This theme requires people to move toward each other to seek understanding; if this does not occur, then "lack of engagement is an ethical concern" (Bergum, 2004, p.495).

Although Bergum's (2004) work suggests that nurses must "attend to the quality of relationships in all nursing practices" and "consider ethics in every situation" (p.487), PMH nurses and their patients have found it particularly challenging to enact engagement. The essential nature of the nurse-patient relationship in PMH nursing is asymmetrical (Hem & Heggen, 2004). Power vested in professional PMH nurses as they engage in observation, assessment, containment and medical treatment coordination (Bowers, 2005; Fourie, McDonald, Connor & Bartlett, 2005) contributes to this

asymmetry. Relational asymmetry is particularly notable when PMH nurses work with involuntarily hospitalized patients, and act as "agents of social control" (Biering, 2002, p.70). The trend toward medicalization of human behaviour is another potent source of power imbalance between PMH nurses and their patients as it removes autonomy from those people classified as mentally ill (Biering, 2002). In these situations, PMH nurses struggle with moral questions about the nature of their therapeutic role (Biering, 2002). Additionally, PMH nurses are constantly vigilant about their own safety and that of their patients; the power vested in nurses to maintain a secure environment creates relational distance (Addis & Gamble, 2004, p.457). Austin, Bergum, and Nuttgens (2004) suggested that in PMH nursing, ethical behavior relies on "genuine connection" that allows vulnerabilities to be disclosed (p. 69). The problem for PMH nurses is that they are expected to adhere to established clinical procedures and routines, making such connections with patients difficult to enact and ethical demands difficult to perceive (Austin, Bergum,

& Nuttgens, 2004).

Cameron (2004) provided a complementary perspective on relational ethics. She described how a nurse's introductory "how are you? (p.53)" is in itself an ethical moment, stating that universal principles of bioethics are inadequate to fully describe that moment. In fact, Schultz and Carnevale (1995) criticized mainstream bioethics as being "overly rationalistic" (Schultz & Carnevale, 1996, p.192); the authors noted that the importance of relational knowledge in ethical clinical decision-making was not fully realized. Cameron's work is supported by Hess's (2003) view that in the nurse-patient relationship both nurse and patient enact a relational way of being, and "ethics and

morality are a creation of the persons in their relationship" (Hess, 2003, p.140). Cameron (2004) stated that "all encompassing principles fall away at the time of meeting another; they are too general to address the personal claim of the other that the 'how are you?' evokes" (p.54). Cameron suggested that a "more situated understanding is required" (p.54). Further, Cameron stated that the next step is not always clear; the next moment in relation is not necessarily governed by convention. According to Cameron, the 'how are you?' opens up "possibilities of engagement and in turn opens up a space for being" (p.60); as we engage with new people, "we are immediately accessing the person's living I" (p.61).

Radden (2002) suggested that the relationship between a psychiatrist and psychiatric patient holds major significance for a person's long term "dispositions, capabilities and social and relational attributes" (p. 54) and poses unique ethical challenges. While Radden's notion of "unique ethics for psychiatry" (Crowden, 2002, p.143) has been criticized, Roberts (2004) espoused a view similar to that of Radden; Roberts stated that PMH nurses enact "unique and appropriate" (p.585) ethical care through engaged involvement with patients. Engaged involvement, characterized by understanding and willingness to respond to the patient's experience, is achieved through an "intertwining of reason and emotion", stated Roberts (2004, p.585). Hess (2003) stated that engagement is "more than moral epistemology, it is ontology" (p.146), and as such focuses attention on the meaning of life for the person inhabiting the world of illness. This idea expands the discussion beyond PMH nursing and leads directly to the work of Schultz and Carnevale (1996), who discussed "engaged caregiving" (p. 193) and its associated medical responsibility, termed *clinical phronesis,* or "practical health care wisdom" (p.193). The concept of clinical phronesis illuminates creative rationality,

through which a clinician is open to understanding "common meanings of illness which often have relevance to therapeutic choice" (Schultz & Carnevale, 1996, p.194). Svenaeus (2003) traced the concept of phronesis in phenomenology and outlined how phronesis is "a key concept for medical ethics" (p.422). If clinical phronesis is an important idea in medical ethics, then it is an important idea in the practice of PMH nursing, regardless of the merit of Radden's claims for a unique ethics for psychiatry. The PMH nurse is called to enact a moral presence with patients experiencing mental illness. Svanaeus' discussion concluded with the suggestion that "the most important thing…is to be open to the horizon of the patient" (2003, p.426); a selection of nurse theorists, nurse philosophers and nurse clinicians hold this view as well.

Summary. The philosophical framework of this inquiry is the hermeneutic phenomenology of Heidegger, as adapted by Benner and Taylor. The self as a human agent is understood not as an isolated being, capable of dissociating itself from the world and objectifying its own existence, but as a self-interpreting being, capable of uncovering meaning in experience. In nursing inquiry, this worldview illuminates the horizons of human understanding that are centered in experiences related to health and illness and makes possible the uncovering of that which matters to nurses and patients. In this particular inquiry, relational experiences of nurses and patients are explored to understand the "strongly valued goods" (Taylor, 1989, p.31) that illuminate the ontology of relationship. Further, the notion of the good in the nurse-patient relationship in PMH can be linked to understanding the moral horizon of the nurse and the potential for engaged knowing.

These ideas are embedded in a phenomenological view of the world; knowledge of relationship lies not in Cartesian reason, but in phenomenological understanding.

Psychiatric-Mental Health (PMH) Nursing

In this section, I will review nursing literature that formed the scientific foundation for this inquiry, describing key findings that relate to relational practice in PMH nursing. I will outline the evolution of the discipline of PMH nursing and the tensions that have come to exist as nurses struggle to practice relationally in a highly medicalized inpatient treatment environment. I will review literature relating to PMH nursing in an acute inpatient psychiatric setting, and describe important contributions to knowledge of the nurse-patient relationship in PMH nursing.

An evolving discipline. The Canadian Federation of Mental Health Nurses (CFMHN) (2006) described PMH nursing as "a specialized area of nursing practice, education and research" (p.9). The modern specialty of PMH nursing can trace its roots to the opening of the first nursing school for mental nursing in Massachusetts, USA in 1882 (Silverstein, 2006). The curriculum included "observation of mental symptoms" and caring for those with physical illness (Silverstein, 2006, p.35). Personal characteristics such as "sympathy, intelligence and trustworthiness", and "knowing how to calm nerves…using empathy and tact" (Church, 1982) were considered to be essential in this kind of nursing.

PMH nursing came into its own in the second half of the twentieth century, in large part due to the development of frameworks by leaders such as Hildegard Peplau and Suzanne Lego (McCabe, 2002). These nurses emphasized the concept of nurse-patient relationship as a foundation of PMH nursing. The therapeutic nurse-patient relationship

consists of those practices that take place in the context of a nurse and patient engaged with each other, working collaboratively to foster the health goals of the patient. One of the major assumptions of Peplau's framework was that "nursing is a significant, therapeutic, interpersonal process…an educative instrument, a maturing force" (Peplau, 1952, p.16). Peplau and Lego, each of whom based much of their work on psychodynamic theory, "inculcated the nurse-patient relationship as the central paradigm for nursing in ways that still reverberate today" (McCabe, 2002, p. 51). According to the CFMHN (2006), PMH nurses "promote mental health and the prevention or diminution of mental disorder" (p.9); the "therapeutic relationship is the foundation" of PMH practice (p.10).

The post-World War II advent of a relational focus in psychiatric mental health nursing came at the apex of the development of psychodynamic psychiatry. The biological underpinnings of "madness" had been studied in the late 19th and early 20th centuries (the concept of madness was commonly used to describe the behaviours of people with what we now know to be psychosis), but a focus on the treating the mind and a focus on treating the brain were generally viewed as competing ideas (Slavney & McHugh, 1987). By the 1950's, most of the influential psychiatrists were psychoanalysts (Slavney & McHugh, 1987). The prevailing view was that people with mental illness suffered from disorders of the mind that were amenable to psychotherapy, and that somatic therapies such as medication played only a marginal role. Ironically, many health professionals, including nurses, believed that psychiatric nurses should not engage in psychotherapy or counseling (Silverstein, 2006).

At the time of publication of Peplau's seminal work, *Interpersonal Relations in Nursing* in 1952, psychodynamic psychiatry was faced with many challenges. The psychotherapeutic tradition as practiced by psychiatrists was not effective in addressing the needs of the severely mentally ill, most of whom were housed in large asylums, and new and effective medications for the treatment of mental illness were being discovered (Kirk & Kutchins, 1992). The view of a disordered mind amenable to psychotherapeutic treatment was replaced with the view of a disordered mind arising "from a damaged or diseased body" (Horsfall, 1997, p.4) amenable to biological treatment. The increasing effectiveness of biological treatment helped shift the focus of mental health care from large institutions; in Canada, there was "a significant decrease in the number of patients cared for in the provincial hospitals" (CFMHN, 2006, p.18). According to the CFMHN (2006), "throughout the postwar years and transition to community care, psychiatric mental health nursing remained central to the care of the person with mental illness" (p.18).

By the end of the 20th century, the transformation from psychodynamic psychiatry to diagnostic and biological psychiatry was almost complete, and this had a major effect on the discipline of PMH nursing. After decades of practicing within a framework of mind dysfunction and psychodynamic theory, the "materialist medical epistemology" of biological psychiatry was "absorbed uncritically and became assumed psychiatric nursing knowledge" (Horsfall, 1997, p.58). In these early years of the 21st century, the concept of nurse-patient relationship is still present in PMH nursing discourse, but since the emergence of a new understanding of brain biology, the focus of treatment of people with severe mental illness has shifted away from relational interventions toward biological

therapies. It has been suggested, "In the last two decades, nursing has paid little attention to the rich knowledge of psychodynamic theory" (Gallop & O'Brien, 2003, p.213). Today, patients are in care for brief, limited periods of time and are view as suffering from disorders that are biological and genetic in origin. Opportunities for long-term nurse-patient relationships in inpatient hospitalization are rare. The nursing paradigm, which focuses on psychodynamic, developmental and cognitive theory, the therapeutic use of self, and the healing value of the therapeutic nurse-patient relationship, seems at odds with brain-based psychiatry (McCabe, 2002).

Howell and Norman (2000) suggested that there is an ongoing debate in PMH nursing and linked each of the divergent views with a label: mental health nursing versus psychiatric nursing. McCabe (2002) stated that the discipline of PMH nursing utilizes two distinct forms of knowledge. The first form is "rooted in psychological, developmental theory, is humanistically oriented, and infuses our profession with the one-to-one nurse patient relationship as our core human identity and function"; it "resonates within almost all psychiatric nurses" (McCabe, 2002, p.53). PMH nurses "draw extensively on psychological theory and interventions, but the relationship between mental health nursing and psychology has not been unraveled" (MacNeela, Scott, Tracey, & Hyde, 2007, p.501). It has been suggested that psychological knowledge fits within the holistic values of PMH nursing and gives nurses a language for understanding clinical work, but it has also been suggested that psychology knowledge may disempower nurses by separating them from nursing discourse and their experiential knowledge of the patient (MacNeela et al., 2007). The use of formal psychological knowledge in PMH nursing may make nursing "a tool of psychiatric medicine"; on the

other hand, if PMH nurses can make psychological knowledge meaningful in the nursing situation, the discipline of PMH nursing may be strengthened (MacNeela, et al., 2007, p. 502).

The second form of knowledge is the body of neurobiological knowledge which "sits so precariously in our paradigm", and "infuses our profession with a brain-based, scientific, empirical, non-personal perspective of mental illness" (McCabe, 2002, p.54). Horsfall (1997) suggested:

> Materialist psychiatric epistemology has profound consequences for psychiatric serve users and nurses, beyond that of diagnosis and treatment by medication. A focus on the physical indicates a narrow view of patients and of oneself as a person and as a nurse. The medical model seriously limits the patient's sense of competence, control, and responsibility. It also excludes or displaces the centrality of the nurse's interpersonal skills in supporting and improving patient resourcefulness and well-being (p. 58).

McCabe (2002) suggested that PMH nurses are "struggling to see how the relational fits the biological", as "the connection between social-psychological and neurobiological foundations of mental health nursing" (p.55) remains unclear. Horsfall (1997) posed the question "What is a nurse to do if mental illness is caused by neurotransmitter excess or depletion and the medication is meant to rectify the uptake at the neurotransmitter site?" (p. 4). Horsfall suggested that nurses have tended to adopt "utilitarian approaches to patients for the purposes of treatments such medication administration, assistance with electroconvulsive therapy, observation for medication side effects, and checking on physically confined (secluded) patients" (p.5), but Horsfall also stated that "the

therapeutic use of self is inconsistent with an epistemology that posits the dysfunctional body as the basic cause of psychiatric distress" (p. 6). There is no doubt that psychiatric mental health nurses are caught in a paradigmatic struggle.

Barker and colleagues (1997) expressed concerned about this struggle, asserting, "Nursing's task is and always has been to help people deal with the human problems they experience" (p. 660). Barker went on to say that "being-with and caring with people-in-care is the process which distinguishes nurses from all other health and social care disciplines, and needs to be recognized also as the process that underpins all psychiatric nursing" (1997, p. 661). He questioned the apparent "re-focusing" of nursing practice to a position that acknowledges some value of relationship, but "appears to promote a form of biological determinism " (1997, p. 661). He proposed a modern paradigm of psychiatric nursing practice, which should be explored through a process of empirical inquiry. The main components of this paradigm are:

- Psychiatric nursing is an interactive, developmental human activity more concerned with the future development of the person than with the origins or causes of their present distress;
- Psychiatric nursing involves the provision of the necessary conditions under which people may access and view experiences (of mental distress) the nurse and the person-in-care are engaged in a relationship based on mutual influence…nursing involves caring with rather than caring for people, irrespective of the context of care the practice of psychiatric nursing is located uniquely within the context of everyday life;

- Psychiatric nursing practice is focused on helping people address their human responses to psychiatric disorder, rather than the disorders themselves (p.664).

It would seem that the two competing paradigms are incommensurate. The notion that psychological distress originates in neurobiology cannot yet be reconciled with the notion that psychological distress is processed by neurobiology (Barker et al., 1997). At the same time, it is clear that human experiences of mental health and mental illness are highly integrated and very complex, although some have held that as yet "there is no conceptual way to…bridge concepts of mind and concepts of biology" (Mohr& Mohr, 2001, p.171). McCabe (2002) suggested that it is not appropriate for the relational "heart and soul" of our tradition (p.56) to be tossed aside in favour of neurobiological knowledge as it is "squeezed into our current paradigmatic educational and clinical practices" (p.56), but she appeared to attempt to bridge reductionism and holism when she stated that a new paradigm of PMH nursing would recognize that "mental health is lived contextually, manifested in a complex array of behaviours" (p.58). When McCabe (2002) stated that behaviour change is the "core" of PMH practice, it appears that she was attempting to fuse a reductionist notion of behaviour change with "contextually situated process and notion" of relational nursing practice (p.58). Researchers reported that PMH nurses used assimilated psychological knowledge, which has been criticized for it reductionist worldview, when they described their work; at the same time, PMH nurses were hesitant to formalize their psychological practices (MacNeela, Scott, Tracey & Hyde, 2007). Researchers suggested that PMH nurses move back and forth between two cultures, and that PMH nursing is a "bicultural" enterprise (Powers, 2002, p.959). The

work of McCabe (2002), Powers (2002) and others (MacNeela et al., 2007) further illuminates paradigmatic struggles in PMH nursing about which Barker and colleagues (1997) expressed so much concern.

The milieu in psychiatric inpatient units. It has been suggested, "Over the last few decades, acute inpatient psychiatry has rather lost its way" (Bowers, 2005, p. 231). Even with a shifting emphasis from hospital to community treatment, inpatient units are still a necessary component of treatment, and "inpatient units have been left to drift with little research, little investment of clinical expertise, discussion and development, and no statement of their positive purpose and benefit" (Bowers, 2005, p. 232).

The policies and practices of the treatment program, the health status and functioning of the patient and the social climate of the unit interact to create ward atmosphere (Moos, 1996). Patient and staff interactions are key elements of the milieu, and "nurses bear primary responsibility for the effectiveness of the therapeutic milieu" (Emrich, 1989, p. 29). That being said, the role of the acute inpatient unit has changed dramatically, and the milieu is no longer expected by some to play a critical role in inpatient treatment. The focus of research has shifted to understanding milieu in long-term treatment, rehabilitation settings, and group homes (Middelboe, Schødt, Byrsting, & Gjerris, 2001). Emphasis is also now being placed on studying factors that influence the effectiveness of community-based programs, and developing and testing new models of care, such as assertive community treatment and case management (Bowers, 2005). Further, research on the inpatient milieu has historically focused on structural aspects of programming rather than relational aspects; "reference to the interactional dimension of

milieu, and the nurse's role in shaping it, has not had much attention in nursing literature" (Emrich, 1989, p.26).

The relationship between characteristics of ward atmosphere and patient outcomes is a complex one. Ellsworth (1983) stated that programs where clinicians are accessible and involved with patients are effective in promoting post-treatment psychological adjustment and role functioning. Moos (1996) stated, "Programs which emphasize personal growth dimensions, especially self-direction and skills development, tend to mitigate patients' symptoms and to enhance psychosocial functioning, self-care, and community living skills" (p.51). In their study of patients perspective of the milieu of an acute inpatient units, Middelboe and colleagues concluded that both "supportive and structural factors" are important in treatment of people with acute psychosis (Middelboe, Schødt, Byrsting, & Gjerris, 2001, p. 218).

In a study of ward atmosphere, patients perceived staff as being more controlling than clinicians perceive themselves (Main, McBride, & Austin, 1991). Patients have also reported that they experience "institutional psychiatry "as "totalitarian" and "threatening" (Lilja & Hellzén, 2008, p.284). After an intensive review of nursing and psychology literature about psychiatric ward rules, a component of unit milieu, over the past forty years, Alexander and Bowers (2004) concluded that the increased emphasis on acuity in acute inpatient units, and that a lack of emphasis on the milieu may contribute to an increasing rigid and oppressive environment on these units. These authors suggested that it is not clear whether a high degree of structure reduces the potential for inpatient aggression or contributes to it: study results were divided. In a phenomenological study about how nurses and patients experience the acute care psychiatric environment,

researchers reported “a disturbing picture of everyday existence in a prison-like inpatient psychiatric unit” where patients “long for freedom” (Shattell, Andes, & Thomas, 2008, p. 247).

Nurses are institutional culture-carriers. A number of researchers identified that nurses are extremely influential in milieu related activities, such as ensuring a secure environment (Beech & Norman, 1995; Fourie, McDonald, Connor & Bartlett, 2005), creation of a “homely atmosphere” (Beech & Norman, 1995, p.121), nature and quality of information transfer to patients (Alexander, 2006; Kuosmanen, Hätonen, Jyrkinen, Katajisto, &Välmäki, 2006), application of ward rules (Alexander, 2006), maintaining surveillance (Alexander, 2006) and professional communication about patient behavior and feelings (Alexander, Skorpen, Anderssen, Øye, & Bjellan, 2009; Fourie et al., 2005). Nurses have been found to play a key role in developing and maintaining a therapeutic environment in the psychiatric inpatient unit (Main, McBride, & Austin, 1991).

PMH nursing practice and the inpatient psychiatric unit. If inpatient psychiatry has lost its way, then inpatient psychiatric-mental health nurses may have lost their way as well. Cleary (2003) stated, “rapid pace of change in service delivery has had a profound effect on mental health nurses working in acute inpatient mental health facilities” (p.214). Acute inpatient mental health settings are those care delivery environments where patients with severe mental illness are admitted for treatment of symptoms which seriously impair their ability to cope with acute symptoms of mental illness, activities of daily living, and achievement of life goals. Patients are admitted to an acute inpatient unit for several reasons, including “dangerousness”, “assessment”, “medical treatment”, “severe mental disorder”, “self-care deficits”, “respite for carers”,

and "respite for patients" (Bowers, 2005, p.232-233). Bowers (2005) suggested that "ward-based psychiatric nursing….is a pragmatic task, based upon the management of psychologically disturbed, distressed and disordered people" (p.235), disputing the notion that the role of PMH nursing is struggling and confused. Cleary (2003) maintained that there is a serious gap between what she terms "the rhetoric of mental health nursing" (p.214) and the practices of inpatient mental health nursing.

There is no doubt that inpatient psychiatric-mental health nurses are experiencing "profound unease" (Barker & Rolfe, 2000, p.180). Ryan, Hills and Webb (2004) reported that acute inpatient psychiatric units suffer from a lack of nurses with the required expertise. High occupancy rates and high acuity has forced nurses to become "reactive to circumstance" (Higgins, Hurst & Wistow, 1999) and abandon systematic care planning, with the results that they have become less responsive to patient needs. According to Barker and Rolfe (2000), nurses are forced to "psychologically withdraw from nurse-patient relationships" (p.181). The findings of Carmack's (1997) grounded theory study led her to determine that the most effective caregivers, including nurses, learned how to balance detachment and engagement, but in part achieved this balance by limiting their involvement with patients and "letting go of the outcome" (p.141). In an ethnography of an inpatient mental health unit, Cleary (2003) identified key elements of inpatient mental health nursing culture, and came to understand that one of the most important beliefs of nurses that it is "neither feasible nor appropriate to address all consumer needs and problems during the course of a brief admission" (p.219). Cleary stated that "the major challenge for mental health nurses in acute inpatient mental health

settings is to develop care plans with consumers that prioritize problems and needs" (2003, p.219) so that realistic goals can be established.

Barker and Rolfe (2000) stated, "introducing therapeutic engagement to clinical settings across the mainstream of acute psychiatric wards brings…many challenges" (p.183). When asked to describe care situations that aroused moral distress (Austin, Bergum, & Goldberg, 2003), nurses talked about poverty of engagement with their patients and other examples of inability to practice within the kinds of relationships that they expect of themselves and that society expects of them. It is evident that there is a gap between the expectations of nurses to provide traditional kinds of programming and their ability to do so in the "crisis stabilization role" (Cleary, 2003, p.220) of an acute inpatient psychiatric unit. Hummelvoll and Severinsson (2001) called acute inpatient psychiatric nursing "a strenuous reality" (p.17), in which nurses have to "reluctantly accept therapeutic superficiality" (p.23). Nurses reported that they want to understand and care for patients as individuals with individual needs, but that they are "unable to do so because of organizational constraints" (Shattell, 2008, p.247). Patients reported that relational aspects of care are helpful (Middelboe, Schødt, Dyrsting & Gjerris, 2001) but there is also evidence that consumers feel their needs are being overlooked (Lammers & Happell, 2003).

Whether related to changes in practice culture, lack of expertise, or organizational constraints, there is evidence from the literature that PMH nurses do not always engage in positive relational practices. In a qualitative-descriptive study, O'Donovan (2007) explored nurses' perceptions of delivery of mental health services in inpatient psychiatry by exploring the use of a patient-centered care model of nursing care on two inpatient

psychiatric units. Participants identified that they used "collaborative, negotiated practices" (O'Donovan, 2007, p.545) in order to understand patient problems, but participants also described "the use of coercion, strict enforcement of rules and lack of choice offered to service users" (p.545). The author concluded, "Many aspects of care contradicted values associated with patient-centered care" (O'Donovan, 2007, p.545). Ryan and Bowers (2005) concluded that psychiatric-mental health nurses "traditionally engaged in a variety of coercive physical, verbal, and psychological strategies that enabled them to deal with the onslaught of patients' challenging behavior" (p.700). In a qualitative study of patients formerly hospitalized in an inpatient psychiatric unit, patients reported feeling "isolated and estranged", and that patients "interpreted the staff as mainly parenting them" (Lilja & Hellzén, 2008, p.283). This study echoed a much earlier study in which Emrich (1989) concluded that "nurses working in relatively fast-paced, acute care settings begin to deal with their environment, including patients, in what they perceive as the most efficient manner" (p.28). Emrich posited, "The parental communication style used so often…is a reflection of a basically paternalistic orientation nurses have adopted" (p.29). While it is not appropriate to suggest that all PMH nursing practices are inherently disengaging, it is reasonable to infer from the literature that in many inpatient psychiatric settings, nurses find it difficult to understand and meet patients' needs.

PMH Nursing and nurse-patient relationships. A major challenge in sorting through the literature on nurse-patient relationship in PMH nursing is that there is a conceptual overlap between the concept of "nurse-patient relationship" and the concept of "therapeutic relationship". There is no doubt that the therapeutic relationship is a central

concern for psychiatric-mental health nurses, but "its identity, its identification, and its practice are still somewhat undefined" (Welch, 2005, p.163); further, nurse-patient relationship is rarely studied outside of its therapeutic qualities. Nurse-scholars have often studied the nurse-patient relationship and therapeutic nurse-patient relationship by seeking to understand the factors which facilitate engagement and positive relationship and which kinds of relationships promote positive patient outcomes (Howard, El-Mallakh, Rayens, & Clark, 2003; Scanlon, 2006). Most studies are framed with the assumption that nurse-patient interaction is valuable and beneficial (Gijbels, 1995; Cleary, 1999), although it has been suggested that this assumption may rest on a shaky foundation (Tyson, Lambert, & Beattie, 1995). For example, Emrich (1989) observed and analyzed interactions between patients and nurses, and concluded that "actual nursing practice in the psychiatric milieu does not regularly promote the interactional responses associated with healthy adjustment" (p.28). Hewitt & Coffey (2005) suggested, "The therapeutic relationship seems to escape succinct quantification, given that its premise is often philosophical" (p.563).

Dr. Cheryl Forchuk is a pre-eminent Canadian nurse researcher who studied the therapeutic nurse-patient relationship using Peplau's (1952) framework as the basis for her research with individuals with severe and persistent mental illness and their nurses. Forchuk (1992) used a retrospective review of records of the work of nurse-patient dyads to identify the length of time it took to move through the orientation phase of the relationship (Peplau, 1952) and attempted to identify the factors that influenced the relationship. The only factors which were found to influence the length of time in the orientation phase were the number of times the patient was hospitalized and the length of

the hospitalization, with the higher number correlating with a longer time in the orientation phase. In subsequent studies, Forchuk (1994) determined that client and nurse preconceptions influenced relationship development and that the same person could have different relationships with different people (Forchuk, 1995a). In a related study, Forchuk (1995b) found that greater frequency and contact time between nurse and patient, and the presence of a more experienced nurse positively influenced the development of the relationship. If the patient had multiple previous admissions, the progress of the relationship was negatively influenced. Forchuk et al. (1998) used interview data from nurse-patient dyads to explore movement from the orientation to the working phase of the relationship (Peplau, 1952). Clients reported that a) attitudes of the nurse greatly influenced the progress of the relationship, and b) factors such as unavailability, differing values and mutual withdrawal prevented the relationship from progressing. Nurses identified factors such as consistency, listening, positive first impression and comfort as promoting the development of the relationship, and inability to trust and unrealistic expectations of the patient as blocking the development of the therapeutic relationship (Forchuk et al., 2000).

In a study of nurse-patient interactions, rather than therapeutic relationship, Cleary and Edwards (1999) explored factors influencing nurse-patient interactions on an acute inpatient psychiatry unit by interviewing both patients and nurses. Nurses identified interaction-influencing factors as a) whether or not there was an opportunity to place patients in structured unit programs, b) individual nurse personality and personally held attitudes, c) acuity of patient illness, and d) availability of instrumental, or administrative support. Patients identified personal attributes of the nurse, perceptions of

the nurse's role, type and perceived appropriateness of clinical care, and nurse availability as factors influencing nurse-patient interactions. The authors suggested that mental health nurses could use clinical supervision to "provide nurses with an opportunity to reflect on their interactions with patients" (1999, p. 476).

Using grounded theory methodology, Dearing (2004) explored the therapeutic value of the nurse-patient relationship by studying relationship factors that influenced outpatients' compliance with treatment. Nurses used observation, assessment and learning to understand the person as key processes in developing knowledge about the patient. Dearing found that in order to know the patient, the nurse has to "spend time with the patient, give the patient an opportunity to talk, and help the person discover the meaning of his or her experiences" (p.161). Dearing suggested that the nurse-patient relationship should be a place of safety for the patient, and the relationship acted as an opportunity for the patient to engage in social interaction, which nurses used as a platform for patient teaching, stated Dearing (2004).

An early and classic qualitative study examined nurse-patient relationships in inpatient psychiatric units (Altschul, 1971). In addition to a period of participant-observation, the researcher asked patients and nurses about their relational experiences with each other and the therapeutic qualities of these experiences. While nurses were not always convinced that their relationships with patients were therapeutic in nature, patients experienced the relationships as helpful. Additionally, patients and nurses who stated that they were in a therapeutic relationship did not necessarily spend significant amounts of time together. Nurses and patients each experience unique perspectives of the nurse-relationship, and differing perceptions have been identified as a barrier to an effective

relationship (Sharma & Carson, 1996). Because of these unique perspectives, some researchers have elected to study the nurse-patient relationship from the point of view of either the person with mental illness or the nurse.

The patient experience. Several studies have focused on how people with mental illness perceive their relationship with their nurses. Patients report frustration with a friendly but impersonal interactional style, nurses' use of power and emotional distance (Müller & Puggenpoel, 1996). Participants identified the following dimensions of interaction with nurses: stereotyping, custodialism, rule enforcement, and lack of empathy and caring (Müller & Puggenpoel, 1996, p.146). In a survey of 204 hospitalized people with mental illness (Howard, Al-Mallakh, Rayens & Clark, 2003), "the presence of a trusting, reciprocal relationship between staff and respondents" (p.214) was a significant factor in consumer satisfaction. Staff availability and respondents ability to talk with staff about their problems" (Howard et al., 2003, p.214) was also linked with patient satisfaction. Conversely, patients who perceived that they had been excluded from treatment planning experienced more dissatisfaction with treatment. Likewise, in a descriptive study, patients reported that they were able to work with nurses who were available, tolerant, and respectful (Beech & Norman, 1995).

In a hermeneutic inquiry (Fredriksson & Lindstrom, 2002), researchers explored how patients with mental illness, admitted to hospital, narrated their experience of suffering with their nurses. This was relevant to understanding nurse-patient relationship in this setting in that patients revealed a "fear of being abandoned and left alone" (Fredriksson & Lindstrom, 2002, p.402), and that healing occurred with the "re-establishment of the interpersonal bridge" as the "sufferer open himself or herself for the

relations with others" (Fredriksson & Lindstrom, 2002, p.402). The authors suggested that nurses "allow time and space for the sufferer to tell his/her story" (Fredriksson & Lindstrom, 2002, p.403) and use patience and sensitivity when facilitating patients' story-telling. In in-depth interviews, patients who were receiving outpatient psychiatric care reported, "The quality of the relationship between the patient and a therapist, and being understood by the therapist, formed the most central aspect of the quality of the care" (Johansson & Eklund, 2003, p.342). Relational elements reported by those satisfied with their care included "warmth, empathy, understanding, enough time, and being provided for" (Johansson & Eklund, 2003, p.342). In the same study, patients who were receiving inpatient psychiatric care cited "the existence and quality of the helping relationship" (Johansson & Eklund, 2003, p.343) as central to their experience of good care. Patients also expressed a longing to be understood and respected as individuals with real needs and problems: "they don't see me, I think they assume a lot" (Johansson & Eklund, 2003, p.343). Significantly, some members of the inpatient group were ambivalent about their desire for a helping relationship. While these patients "expressed a longing for deeper contact", they also stated that they were unsure if they wanted a deeper relationship with staff, because staff were unable to meet patients' expectations (Johansson & Eklund, 2003, p.343). One patient stated, "What you can ask for is a kind reception, and that's what you get here" (Johansson & Eklund, 2003, p.343). Patients understood staff members' distance and lack of affirmation as a function of workplace stress, and modified their expectations and behaviour accordingly: "I think they're under stress; you have to calm down and be patient with them" (Johansson & Eklund, 2003, p.343).

In a naturalistic inquiry, Schafer and Peternelj-Taylor (2003) interviewed twelve forensic psychiatric patients. The authors stated that patients' perceptions of factors that hindered or promoted their relationships with staff depended on the consequences patients experienced. For example, a patient may have identified a large amount of contact time as a positive factor, until the patient received an unfavorable report from the staff member. Patients identified the following factors as significant to relationship development with their primary therapists: "Being there or not being there", "no voice or being heard", "feeling objectified", "receiving or not receiving feedback", direct or inauthentic approach, "clear, shared direction" and "defining roles" (Schafer & Peternelj-Taylor, 2003, p.617). Patients identified caregivers as operating from one of four different interactional styles; these categories included strict and rule-governed ("the heads"), caring and feeling ("the hearts"), both concerned and knowledgeable ("heads and hearts") and those who were only there for the paycheck ("the wallets") (Schafer & Peternelj-Taylor, 2003, p.619-620). The authors recommended that the patient perspectives are a key to helping clinicians develop an awareness of clinical practice within the context of a therapeutic relationship. In a qualitative inquiry that generated similar findings, Lilja and Hellzén (2008), sought to identify how ten former psychiatric patients experienced their hospitalizations. Former patients stated that nurses tended to interpret all of their behaviour as indicative of psychopathology or mental illness. Patients reported that they were forced to mute their identities in favour of accepting identities as persons with mental illness, leading the patient to feel rejected and lonely. Patients stated that they often "pretended to adapt, playing a role when they were around

staff." (Lilja & Hellzén, 2008, p.282). The authors concluded that patients were "forced into an environment where their individuality is lost" (Lilja & Hellzén, 2008, p.283).

The nurse's experience. Many researchers have focused solely on the perspective of nurses in therapeutic relationships. Welch (2005) interviewed nurses and asked them to describe the factors that made a difference in their therapeutic relationships with clients. The major themes that emerged were trust, power, mutuality, self-revelation, congruence and authenticity. Nurses stated that these factors enabled relationships. Welch made the point that these facilitative factors are consistent with humanistic principles and psychodynamic psychology, and concludes that the study "highlights the intensely interpersonal nature of nursing work" (p.164).

Cleary's (2003) ethnography of an inpatient psychiatric unit revealed that nurses identified "just being there", and "honesty and trust" (p.141), as important elements of their relationships with patients. Cleary concluded, "The nurse-client relationship remains foundational to nursing practice" (2003, p.143), but that it was challenging to establish partnerships in the context of power and control dynamics of the inpatient unit. The authors highlighted the conflict in values that occurs when nurses attempt to establish therapeutic partnerships with patients in an atmosphere of compulsory treatment, and must occasionally act in manner that is opposite to the patient's expressed wishes.

It is a daunting task for nurses and patients to develop therapeutic relationships in a forensic psychiatric setting: "forensic patients present with a multitude of mental health problems and their potential for violence evokes strong feelings in nurses" (Schafer & Peternelj-Taylor, 2003, p. 606). In addition, nurses in this setting exert the ultimate control over patients in that they can deny patients their freedom. Martin and Street

(2003) interviewed nurses and examined their chart entries in order to look for evidence of therapeutic relationship. These authors suggested that nurses and patients needed to participate in "significant engagement" that is "responsive to mutual long-term goals" (Martin & Street, 2003, p.9). In this setting, nurses reported that nurse-patient relationship did not often move beyond social interaction. Processes such as formal mental status assessment, documentation of offence issues, counseling, and educating, all of which required significant contact and conversation with patients, were not evident in this study. Martin and Street concluded that the "therapeutic potential of nursing was not evident in (chart) entries and nurses represented themselves as passive observers of patients" (2003, p.9). The findings of another study told a slightly different story: in a survey of nurses working in forensic care (Rask & Levander, 2001), the most common "interventions" cited by nurses were "social interaction, regular verbal interaction, and social skills training" (p.325). All of these actions required the platform of a therapeutic nurse-patient relationship. It is notable, however, that "more than one-third of the respondents stated that they never, or only sometimes, had regular verbal interaction with the patients" (Rask & Levander, 2001, p. 330). Not surprisingly, the authors suggested that there "is a need for studies on the meaning of the nurse's interpretive verbal interaction with patients, how the patients experience it, and how it affects treatment outcome" (Rask & Levander, 2003, p. 331).

Heifner (1993) used an exploratory, descriptive, qualitative design to study the psychiatric nurse's perception of positive connectedness in the nurse-patient relationship. Emergent themes included a) nurses' vulnerability as a precursor to increased sharing, honesty and risk-taking b) nurses' identification of commonalities with patients c) nurses

investing themselves and their time when patients expressed vulnerability and openness. Heifner defined positive connectedness as a "therapeutic state of interaction", which "develops progressively" (1993, p.14). In this study, the concept of positive connectedness appeared to merge with the concept of therapeutic relationship (1993, p.14).

Peplau's (1952) framework of nurse-patient relationship emphasized that the most important qualities of a therapeutic relationship are "presence, congruency, respect, self-esteem, value clarification, empathy, forgiveness, trust, empowerment, patient-centered objectives and goals, insight, openness, self-disclosure, self-exploration and unconditional positive regard" (Stockman, 2005, p.912). The relevance of the therapeutic relationship to the care of people with schizophrenia has been questioned (Hewitt & Coffey, 2005). While there is an increasing body of literature identifying the effectiveness of psychotherapeutic approaches such as cognitive- behavioural therapy (Chan & Leung, 2002) in schizophrenia, it has been commonly held that the effect of many kinds of therapies may actually be predominantly the result of non-specific therapist factors such as empathy, warmth and the quality of the helping alliance (Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000). This suggests that relational factors, not specific techniques, are worthy of investigation.

Summary. The concept of nurse-patient relationship has been prominent in nursing discourse for over fifty years. For much of that time, psychiatric nursing was the vanguard of relational practice, but in recent years, psychiatric nursing has struggled to adjust to brain-based psychiatry and its associated technological imperative. Nurse researchers have attempted to describe the elements of therapeutic relationships between

psychiatric nurses and their patients. Despite the fact it is becoming increasingly clear that the nurse-patient relationship cannot be "succinctly quantified" (Hewitt & Coffey, 2005, p.563), research still focuses on describing the behaviours of nurses and patients and the connection between these behaviors and the value, or the therapeutic outcome of the relationship, rather than the nature of the relationship itself.

CHAPTER THREE

Mode of Inquiry

The focus of this inquiry is the meaning of relationship as experienced by patients and nurses on an acute inpatient psychiatric unit. This inquiry was situated within a qualitative paradigm using interpretive phenomenology. A phenomenological inquiry seeks to understand the experience as it is lived by the person and shared with the person undertaking the inquiry. As a method of inquiry, phenomenology is a way of understanding the person's world, by understanding what matters to the person, what the person knows, and what the person seeks to know. The interpretive framework abandons a deterministic and mechanistic view of causality, instead seeking "to develop explanations and understandings that are based on concerns, commitments, practices and meanings" (Leonard, 1994, p.56). Interpretive phenomenology "considers contextually meaningful experiences", and "seeks to understand "daily living and practical concerns" (Annells, 1996, p.709). According to Leonard (1994), an interpretive account gives the researcher the opportunity to "commonalities in meaning" (p.56). Interpretive methodology approaches a human experience as an event to be explored and interpreted through the use of interviews and observations, in which "the researcher asks for meanings of a phenomenon with the purpose of understanding the human experience" (Crist & Tanner, 2003, p.202). The purpose of interpretive phenomenology is "the direct investigation and description of phenomena as experienced in life by using the practice of phenomenological reflection" (Van der Zalm & Bergum, 2000, p.212).

In this inquiry I do not hold a Cartesian view of the person, in which personal meaning is "private, idiosyncratic, and imperfect" (Benner & Wrubel, 1989, p.41), and

the self is "an uninvolved self passively contemplating the external world of things via representations that are held in the mind" (Leonard, 1994, p.44). If I had accepted this view, than an inquiry focused on the person's understanding of the world would be both unfruitful and illogical, and would be found lacking when considered in light of evaluating truth claims. Instead, I viewed the person as a being who is "constituted by our personal understanding" (Leonard, 1992, p.52). Taylor (1989) stated that individuals, by virtue of their personhood, are self-interpreting, and thus fully able to articulate aspects of their lived experience. In Taylor's words, "the horizons within which we live our lives and in which we make sense of them have to include those strong qualitative discriminants" and "living within strongly qualified environments is strongly constitutive of human agency" (p.5). Taylor was saying that individuals have a perspective, a position, an idea of what matters, and that they have language and other forms of expression in order to share those ways of being. In this inquiry, the person is anything but passive, but fully engaged in understanding the world.

Phenomenological inquiry is particularly suited to nursing research as it emphasizes "understanding people in a non-reductionist manner…on their experience within their environment, as well as the nurse-patient relationship (Van der Zam & Bergum, 2000, p.217). It is important to utilize a hermeneutic approach in this inquiry because there may be many "meanings that are not immediately understandable but require interpretive effort" (Streubert & Carpenter, 1999, p.54) in the complex and chaotic situations encountered on an acute inpatient psychiatric unit. I explored the lived relational experiences of patients and nurses as understood from within the situation, as they shared "what counts as real" (Benner & Wrubel, 1989, p.46). A basic assumption of

this inquiry is that hospitalized patients with severe mental illness, and those who work with them, have the ability and the desire to interpret their experiences in such a way as to illuminate and reveal their understanding of phenomena; in this case, the phenomenon of relationship.

Context

The participating units were situated in a tertiary care setting in two sites of a regional health authority. Each unit had between 20-25 inpatient beds and between 20-30 Registered Nurses and Licensed Practical Nurses. Each unit had two-three staff psychiatrists and a small number of unlicensed assistive personnel such as patient assistants, ward aides, ward clerks, and security guards.

Methodology

Hermeneutic phenomenology: basic assumptions. In hermeneutic phenomenology, the researcher enters the world of participants and seeks their perspective on their life world experiences. In outlining some basic assumptions of the interpretive approach, Leonard (1994) stated, "the researcher has a preliminary understanding of the human action being studied" (p.57). The interpreter "acknowledges as much as possible any assumptions that could both influence the investigator's conduct of interviews and observations"; this experience can be understood as "the forward arc of the hermeneutic circle" (Crist &Tanner, 2003, p.203). One aspect of this *forestructure of understanding* is that "we approach our research question with a point of view from the perspective of a particular interpretive lens…that orients us to the phenomena in a particular way" (Crist & Tanner, 2003, p.57). The researcher is given access to the phenomena as meanings are exposed (Leonard, 1994). Another aspect of the

forestructure of understanding is that the researcher has "a preliminary sense of what counts as a question and what would count as an answer" (Leonard, 1994, p.57).

Hermeneutic phenomenology in this inquiry. I enacted the methodology of hermeneutic phenomenology by adopting the approach of Benner (1985, 1994). This inquiry involved both conversation and participant-observation. According to Benner, data may come from "interviews, participant-observation, diaries, and samples of human behavior" (Benner, 1985, p.6), and the researcher uses text analogues of these activities for interpretive analysis. It is important establish a "naturalistic communication context" (Benner, 1984, p.108) so that participants are able to tell their stories as narrative accounts rather than judgments or retrospective viewpoints (Benner, 1994). According to Benner (1994) "multiple interviews are preferred" because they "allow researcher and participant a second change to make sure that understanding has occurred" (p. 107). Participant-observation is another way of establishing a "familiar communication context" as it allows "the sights, sounds, smells and demands experienced become visible in ways that simply do not occur to the participant outside the situation" (Benner, 1994, p.108)

Interpretive analysis consists of "thematic analysis, analysis of exemplars, and the search for paradigm cases" (Leonard, 1994, p.59). In thematic analysis, the researcher reviews the text and identifies themes that emerge from the data. After reading all texts, the researcher creates an "interpretive plan" (Leonard, 1994, p.59) that offers a lens through which the researcher reviews all texts. At any point in the process, additional lines of inquiry may be exposed, and all texts are subject to additional reading. In the analysis of exemplars, the researcher analyzes a specific experience, which

highlights the person's "concerns, actions, and practices" (Leonard, 1994, p.59). Finally, the researcher identifies paradigm cases, which are "strong instances of particular patterns of meaning" (Leonard, 1994, p.59).

Participants. Patients and staff on one of three acute inpatient units were invited to participate in this study. Patients who had been recently (within one week) transferred from an acute inpatient unit to a short-term rehabilitation unit were also eligible to participate, but no participants were recruited from this unit.

In order to be eligible to be included in the study, patients were required to be:

1. Currently admitted to an inpatient psychiatric unit for treatment of an acute exacerbation of a chronic and severe mental disorder

2. Capable of consenting to treatment by the attending psychiatrist

3. Judged to be within two weeks of discharge or transfer to another program. Patients diagnosed with severe cognitive dysfunction, such as that which occurs with dementia or delirium, were not be considered for participation.

Nursing staff members, either Registered Nurses or Licensed Practical Nurses who have worked full or part-time on either of the two units for at least period of six months were invited to participate in this study. Because of the unique and intermittent nature of their work, nurses who work on a casual basis were not be invited to participate, unless the nurse worked more than 50% of full time hours on a designated unit. The decision to enroll both Registered Nurses and Licensed Practical Nurses was based on the fact that in the two study units, both categories of nurses work collaboratively in a primary nursing care delivery model. Given the differences in educational preparation and role definition, Registered and Licensed Practical Nurses are each likely to have

unique perspectives on relationship. Likewise, given that Registered and Licensed Practical Nurses share many aspects of professional knowledge and history, each was likely to share some perspectives on relationship. Because of this, exploring both perspectives enriched our understanding of relationship in the context of an acute inpatient psychiatric unit. In phenomenological research "the size of the sample is considered adequate when interpretations are visible and clear, new informants reveal no new findings and meanings from all previous narratives become redundant", but at the same time "sample size is limited by the size of the text that will be generated and the number of researchers available to analyze the text" (Benner, 1994, p.107)

Recruitment. Participants were recruited in one of two ways:

1. Posters were placed on unit bulletin boards with information about the study and the researcher; patients interested in participating in the study were asked to identify themselves to the ward clerk or nurse. The researcher obtained the names from the unit staff. Nurses who were interested in participating called the researcher directly.
2. Patients who were eligible to participate were given written information that outlined the purpose of the research and the responsibilities of the researcher and participant. Patients read that they should tell the ward clerk if they were interested in participating in the study. Nurses were directly informed about the study by the researcher at a staff meeting.

In order to avoid enrolling patients for whom participation would pose a significant risk to health, the nurse-in-charge was asked to screen eligible patient participants. It is possible that the nurse-in-charge could have chosen to steer me away from patients who

she believed might share stories that would reflect badly on her or on other nurses. Nevertheless, this method of recruitment was appropriate. Firstly, each patient's stories were a source of understanding for me, regardless of their experiences with nurses; I was not attempting to generate a randomized sample of patients for the purpose of creating generalizeable findings. Secondly, patients admitted to an inpatient psychiatric unit are vulnerable persons. It would be difficult for me as a stranger to assess the potential risk of participation to the health of individual patients by reading a medical record. I minimized any potential vulnerability related to problems in relationships between patients and nurses by recruiting individual patients and nurses and not patient-nurse dyads; it would be difficult to associate a particular patient's experiences with a particular nurse, and the nurse-in-charge was aware of this. After being screened by the nurse-in-charge, patients were given an information sheet that described the study. A member of the psychiatric or nursing staff who was known to the patient gave this information to the patient. The staff member introduced me to the patient as a nurse researcher who would be asking them if they were interested in participating in a nursing research study.

I originally anticipated that approximately 10 patient and 10 nurses would be interviewed in this inquiry. In approximately 550 hours over a thirteen-month period, I screened over fifty patients and had formal interviews with nine nurse-participants and six patient-participants. I had little difficulty recruiting nurse participants, but I had serious difficulty recruiting patient-participants. In my view, these challenges were primarily related to the study's restrictive eligibility criteria and my approach to the consent discussion. The inclusion criteria stated that only patients found capable of consenting to treatment by the attending psychiatrist could be enrolled. Those who were not capable of

consenting to treatment, or those diagnosed with severe cognitive dysfunction, were not eligible for participation. When I began recruitment, it became clear very early that far fewer patients were capable of consenting to treatment than I had anticipated. On average, fewer than 15% of patients on the study units were capable of consenting to treatment, seriously reducing the recruitment pool. Additionally, when I asked unit nurses about the appropriateness of approaching individual patients for participation, nurses often screened out certain patients because in their opinion the patient would not be a good candidate, even if they did meet eligibility requirements. Nurses made statements such as "He hasn't been doing that well in the past few days", "she has been really disorganized lately and she can't tolerate a lot of stimulation", and "We just told her that her husband doesn't want her back home—can you check again next week?" when citing reasons why a particular patient with capacity to consent would not be appropriate to approach for possible participation in the study.

When nurses did encourage me to attempt to enroll particular patients, and I described the study to patients, many were initially interested, but after reading the consent form, most kindly refused. I attempted to allow sufficient time for patients to read the consent form and ask questions, but on several occasions, patients who had read the consent form on their own, after receiving an initial description of the study, declined to participate. Some indicated that they would be willing to talk to me casually, but that they did not want to be audiotaped. When asked if they had specific questions or concerns that I could address, most patients stated something to the effect that they just were not interested in participating. On at least three occasions, patients who had initially agreed to participate declined to be interviewed when I showed up for the scheduled interview because they were

being discharged the next day and they did not want to commit to anything after they had left hospital. On one occasion, a patient repeatedly postponed a formal interview, while encouraging me to return for informal conversation. I became uncomfortable with what appeared to be a desire to engage me in a supportive, therapeutic relationship rather than a researcher-participant relationship, and I discontinued my attempt to recruit that person.

When recruitment challenges became apparent, I sought an amendment to the study protocol that would allow recruitment from two additional inpatient psychiatric units. These units admitted patients discharged from acute inpatient psychiatric units; the program on the new units prepared recovering patients for community living. I hoped that the patients on the community living units would be more likely to meet the eligibility criteria related to consent capacity than those on the original study unit. In fact, after the institutional research ethics board approved the amendment, I learned that these community living units had been recently converted to acute care units; patient characteristics were the same as those of the patients on the original study units. Only one additional patient was recruited using this strategy. I also changed my approach to the consent discussion. After the unit nurse introduced me to the patient and we briefly chatted, I did not leave the consent form with the patient; rather, I sat with the patient, explained the study and consent form in detail, and obtained the consent if the person was willing. It is difficult to determine the specific impact of this change, except to say that three patients were recruited after I made this change.

Data collection. I invited participants to engage in a series of conversations about their relational experiences with nurses and patients on the inpatient unit. Conversations with patients took place while the participant was in hospital or within several weeks of discharge. While I valued contextually situated anecdotes and stories, I

understood that some patients may perceive that participating in this kind of conversation while still in hospital would be too risky; I was prepared to offer them the opportunity have the initial interview take place either while in hospital or within one week after discharge from hospital. In fact, no patient asked for this. I scheduled interviews for a mutually agreeable time, and on several occasions, rescheduled interviews because the original time became inconvenient. I met with patient-participants and nurse-participants in a private area that was either on the unit or adjacent to the unit, and most interviews with nurses took place during or immediately after their work shift.

In planning this inquiry, I anticipated that I would have at least three interviews with each participant in order to gain in-depth access to the participant's story, to elaborate on themes and issues that emerged during the first interview, and to provide an opportunity for researcher and participant to talk about interpretations (Seidman, 1991). I found it necessary, however, to accept that some patient-participants would not agree to follow-up interviews. Because of ethical considerations related to qualitative methodology and the use of process consent (described below), participants were free to withdraw from participation in follow-up interviews. Fortunately, that was not a common occurrence. All fifteen participants agreed to engage in serial interviews when they were enrolled in the study.

The following questions formed the structure of the initial patient-participant interview:

1. Tell me about the interactions you have with nurses while you have been patient here on this unit. What is it like to be with nurses on this unit?

2. When have you been with a nurse in a way that you have found to be helpful? Tell me more about it.
3. When have you been with a nurse that you have not found to be helpful? Tell me more about it.

The following questions were used to structure interviews with nurse-participants:

1. What is it like to be with patients on this unit?
2. Tell me about your relationships with patients on this unit.
3. Tell me about times when you with a patient and you felt it was working as it should.
4. Tell me about times when you with in a relationship with a patient and you felt it was not working as it should.

Subsequent interviews were structured according to the themes that arose out of initial interviews.

I observed nurses and patients who had given their consent in situations involving relational practices, and engaged them in conversation about these practices during the observation period. These observations took place over the duration of the study. I kept field notes of these observations and used data from these observations in follow-up interviews. I completed approximately sixty hours of participant-observation.

Analysis and interpretation. The interpretive process began as soon as interviews took place after the informed consent process (Crist & Tanner, 2003). Data consisted of texts transcribed from the accounts of patients and nurses, as well as my observations and journal notes. I tried to identify situations which seemed to hold rich reservoirs of knowledge and which participants considered important to share. At all

times during the interpretive process, I attempted to remain open to any new lines of inquiry that emerged from the accounts of patients and nurses, and used these to provide a focus for subsequent interviews (Crist & Tanner, 2003). I facilitated openness to new lines of inquiry by writing in a reflective journal shortly after the interview and reviewing the printed transcript as soon as it was available, and I brought these new questions to subsequent interviews. In essence, the process of "interviewing, observing, identifying lines of inquiry and interpreting" (Crist & Tanner, 2003, p.203) was a simultaneous one. The interpretation process was one of moving back and forth from parts of texts to the whole, so that the text could be given larger meaning (Drew & Dahlberg, 1997).

As the inquiry unfolded, the following process took place (Crist & Tanner, 2003):

1. Identification of meanings that "are unfolding for the participant" (Crist & Tanner, p.203) or "the way the person is oriented meaningfully in the situation" (Benner, 1994, p. 105).
2. Exploration of the relationships between individual participants' current and past experiences;
3. Development of the interpretation through interpretive writing, which summarizes central concerns and identifies exemplars of important themes emerging from anecdotes and stories;
4. Discovery of "connection between meanings found within and across stories" (Crist &Tanner, p.204);
5. Development of in-depth interpretations and interpretive summaries;
6. Address of any line of inquiry that has not yet been explored in final interviews and observations.

It is important to emphasize that interpretation is an ongoing process that continues when manuscripts describing the inquiry are published and read.

Ethical Considerations

Qualitative research methods generate many ethical considerations, some of which are unique to the paradigm, some of which are not. The first principle of ethical research is that the inquiry is scientifically sound, but there has been debate as to how to assess qualitative research for scientific rigor (Sandelowski, 1986). Sandelowski (1986) described how certain components of scientific rigour could be interpreted for qualitative research. The first of these is *truth value*, which "generally resides in the discovery of human phenomena or experiences as they are lived and perceived by subjects, rather than in the a priori conceptions of these experiences" (Sandelowski, 1986, p.30). Truth emanates from the subject, not the researcher, and therefore credibility is the criterion of truth value. The credibility of this inquiry rests on the fact that the life world descriptions of participants were faithfully rendered in the transcribed accounts of patients and nurses, and interpretations were discussed with most participants in subsequent interviews. The second component, applicability, is impossible to apply to qualitative research, so the criterion *fittingness* is substituted. According to Lincoln and Guba (1985), fittingness is the "similarity between two contexts" (p.124). The researcher provides enough information about the context of the inquiry so that the reader can make a judgment of transferability based on the information supplied (Lincoln & Guba, 1985). In this inquiry, experiences of nurse-patient relationship were explored with patients and nurses on acute inpatient psychiatric units as they were experiencing relationship. In addition to interviews, I engaged in participant-observation to expand my understanding of

participants' experiences. Readers will understand the very specific nature of the research setting. Lincoln and Guba's third component relates to the quantitative criterion of consistency, or reliability. It is suggested that *auditability* is the comparable criterion in qualitative research. In this particular inquiry, auditability was achieved as I situated myself in the research, identified specific purposes of the study, described the data collection and interpretive process in detail, and engaged in reflective journals.

In relation to qualitative "life world" research, Dahlberg and Drew (1997) emphasized that:

> Accompanying the goal of knowledge is the ethical concern for a fellow human being. An important aspect of the life world perspective is the understanding that in every research endeavour there is an experiencing subject, the individual who has agrees to participate in the study…In such research, attention is given not only to the information the individual conveys about his/her experience of the health phenomenon being examined, but also to the way in which he or she experiences being a part of the project. Holistic nursing researchers strive to make the research relationship an equitable one, cognizant of having entered a private domain, the participant's experience (p. 309).

The Tri-Council Policy Statement (Medical Research Council of Canada, Natural Sciences and Engineering Research Council of Canada, and Social Science and Humanities Research Council of Canada, 1998) outlined the guiding principles for human subject research in Canada: free and informed consent, respect for vulnerable persons, respect for privacy and confidentiality, respect for justice and inclusiveness, balancing

harms and benefits, minimizing harm, and maximizing benefits (p. i.5). In the following section I discuss how each of these principles was upheld in this inquiry.

Free and informed consent in qualitative research. The Tri-Council Policy states that "free and informed consent refers to the dialogue, information sharing and general process through which prospective subjects choose to participate in research involving themselves" (Medical Research Council of Canada, Natural Sciences and Engineering Research Council of Canada, and Social Science and Humanities Research Council of Canada, 1998, p.2.1). If participants sign an informed consent, it is assumed that they "are fully aware of both the health benefits and the actual or potential risks to their health" (Streubert & Carpenter, 1999, p.34) of participation in the activity. There are two major principles of informed consent: firstly, that the participant alone has the right to give consent and secondly, that consent is based on information that identifies known and suspected risks (Usher & Arthur, 1998).

It is this latter principle that is most challenging to uphold in qualitative research. The nature of information shared with the participant includes details about the "purpose, risks, benefits and alternatives" and the process of "explaining and clarifying values, roles and responsibilities" (Roberts & Roberts, 1999, p.1027). Because "there is little control over what will emerge in a qualitative interview" (Streubert & Carpenter, 1999, p.33), it may be impossible to share specific information about known or suspected risks of participation. In my conversations with participants, I encouraged them to make life world meanings explicit, and it was unavoidable that the encounter evoked new and sometimes unexpected feelings, perspectives and experiences. I encouraged participants to share their life stories and this exposed participants to previously unexpressed and

unknown thoughts. As an ethical researcher, I was required to be completely accurate, complete and balanced in my communication efforts, and be respectful of the ethical requirements of conducting this study. According to Roberts and Roberts (p.1027) if the researcher has paid "insufficient attention to process", the participant may experience unintended harm.

In order to strengthen the information exchange with participants, and strengthen information sharing with the participant, I used an approach to informed consent called "process consent" (Usher & Arthur, 1998, p.695) with "consensual decision making" (Streubert & Carpenter, 1999, p.36). This approach to informed consent required that I engaged the participant in an open discussion of research-related issues as they arise. For example, in discussing the inquiry with a potential participant, I highlighted the fact that the participant could experience unexpected or uncomfortable feelings, insights and perspectives during the interview. I described the detail of these potential harms in the consent form. In addition, I upheld the principles of informed consent in qualitative research:

- I instructed participant that they were free to refuse or withdraw consent at any time during the study;
- I recognized that the participant's "competency to make decisions and choices must be seen as an ongoing process" (Usher & Arthur, 1998, p.696). Therefore consent was re-established at each interview and each participant observation session;

- If I identified possible harms or vulnerabilities to the participant during an interview or at any other time, such as during participant-observation, then I identified the issue;
- I refrained from probing if I assessed that there was a potential that the well-being of the individual would be affected (Kvale, 1996).

Vulnerable persons and informed consent. A source of participant vulnerability in relation to informed consent in this inquiry is the fact that a portion of the participants (patients) are people with identified severe mental illness, which in certain situations may have an effect on decisional capacity. In human subject research, it has been shown that the presence of a mental illness can affect the cognitive aspects of consent (Shacter et al., 1994). The Tri-Council guidelines state that research participants must "have the ability to understand the information presented, to appreciate the consequences of a decision" (Medical Research Council of Canada, Natural Sciences and Engineering Research Council of Canada, and Social Science and Humanities Research Council of Canada, 1998, p.2.9), and that researchers have a "high obligation toward vulnerable persons—to those whose diminished competence and/or decision-making capacity makes them vulnerable" (1998, p.i-5). Decisional capacity includes "ability to express thoughts and preferences, ability to take in key information, ability to understand, think through and rationally assess the decision at hand, ability to integrate and appreciate the meaning of the decision within one's life" (Roberts & Roberts, 1999, p.1027).

It is also understood that "mental illness does not as such deprive the patient of the ability to judge and thus to decide on his consent" (Cuenod & Gasser, 2003, p.20). It is important to recognize that decisional capacity "is not a fixed attribute; it changes

according to the nature of the specific decision, the enduring and fluctuating abilities of the participant" (Roberts & Roberts, 1999, p.1028). To suggest that people with mental disorders lack capacity because of their illness to consent is to deprive them of their status as autonomous human beings. Applebaum and colleagues (1995) studied the competence to consent to treatment of patients with schizophrenia and depression. While acutely ill patients with psychiatric disorder demonstrated poorer decision making abilities than patients with biological illness, their decision making improved once treatment was started. It has been suggested that people with severe mental illness "also exhibit strengths with respect to giving informed consent" (Roberts & Roberts, p.1031) such as ability to understand the implications of taking psychotropic medication.

Decisional capacity is only one factor that creates potential vulnerability in a person with mental illness. Another important factor is the fact of being a person who is hospitalized on an inpatient psychiatric unit. Many patients on inpatient units have been hospitalized against their will; even if the patient's status under the law changes during hospitalization, there is no ignoring the fact that at one time the person's liberty was controlled by the health care team, who are led in this decision by the treating psychiatrist. This power imbalance may exert a subtle coercive effect on the patient's predisposition to participation in research; it is not too far-fetched to imagine that patients would agree to participate because they believe that their treatment team would wish them to do so. Potential participants may feel "desperate and constrained" or feel "indebted or dependent on the research recruiter" (Roberts & Roberts, 1999, p.1028). In interviews with 63 people with schizophrenia, Roberts and Roberts (1999) "affirmed the role of altruism, trust in science and clinical professionals, and the inspiration of hope as

leading to research participation" (p. 1032). It has been concluded that "consent given by people with mental illness may present special difficulties, but their impact may not always be greater than with other potentially vulnerable populations" (Roberts & Roberts, p.1033).

Nurse-participants may also be in a vulnerable position in relation to the consent process, albeit they are likely to be less vulnerable than patient-participants. When research is conducted in a workplace setting, it is important that workers do not experience either subtle or overt pressure to participate from their supervisors and employers. In this inquiry, it was critical that my independence as a researcher was emphasized, and that supervisors and employers did not directly invite nurses to participate.

Respect for privacy and confidentiality. It was impossible to maintain complete participant anonymity in a phenomenological inquiry; I interacted directly with participants. Interviews were audio-taped, and the fact that participants' personal stories were recorded and transcribed into written accounts was a potential threat to participants' privacy and confidentiality. In this particular inquiry, only the transcriptionist and the researcher had access to the audiotapes. Names, ages, gender, and some other details were altered to prevent recognition of the informant by the listener or reader. Audiotapes were destroyed after transcription and verification, and transcriptions are kept in a locked filing cabinet. I informed participants that excerpts of their stories might appear in publications and presentations, but that I will never identify individual participants. If the small number of participants and the context of the situation created the possibility that a participant's identity could be revealed, then the participant was asked for specific

permission to use that aspect of the account. If permission had not been granted, then the information would have been withdrawn from the study.

In relation to participant-observation, I did not record observations of nurses or patients who did not consent to participate in the observation. It was impossible to avoid observing non-participants in this particular inquiry, due to the nature of the physical environment. All nursing staff and patients were aware of the ongoing study and understood the purpose of the researcher's presence on the unit. All nurses and patients were informed that no observational data stemming from non-participants would constitute any part of a research report unless permission is given in writing (See consent forms, Appendix A and Appendix B).

Justice and inclusiveness. The Tri-Council policy states that there should be "a distribution of the benefits and burdens of research" (Medical Research Council of Canada, Natural Sciences and Engineering Research Council of Canada, and Social Science and Humanities Research Council of Canada, 1998, p.i-6). According to the Tri-Council, a researcher is required to be consistent with the principle of distributive justice and "neither neglect or discriminate against individuals or groups who may benefit" (p.i-6). Further, the Tri-Council states, "no segment of the population should be unfairly burdened with the harms of research" (p.i-6). Baylis, Downie, and Sherwin (1998) challenged underlying assumptions about the conduct of research, suggesting that researchers should avoid perpetuating "patterns of privilege" (p.236) that exclude women and other oppressed groups from the benefits of research. According to Baylis and colleagues (1998), "scientific research can promote the well-being and autonomy of members of oppressed groups" (p.244) and the ethical practice of research demands that

the results of the research will be of "specific benefit to the group in question" (p.244). If it is important to understand the experience of people hospitalized with severe mental illness and their nurses, and disseminated knowledge of that experience is potentially beneficial, then it is unjust to exclude these groups from research that could potentially benefit them.

Harms and benefits. It is commonly held that "modern research requires a favourable harms-benefit balance" (Medical Research Council of Canada, Natural Sciences and Engineering Research Council of Canada, and Social Science and Humanities Research Council of Canada, 1998, p.i-6); the Tri-Council policy states, "Harms must be proportional to benefits" (p.i-6). Weighing the harms-benefit balance is influenced by the principles of beneficence, or the "duty to maximize benefits" (p.i-6) and non-maleficence, "the duty to avoid, prevent or minimize harm to others" (p.i-6). Van Ness (2001) (assuming that "hazards", or harms, and "risk" refer to the same concept) defined risk in the following way: "Risk…describes circumstances in which one knows the number of possible outcomes and the probabilities of each of them" (Van Ness, 2001, p.364). Van Ness stated that there are two components of risk: "the probability that a certain adverse event will occur and a characterization of the consequences of that event" (Van Ness, 2001, p.365). Further, "the concept of risk involves the idea of chance…the probability of harm may be predictable to a certain degree but never controllable with certainty" (Van Ness, 2001, p.369). Van Ness emphasized that risks and benefits cannot be compared directly, because they are asymmetrical concepts. Because the concept of risk is, in essence, describing a probability, risk should be contrasted with the probability of benefit. In other words, both

risks and benefits may occur, but neither is certain to occur. In order to understand the "harms-benefit" balance, it is necessary to understand that risk, or probability of harm, is most appropriately compared with the probability of benefit.

Rajczi (2004) suggested that an assessment of risks and benefits should avoid the pitfall of assuming that a protocol "has an acceptable combination of risks and benefits only if the protocol will do more good than harm" (p.324); he maintained that it is not normally possible to know enough about the outcomes of research to make this determination. Rajczi (2004) proposed that a protocol could be considered to have an acceptable combination of risks and benefits if "it would be entered into by competent and informed decision-makers" (p.342). The key point here is that Rajczi abandoned the "improvement" principle, which assumed that it is always possible to calculate a risk-benefit ratio, in favour of an "agreement" principle, which assumes that health research is likely, in certain cases, to pose vague questions about risks and benefits, which may yield uncertain conclusions. Given Van Ness's (2001) position, described above, on the asymmetry of the concepts of risk and benefit, and Rajczi's argument about the need for a decision principle that can cope with "the vagaries of medical research" (p.346), it is reasonable to take the agreement principle into consideration when determining the risks and benefits of this particular inquiry. Competence (including decision-making capacities) of participants then becomes central in understanding whether the inquiry has an appropriate risk-benefit ratio. Therefore, according to the Rajczi's agreement principle, the individual has to be able to make a judgment about risk, and according to Van Ness, the individual has to be able to judge the probability of harm or benefit.

While I have already stated that individuals with mental illness do not necessarily lack capacity to consent, it is necessary to consider the abilities of people with mental illness to "appreciate the personal consequences of possible research and treatment decisions and to use that appreciation to rationally weigh the options" (Prentice, Gold, & Carpenter, 2005, p.507): in other words, to weigh potential risks against potential benefits. Researchers, especially those who are conducting higher risk studies, want to avoid a situation where potential participants minimize the potential for risk or inflate the potential for benefit (Prentice, Gold & Carpenter, 2005). Prentice and colleagues studied the role of "optimistic bias" in decision making in people with schizophrenia. Optimistic bias is the tendency for individuals to "feel they are less likely than other people to experience unpleasant or armful events in their lives but more likely to experience pleasant or beneficial events" (Prentice, Gold, & Carpenter, 2005, p.507). The authors determined the following:

- Even though both healthy adults and people with schizophrenia have considerable optimistic bias when evaluating research participation;
- People with schizophrenia tend to have less optimistic bias than healthy adults;
- "There is no apparent relationship between psychosis which one might expect to be an important contributor to the groups" vulnerability to decisional incapacity and the extent of bias" (p.510);

- Patients with schizophrenia are "at an uncharacteristic advantage over healthy comparison subjects who tend to have a deeper bias" (p.510).

Prentice et al. did not discount the significance of optimistic bias, but they suggest that people with mental illness are not more susceptible to it. Therefore they recommended that researchers "predict and respond to potential biases in risk perception" (p.511). This study is consistent with the findings of Roberts et al. (2002), who found that patients with schizophrenia "expressed greater reluctance to participate in projects which, in their eyes, posed greater potential harm" (p.580). Patients were found to be able to carefully read and understand the research protocol, use features of the protocol to decide for or against participation, and were "capable of expressing logical decisions and of indicating clear person reasons behind their choices" (Roberts et al., p.581). In conclusion, a discussion of the probability of risks and benefits in this inquiry needs to take into account the fact that risks and benefits are assessed by both researcher and participants, and that those potential harms and benefits cannot be compared in ratio-like operations.

Considering harms and benefits in this inquiry. The probability that any individual participant will receive any benefit from this research is low. It is possible, however, that some people will experience "gratification in being able to discuss their situation….with a nonjudgmental person" (Polit, Beck & Hungler, 2001, p.77). The most likely benefit that participants may experience is the knowledge that knowledge gained from the study may help others in similar situations.

I understood that there would be risks to participants. In the context of this inquiry, decreased psychological distance between the participant and the researcher

yielded a greater probability that the participant would be inadvertently exploited (Polit, Beck & Hungler, 2001) and that participants would experience psychological distress related to self-disclosure, "introspection…fear of repercussions, anger or embarrassment at the type of questions being asked" (Polit, Beck, & Hungler, 2001, p.77). Conversations centered on participant's relational experiences were likely to uncover thoughts and feelings about those experiences that may otherwise remain unconsidered and unexpressed. When I viewed this possibility through the lens of interpretive phenomenology, I understood that exposing thoughts and feelings about relationship would change how individual patients interpret their past, present and future experiences with nurses; this may have posed a potential risk to the integrity of any ongoing relational work.

In order to minimize potential for harm in this study, patient- participants were screened by the nurse-in-charge, who considered whether or not the patient is at risk for harm if patients" relationships with nurses are significantly altered. In making this determination, the nurse-in-charge sometimes chose to consult with the attending psychiatrist, psychiatric resident, primary nurse, any other member of the patient's care team, or the patient. If patients had become distressed during an interview or had expressed a need to debrief after an interview, I would have referred them to an appropriate member of the nursing staff, or a psychiatric resident or attending psychiatrist, as determined by the nurse-in-charge. There were no occasions in which I was required to take this action. It is possible that the risk of exploitation and participant distress was reduced by my clinical expertise in working with people with mental illness. In the case of nurse-participants, they could have been given specific information about

the hospital's Employee Assistance Program. I made particular effort to reinforce the fact that the interview process was not a therapeutic process, and in all cases was prepared to choose an action that supports the health of the participant over the demands of the research process. In order to minimize risk to a potentially vulnerable population, the following special safeguards were in place in this inquiry:

- In relation to patient-participants, only those who have been deemed capable of consenting to treatment and who are voluntary patients were eligible to participate in this study. A patient was capable of consenting to treatment if a patient had been declared so capable by the patient's psychiatrist.
- Once possible patient-participants were identified, I asked the nurse-in-charge (who may have consulted with other care team members and the patient) to assess whether the patient's participation in the study would expose the patient to such a risk that participation in the study would not be advisable. If the patient was determined to be at significant risk, then the patient was not invited to participate.
- Patient-participants were offered the choice of having the initial interview with the research either while they are still in hospital or within one week of discharge.
- Nurses who chose to participate in the study were neither recruited by nor identified to their managers.

Summary. This particular inquiry operated within a framework of ethical research and ethical mental health nursing practice. A guiding principle in the conduct of

this study was that the probability of risks will be minimized and the probability of benefits will be maximized, and that assessment of risks and benefits is shared by researcher, participant, and attending psychiatrists. There is little evidence to suggest that patients with severe mental illness are more likely to take risks in research participation than the general population, and having a mental illness does not necessarily mean that a research participant is not capable of giving informed consent. Although it is reasonable to recognize that people with severe mental illness may be more vulnerable than the general population of research participants, they should not be excluded from the possibility of participating in research. It is most likely that most patient participants will experience no direct benefit from participation. This may lead one to question if the risk of participation is worth the very real probability of little direct benefit. The most important benefit of this research relates to the fact that this population is underrepresented in nursing research, and it is highly probable that the knowledge gained from this research will be significant in understanding the nature of relationships between nurses and patients. This knowledge will emerge at an important time in the development of psychiatric nursing practice, as nurses are "struggling to understand how the relational fits the biological" (McCabe, 2002, p.55). Just as the essences of biological phenomena are studied, so must the essences of relational phenomena be understood. This is the significance of this inquiry.

CHAPTER FOUR

Analysis

Relational experiences between nurses and patients in an acute inpatient psychiatric unit are enacted in a broad context of care-giving and care-receiving. In this inquiry, I sought to explore this world of care-giving and care-receiving and uncover the intricate meanings embedded in participants' relational experiences. I searched for that which was important to each participant. In other words, I sought to uncover "strongly valued goods" (Taylor, 1985, p.31), situated in participants' social existence in acute inpatient psychiatric units.

Types of Nurse-Patient Encounters

In order to better understand the nature of nurses' and patients' relational experiences, it is useful to note that in the social context of the acute inpatient psychiatric unit, nurses and patients experience different kinds of encounters with each other. In this inquiry, an encounter is understood to be that moment in time when nurses and patients inhabit a common space in which each has an awareness of the other. In the context of this inquiry, three different kinds of nurse and patient encounters were identified:

- Incidental encounters, in which nurses or patients approached the other to share or ask questions about practical information, which was not related or only marginally related to the patient's health status or treatment;
- Informal encounters, in which nurses or patients approached the other to express concern, share information, or seek the other's perspective about an issue related to the patient's health or illness experience;

- Formal encounters, in which nurses and patients participated in conversations with specific expectations related to action and outcome.

I observed nurses and patients during incidental, informal, and formal encounters, and I had conversations with nurses about all three types of encounters.

The assessment conversation is one kind of formal encounter that I observed nurses and patients enacting. Once admitted to the inpatient unit, a patient is assigned to a primary nurse, so that whenever a particular nurse is working, he or she provides care to a consistent caseload of patients. Primary nurses create and participate in standardized assessments that allow nurses to explore and better understand a patient's health status, life experiences, and matters of concern. On this unit, the interview is termed a "holistic" assessment, and the goal of the assessment is to give patients the opportunity to tell their stories, and help nurses to gain intimate knowledge of patients" experiences.

Approach to Analysis

I entered into conversations with individuals so that I could understand that which they disclosed and in this inquiry, the structure of that disclosedness is meaning (Heidegger, 1962, p.124). I was guided by the following understanding of interpretation:

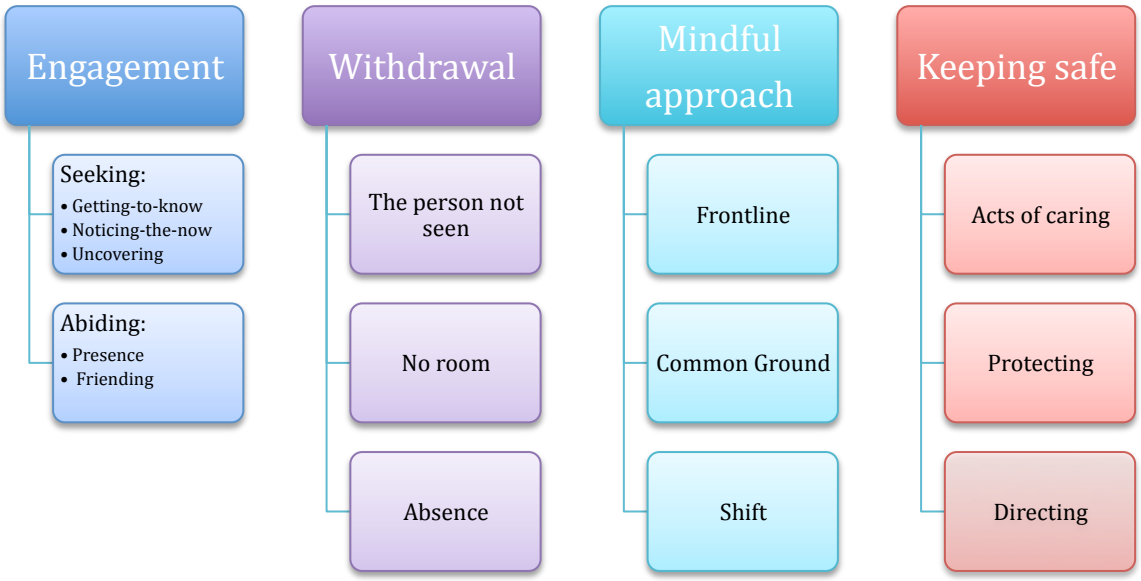
- Meaning, in the ontological-existential sense, is not a property of an object but that which becomes "intelligible as something" (Heidegger, 1962, p. 124).
- Interpretive phenomenology involves "questioning, comparing, and imaginatively dwelling in the situation" (Benner, 1994, p.99)
- Interpretation is grounded existentially in understanding (Heidegger, 1962)

- Interpretation is “an attempt to make clear, to make sense of, an object of study” (Taylor, 1985, p.15)

In this analysis, I identify how each person invited the other into shared experience and uncover meaning in how each person searched for language to create a connection, a link, an understanding. I organize my commentary in patterns of commonality, or themes, in the manner of Benner (1994), who suggested that, “thematic analysis may...be done across cases to clarify distinctions and similarities” (p.115). Thematic analysis is “the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the work” (Van Manen, 1998, p.78). In a phenomenological inquiry, a theme is not a fixed category with inclusionary criteria and strict boundaries. According to Van Manen (1998), a theme is an instrument for understanding the meaning of experience, not the experience itself; as Goldberg (2004) stated, “words may not fully capture the depth of an experience” (p. 50).

I have identified “salient excerpts” that “characterize specific common themes or meanings across informants” (Crist & Tanner, 2003, p. 204), and I include all salient excerpts in this analysis. I present excerpts from texts and interpretive commentary to “give greater access and understandings of the texts in its own terms” (Benner, 1994, p.101). By identifying themes, and commenting on texts within themes, I am able to understand more fully both the consistencies and incongruities that emerge from the life worlds of the nurses and patients in this inquiry. The pattern of themes recovered in this inquiry is illustrated in Figure 1.

Figure 1 Thematic Patterns



In addition to noting commonalities of meanings across all informants, I make special note of similarities or differences in the accounts of nurses and patients. I note that while many sub-themes seemed to account for the perspectives of both patients and nurses, the sub-themes signified as "noticing-the-now", "directing", and "protecting", are predominantly inhabited by the perspectives of nurses, and the sub-themes of "friending" and "absence" are inhabited predominately by the perspectives of patients. In the discussion below, I highlight possible areas of convergence between the perspectives of patients and nurses, although I am mindful that any "convergence of belief" in the intersubjective experience of patients and nurses "presupposes a common language in which these can be formulated" (Taylor, 1985, p.37); it may be the rare experience in which patients and nurses share the social practices and language which would create common meanings. It is important to note, "narrative is not a retrospective closure that

takes specifically after events but an ongoing phenomenology of daily life" (Steele, 2003, p.44), and any interpretation must be understood to be speculative, imperfect, and incomplete.

Engagement

> *When I talk to them they are genuinely interested, they answer questions appropriately, they are into eye contact, not looking over here, or acting like they are busy or whatever. (Patient Laura)*

In the everyday world of an acute inpatient psychiatry unit, there are moments in time when nurses and patients "move toward each other as a person" (Bergum, 2004, p.495). In this inquiry, nurses and patients characterized engagement as an emerging awareness of the other, an awareness of the self in relation to the other, and the intention to "be" with the other. I learned how nurses and patients began to engage by inhabiting a relational space of relative unknowing and moved through active periods of noticing and uncovering before being fully immersed in an engaged relational experience. The first three sub-themes that illuminate patients' and nurses' experiences of engagement are "getting-to-know", "noticing-the-now", and "uncovering". In the accounts that yielded these three sub-themes, nurses and patients seemed to be actively seeking knowledge of the other; I qualified these sub-themes as "seeking". Two other sub-themes, "presence" and "friending", illuminate experiences in which patients and nurses engaged in a way that created the possibility of more complete knowledge of the other, but in which neither expected nor actively sought that knowledge. I qualified these two themes with the word "abiding". To abide means "to wait for, to remain ready for" (Oxford University Press, 2010) and an "abider" is "a person who stays in a place", or "perseveres" or "waits". The

theme of engagement is also illuminated by exploring its complementary theme of "unknowing—withdrawal", which will be discussed in a later section.

Seeking: Getting-to-know. For many nurse-participants in this inquiry, engagement implied that the nurse and the patient shared a specific kind of knowing. For Nurse Samantha, the journey of engagement was a journey from "superficial" knowledge to "depth" knowledge of the patient. Even though she valued and actively participated in the holistic assessment process, Samantha declared that all interactions between nurses and patients were potentially facilitative and productive. After a patient arrived on the unit, Samantha used the orientation tour as an opportunity to begin to know the person. Samantha implied that even generic and relatively impersonal questions created possibilities for more engaged interactions at a later time.

> I often think that all interactions are meant to help you, and start off on the superficial stuff: "Oh, can I give you a tour of the unit, are you a smoker or non-smoker?", and questions that get to know them. You are getting to know little facts, nothing really in great depth. But even things like taking a patient on tour when they first arrive and then making them feel comfortable allows you to say: "We've finished the tour, why don't you have something to eat? Maybe later we can sit down and you can tell me your story." There's a good sort of headway in that. (Nurse Samantha)

Samantha was intent on "making headway", or progress, so that she could arrive at a place of knowing. Samantha linked time with knowledge: "good" headway moves toward "depth" knowing, and "depth" knowing is more than "little facts". The implication here is that patients" stories are complex and multi-layered, and getting-to-

know the patient requires several encounters over time, not just one encounter in one moment in time. While Samantha valued this initial encounter, she also helped the patient understand one of the nurse's expectations: that the patient would share her story later. The nurse exposed her intention to learn more about the patient at a "later" time; by doing so, the nurse expressed to the patient that more "depth" knowledge was both expected and valued.

Samantha described another situation in which she created an opportunity for the patient to tell her story. Unlike the situation described above, this was not an informal encounter; it was the carefully scripted exchange of an assessment interview. Despite the fact that the patient was responding to specific questions, the chance to tell her story led to her sharing more about herself than the nurse expected at the time.

> The patient had a lot of frustration when she first came here. She didn't know what was happening. She had no previous psychiatric history. She has two children at home, children's aid is involved. Kind of a messy situation...She really needs a chance to tell her side of the story. She took (the assessment interview) and ran with it. The questions, I think we only go through half in about an hour and then we revisited it again. (Nurse Samantha)

Samantha described a situation in which her own professional imperative to complete an assessment interview fitted with the patient's need to tell her story. As an assessment interview, the conversation would have had some specific parameters, or areas of concern that the nurse would focus on. Samantha suggested, however, that regardless of any perceived constraint on the conversation, the patient "ran with it". In the patient's need to

be understood and the nurse's need to understand, the patient and the nurse moved toward each other and inhabited a space of compatible interest.

In the following account, Nurse Caroline describes a series of moments when a nurse and a patient share exchanges about "little facts".

> We have a patient who is extremely suspicious and paranoid and he will peek out around the door. He's very paranoid, and I knew that when I got him yesterday, for the first time, I went in, in a non-threatening way, just said hello and told him who I was, what my name was and he wanted to know my last name so I told him and from that he said, "Oh, I used to know somebody with that last name", so a little tiny conversation started there. But when he was finished, that was it, like, okay, you can go now, so I felt as though I got in there a little bit. Then today, I asked him if he had remembered my name from yesterday and he said no, and I told him Caroline, and he was "Oh, yeah, what's your last name?", and I said, "Brown" and he said, "Oh, yes that's right, I remember you." So it was like, even if I can't sit down and touch his hand or do anything for him, because he wouldn't let me, at least I felt as though there was a little connection there, like we were able to have a meeting of the minds, you know, but I knew where the line was drawn. (Nurse Caroline)

Caroline described two encounters, in the first, she enacted a tentative, experimental approach to getting to know the patient, creating the possibility of engagement. Caroline understood the tentativeness of the connection as "getting in there a bit"; there had been a small movement toward the other. In the first encounter, the patient drew the line, not Caroline, and in stepping away, Caroline was being respectful of the patient's personal

boundary but expectant that engagement would continue. In the second encounter, Caroline's expectation was strengthened by the fact that time had passed, and the patient had not rebuffed her; he remembered what he knew about her from an earlier meeting. The patient's conscious knowing of the nurse's identity allowed the nurse to understand that some person-to-person intimacy had been uncovered: Caroline characterized the encounter as a "meeting of the minds". This meeting was a moment of conscious knowing for Caroline in which she learned something quite significant about the patient: the boundaries that he needed to draw in order to continue to feel safe.

Nurse Joy described an informal encounter in which she approached the patient as a nurse not yet known to the patient.

> When you first meet these people, they don't know me, all I am is someone that's trying to dispel their beliefs. So I come on board saying, "Hi, I'm Joy, how are you today", and they are like "I don't want to talk to you" and given that I talk with them and not above them or below them and you say, "OK when you are ready I can come and talk to you about your situation" and get to know them. (Nurse Joy)

The nurse understood and respected the boundary set by the patient, but in the patient's experience of illness and health care professionals, the nurse was someone who would not believe that the patient's delusions were real. This amounted to a gap in understanding the other that was difficult to bridge. In this situation, both nurse and patient found it difficult to move toward the other, because the patient's understanding and intention differed so markedly from the nurse's own. In "talking with" rather than "above" or "below", Joy attempted to open an access point for the patient, a place where

power and status might be less relevant, and therefore a place where the patient could come to know the nurse's intentions with more clarity.

The following story demonstrates how the reciprocal nature of the getting-to-know experience.

> He was very sick. His name was Joey, and he was attending to voices, he was grandiose...pick one day, he believed he was God, the next day he was the messiah, and he was really into it. I got assigned to him that day. I said, "Joey, I have no idea how it feels." He kind of stood there and he looked at me and said, "You don't?" I said, "I would love to hear more about this stuff and how it is going on with you". "You do?" Because most times in the past, it's "No, you've got to get your meds, that will make you feel better." The patient says, "Well, how are you going to help me then?" I say, "Well, through training, I've been here a long time, and through medications and just talking, the voices do go away eventually. That, I do know." I have to tell him, "OK Joey, you know, to me, really, that's not what's happening". I always have to tell him that...when he was getting into those moments of being psychotic, everyone was saying, "take a pill it will go away." He hadn't been given a chance to express how he was feeling...Yes it's crazy and yes it's delusional, and yes, it's off the wall, but no one had been listening, no one sat there and said, "I am really interested in how you feel." (Nurse Diane)

By expressing a sincere desire to understand the patient's experience, the nurse did not act according to the patient's expectations. The nurse expressed concern that reached beyond the patient's illness to the patient's feelings, the patient's sense of self. The

nurse's concrete expression of her state of not knowing ("I have no idea how it feels") aroused the patient's curiosity; in actively questioning the nurse about her intentions, his understanding of her deepened. Joy's declaration set her apart from other clinicians. This patient and this nurse were moving toward a place of fundamental respect for the other; fundamental knowledge of the other fueled that respect.

Like the patient in the previous story, many patient-participants highly valued the nurse-patient encounter, but getting-to-know the nurse was complicated by distrust. She stated, "It's hard for a person like me to come in here and to trust that someone actually does care about you and it took me a while to really believe that." Marta suggested that she struggled to generate trust in the nurse, and that trust was created when she understood the caring stance of the nurse. In order to arrive at a place of understanding, Marta had to dispel some of her own pre-understandings of what it meant to be a patient. This patient viewed the world through the lens of a patient who felt less than human, in relationship with nurses who were somehow more human and therefore not knowable.

> For me it was very tough to adjust when I came in here the first week because I had a lot of judgment about what it meant to be on a psychiatric unit. When you are a patient, you feel like if the nurses aren't treating me as another human being and aren't relating to me on a human level. I would have a lot of trouble confiding in them because I would feel less…I'm this person who can't cope and there's distance and how could they understand if they're doing well and I'm—how can I trust their help, their support? (Patient Marta)

Marta's words suggested that trusting was strongly connected to understanding, and that each needed to understand the other. Marta needed to know that the nurse understood, not in a detached, intellectual way, but in an integrated, fully embodied way.

> But when they express that "OK, I've also had a tough time" or not just saying, "I understand", but showing me that they understand, it's a lot easier to believe that you can trust them that you are going to get better. (Patient Marta)

In Marta's experience, trust emerged from knowing the other, and knowing the other emerged from a demonstration, not a declaration of understanding.

While most nurse-participants described active approaches to getting to know patients, and patient-participants valued these approaches, the nurse in the following example described a more passive approach.

> We have two patients now…I am really trying to get them both into groups and acupuncture and all that stuff, and (for one) try to show empathy, ask what nurses can do. It was so very difficult and how that worked it was like "stop baiting me, I am not interested". So then really you would be too pushy if you did too much else. It is like this every day. I will wait for an opening. With one of the ladies, I don't really think I am going to get to the place where she is interested, I can tell that about her, but with the (other) lady I will do this each day. I will make an attempt and I do believe there will be some kind of opening—she is on the unit more, her eye contact is stronger than it was, she is not avoiding me like she was…she doesn't shut me right down, she might come

> and look at me, she might pay more attention to what I am doing. There will be an opening soon. (Nurse Colleen)

The nurse wanted to "get to a place where she (a patient) was interested"; in the case of one patient, the nurse knew intuitively ("I can just tell") that she would be unlikely to become engaged with the nurse. The nurse also recognized that another patient's behaviour shifted from avoidance to approach, and she interpreted this as the promise of a more engaged relationship. In standing back and waiting for an "opening", some kind of permission from the patient for the nurse to approach and engage, the nurse was expressing an embodied intelligence, expressed in an integrated physical, emotional and intellectual restraint. The patient was left to create her own opening.

Seeking: Noticing-the-now. During participant-observation, I observed that nurses frequently registered or perceived something about the patient and communicated that understanding to the patient at the time of the noticing. The action was related to but distinct from "getting-to-know"; the distinction was drawn by how these actions were temporally situated. The experience of "getting to know" was usually enacted over several hours or days in which patients and nurses created mutual understanding of the others" intentions and in which present knowing blended seamlessly with past understanding and future possibility of knowing. In contrast, the experience of "noticing the now" was enacted in the moment; in other words, the nurse registered understanding, communicated understanding, and the patient changed her self-understanding within seconds or minutes. This kind of noticing was most apparent during incidental encounters between nurses and patients. A patient described her experience:

> They will point out when I am high or low, cause sometimes I don't even realize it...sometimes I am spinning around like crazy...they will keep me in check, they will notice. Sometimes it's annoying but I am glad they are noticing things. "You seem a little high today"--it is a two-second thing (Patient Laura).

Some nurses and patients characterized this kind of encounter as "checking in", and led to a longer encounter:

> They just check in with me…I wanted to talk about my pass last weekend, the ups and downs and everything that went with it, just bouncing off some ideas and they took time and we went into a room and we talked for like 45 minutes. And she took time. I was worried about the time, I was like, "I know you are busy"—"Oh, no" she said—and it was a great experience. (Patient Laura)

When this nurse approached Laura in search of understanding what she patient was experiencing at that moment, the nurse had little idea what response, if any, would be required. In this situation, the nurse enacted the encounter because the patient looked as though she had something she needed to say. The nurse anticipated an incidental encounter, but the nurse needed to be open to the prospect of a more committed exchange. Because of the noticing, the moment changed to one where time was taken; the encounter changed from a temporally situated moment of "now" to a blended experience of time past and time future. In another situation, I observed a nurse respond to a patient who was skipping down the hall, verbalizing loudly in a child-like manner. The nurse, who was standing at the nurses' desk, and was not the patient's assigned nurse, said, "You're speaking really loudly, Mimi, what's going on?" When the patient responded in a manner that suggested she was experiencing disorganized thinking, the

nurse followed the patient down the hall and engaged in further conversation with the patient that lasted at least five minutes. At the end of the conversation, the patient and the nurse agreed that the patient should stay in her bedroom for 1/2 hour. Once the nurse decided to verbalize her impression of the patient's behaviour, she committed to moving toward the patient and discerning the patient's current experience. Once the patient's inner experience was revealed, the nurse's understanding of her own moral requirement to act in the face of the patient's disorganization, the encounter shifted from brief and incidental to extended and engaged, and in doing so, the meaning of the relational experience changed.

Seeking: Uncovering. In an engaged encounter, nurses and patients moved toward each other to expose a concern; I have named this experience "uncovering". In this inquiry, I observed patients and nurses intimately sharing a relational space where patients" concerns were revealed. In the following anecdote, a patient described how she both recognized and valued the process of uncovering.

> At first I didn't realize, "God, this is great, I'm getting along with all these nurses who love to talk and chat." I didn't realize that it was therapeutic and therapy. How easy is that? It made it such a pleasure to talk about these things that you don't want to talk about, because it just comes up…it puts you at ease, and it's not a trick. It's sincere. (Patient Marta)

Uncovering suggests more than removing a covering; it suggests a revelation in which something previously hidden is exposed to the light and understood. For example, Nurse Laura stated, "she's doing the talking, I'm doing the listening…I recognized that these things were particularly troublesome for her." It was not sufficient for patients to expose

a concern; the nurse needed to be open to the other's viewpoint, commit to understanding its significance, and act in recognition of its truth value, so that the patient and nurse could share the understanding. A nurse stated,

> (A patient) screaming at me was actually a good thing because I recognized that was just her anger…She noticed how her mood fluctuated there. I said, "that's been happening a lot and it must be very distressing for you." (Nurse Samantha)

I was surprised when Marta characterized her initial formal meetings with nurses as social encounters. Even though I understood how a young, gregarious woman like Marta might derive social meaning from relationships with nurses who were mostly female, it seemed to me that the social context of the unit would do little to sustain that interpretation. I came to understand that for Marta, her initial evaluation of encounters with nurses were so distinct from that which she had experienced with psychiatrists, that she had few social references to help her understand nurses" relational practices. She stated, "I like that method much preferred to the doctor and the big chair with a notepad scribbling down, not making eye contact with you while you talk." This patient reported that she placed an extremely high value on the expressions contained in a person's eyes; in this patient's experience, the psychiatrist was an inquisitor who rarely met her gaze. The patient was uneasy in that situation, because one of her highly valued ways of connecting with another person was blocked. Just as significantly, she learned that therapy (involving revelations of suffering) was enacted with a powerful, disengaged other. She did not recognize the nurse-patient encounter as therapeutic until she began revealing her experiences and learned to interpret and name her distress in conversation with nurses. Marta further illuminated the notion of uncovering as an engaged, relational

nursing practice by noting that in uncovering, nurses behaved in a "genuine" manner, with no "tricks", Marta experienced confirmation that she was a person worthy of dignity and respect.

In the following story, Charles described a complex and layered series of interactions with a patient.

> We have this gentleman. He's extremely agitated and has a lot of rumination. We were having a hard time and the doctor at one point decided that's it, we're going to put him in the dining room and he's got to stay there and eat. Well the whole thing backfired on us and he wouldn't eat...We went back to the doctor and said let's put him back in his room, let's make that connection first, let me bring him the tray, let's slowly build this rapport and then we'll transfer him slowly....He's still doing heavy ruminating, he doesn't want to get out there, but at some point we had to be clear and decisive with him; "that's it, you're getting dressed, let's go, you are going to sit down, you have to sit there for an hour." So we decided to go with that part to be a little bit more firm, because if we left him on his own, eventually he would start to develop some bedsores... I was curious to see if he could actually handle it that fast, that quickly. He clamped down and did not touch anything. I was there for one day, off the second day, came back on another day. It was two days and he hadn't touched anything (Nurse Charles).

This patient experienced intense psychological distress, and in providing a constant narrative of physical complaints, one might understand that the patient was expressing his suffering as an "other", a nonetheless embodied other that may have helped the patient distance himself from his suffering. The nurse was confronted with the patient's

objectified self, and responded to the patient's suffering by attempting to force the patient to eat. This focus on the mechanical body, while somewhat consistent with the patient's objectified view of the self, did not merge with the patient's understanding of his physical ailments. The nurse enacted a way of being that reflected the reasoning, values and intention of the professional nurse: a concern for the patient's basic need for nutrition. None of these interactions yielded any resolution of the client's agitation, until the nurse averted his focus from the patient's mechanical body to the personhood of the patient. The nurse and patient created an inter-subjective space where the patient revealed some closely held values and beliefs.

> What happens, I slowly start building a trust bond between us, and as time went, came to find out that he is a very intelligent man, has a university degree, worked in mental health himself for a number of years and ended up studying at post-graduate school. As I started to get him a bit more, someone else did a holistic nursing assessment on him, and I noticed somebody had left a box empty. They did the whole assessment except for the part where there's values, beliefs and so forth, so one day I grabbed that and went into the room with him and we had a nice long conversation....I tend to go with things, sometimes not directly...he trusts me a lot more now, and now if I tell him "OK, now your skin is breaking down, you really have to go now, its breakfast, he's like "No, no, no, I can't, my neck, my neck, my neck." He goes back to this ruminating thing that he does, but he still follows me, he dressed by himself, and he followed me down. (Nurse Charles)

In this encounter, Charles did not abandon the values through which he had initially evaluated the situation; rather, he came to understand them more clearly. He made the transition from a constricted perspective to a more humanistic one, allowing him to more fully understand and value the totality of the patient's experience. In this situation, "uncovering" signified two examples of revealed knowledge: the first, in which the nurse and the patient arrived at a more unified and shared understanding of the patient's suffering, and the second, in which the nurse uncovered a previously tacit understanding of what constituted a more enlightened way of being in relationship, and the potential for connection that had been previously hidden.

A person who is admitted to a psychiatric unit is often experiencing reality in ways that are terrifying to that person. Nurses stated that patients who are experiencing hallucinations and delusions were challenging to engage. Nurse Joy related a conversation with a person who was hallucinating. In the following series of accounts, Joy actively engaged the person in a conversation about specific aspects of his experience and continued to move toward the patient despite the real difficulties in achieving a shared understanding of the person's experience.

> I say, "Tell me what you see. Is it a man, is it a woman? Are you seeing more than one? Do you know these people? Are they familiar with you? What do they talk to you about?" Most times, they'll say, 'they won't let me tell you what they are saying." I say, "Fine, Ok, is it a man's voice? Is that you when he says those things or she says those things? He says, "Well, yeah. He wants me to kill myself." (Nurse Joy)

Together, Joy and the patient uncovered details of the patient's experience. Joy moved carefully toward the patient. When she asked about the details of the hallucination-based conversation, and the patient explained that he wasn't allowed to tell her what the voices were saying, Joy continued to invite the patient to expose certain dimensions of the experience, while respecting the patient's initial inclination to protect that knowledge. The patient did not withdraw, but continued to share his experience, and Joy continued to expand her understanding. The conversation became even more complex when Joy introduced her own perspective, exposing that which she personally valued, "I don't want you to die and that's why I am here for you." Joy expressed the highest respect for the patient by placing her intentions in the inter-subjective space, where they were accessible to both patient and nurse.

> But at least I am getting inside and I'm also listening to what the voices, what the delusions are. Then down the road I can say ... the person over there, in my eyes, there's no one there, but you see them and that's your brain telling you that it's there. He says, "Go on with you, they're real, they're really there. I say "I don't see them, I really don't. What kind of outfits do they have on?" and he goes into detail. He says, "You don't know me, you don't know my situation." I say, "No I don't, but let's sit down and talk about it, let me get to know you more." To me I am not being the threatening part of the whole thing there, but I want to get into their minds and find out what they are actually thinking. (Nurse Joy)

The patient continued to separate from Joy's intention to know, but Joy's authentic declaration of "not-yet-knowing" was an articulation of the synchrony of the present with

a more knowing future, in which the intimacy of uncovering expressed the careful movement toward the other that is engagement.

In the following story, Nurse Colleen described how the "checking-in" moment was transformed into an "uncovering" moment. Colleen acted on her intuitive understanding of the patient in the moment, as it transformed from "just" talking, to a "feeling" that it would "open up something":

> I was in her room, and each shift I would go in her room and I'd just talk to her. And at one point, I asked the question, feeling that it would open up something, I said, do you trust your parents? We talked about trust. And then from there it went on to her revealing things. So around me it was quiet, it was just her and I in a room, and no interruptions and there was gentleness in the conversation and respectfulness and a real interest and a real caring as well….she was nervous, and very scared. She was scared to death to talk. Talking about abuse is difficult, you know. (Nurse Colleen)

Colleen's intention to uncover the patient's experience of trust in the parental relationship was enacted by entering the patient's physical space and by sensing that the patient's experience could be brought to the foreground. The nurse created a context within which the patient exposed the nexus of her trust experiences and gave meaning to her anxiety. In the wake of that exposure, the patient uncovered more than facts and details of a life lived; she exposed the fear embedded in her life, and in doing so, learned that it mattered, to the nurse and to herself, to heal her suffering. For the nurse, the patient's telling of the story yielded clarity of understanding: "the desperation that I got from her that nobody

was hearing her, her side and her story. I just wanted to take the opportunity to hear from her, how she saw things. When things started unraveling then I had a clear picture".

Nurse Colleen described a situation in which she seems to be referring to the historical and temporal nature of uncovering:

> I was a prime nurse of somebody that I had spent a lot of time with. Towards the end of admission, that patient did see what kind of cocoon he had built in his life, to cope, that he hadn't seen when he first came in, but when he left he actually didn't do anything about….he hadn't changed many of them. It was just kind of exciting and rewarding to have these conversations where layers unfolded and the person was able to see his life in a way that he didn't see before.
>
> (Nurse Colleen)

The nurse noted that as the admission (days measured in human time) came to an end, the patient came to understand certain aspects of his life experience that preceded hospitalization. The nurse highlighted the revelatory nature of the uncovering and expected that the patient would experience this understanding, as new set of possibilities to be taken up in the future. Significantly, the nurse stated that she had "spent lots of time with him", and in the social practices of nursing, time spent with the patient was highly valued and productive. The nurse did not have any factual knowledge that the patient's hospitalization led to any significant change in his everyday existence, but at the time of our conversation, Colleen's past and present experiences with the patient gave her hope for the patient's future.

Abiding: Presence. Nurses' ways of being with patients are ways of creating connections in order to bring patients' and nurses' experiences closer together. In this inquiry, I noted that at times this proximity seemed to hold no clear purpose other than to commit to a future time when patient and nurse would have more involvement and more complete knowing of the other. Patient Marta expresses the notion of possibility when she said, "I know that I would not be able to have sustained being here as long as I have been if I didn't have that interaction on a daily basis with them. It's just, you know, their being here." Her daily interaction with nurses was something more than a discussion of her feelings, stress and coping experiences, and psychiatric symptoms: it was "their being there". Interactions were valued as evidence of the constancy of nurses, who resolutely directed their attention to patients even when patients might reject such attention. In the following anecdote, Nurse Colleen described a moment in which she presented herself in a fully embodied way, touching the patient carefully and reaching out to the patient through eye contact.

> She would be lying on her bed, looking at me, and me leaning in toward her, maybe even holding her had…like a very, caring, attentive presence about me, to make her feel safe enough to talk. I was probably leaning forward, looking right in her eyes, looking right at her, and trying to have a gentle expression about myself and maybe hold her arm at one hand, at one time, and then not at another. (Nurse Colleen)

The nurse projected a "gentle expression", attempting to present herself as undemanding yet concerned, and sought direct eye contact, communicating a desire to connect. In this

moment, the nurse and the patient did not yet know each other, but the nurse created an awareness of her way of being, inviting the patient to approach when she was ready.

The experience of presence seemed to be related to the idea of a patient's feeling of safety. One nurse talked about being "completely there in the moment" and directing "the conversation appropriately in such a way that they feel safe". The nurse described something more than just being physically present; the nurse expressed her existence in that moment in a more integrated way, "really thinking and connecting", and fully aware of her professional values: "have the wisdom that, with that, you don't get too connected or that…you have to make sure you are appropriate". The nurse understood "presence" as a skilled practice, an authentic way of being as a nurse, and an action that created a sense of security for the patient, which opened up possibilities for shared understanding in the future.

In relating the following, Nurse Charles described "presence and calmness" as a way of being that supported another action. In this situation, the nurse was trying to engage with a person who was angry. In my observations I noted that most patients who were agitated were not invited into an interview room for conversation and intervention, but either asked to return to their bedroom or escorted to the seclusion room. Unusually, this nurse understood that if he met the patient, accepted the patient's current agitated state, and did not leave the patient when confronted with agitated behaviour, the patient would come to allow the nurse to offer more structured feedback. In this situation, presence created a possibility for an engaged encounter, and the nurse and patient entered into that experience very quickly.

> Even if they want to throw the chair around a little bit, if they kick the chair, (I) stay nice and calm. Often just the fact that you're able to keep that presence and that calmness, you see them de-escalating by themselves without too much of an effort on your part. Sometimes a bit of guidance, you know, some verbal guidance. (Nurse Charles)

The nurse linked presence to calmness; this nurse understood that in his practice, inner calmness created a capacity to respond to the person intelligently and effectively. By accepting a way of being in which he was present and calm, the nurse was able to grasp the meaning of the situation for the patient, and affirmed the patient's agency when he allowed for the possibility that the patient would calm himself.

A nurse expressed presence as "sitting and listening". The power of presence, rather than responding with empathy or offering some other kind of intervention was illuminated in her anecdote:

> I have a client right now...when he came in initially he was sort of rocking back and forth on his bed and had somatic obsessions regarding his neck and his neck sort of drooping down and his head falling forward and his eyes turning in on him and really we couldn't have a two way conversation…because he was ruminating and he was just very repetitive in rocking back and forth…and he was severely agitated...whenever we would say, "Oh, I recognize that you are agitated", he didn't agree with you. "This isn't agitation, this is a medical problem, I need an X-ray", that sort of thing. By sitting with him and listening, he really did appreciate that. We were eventually able to have a two-way conversation. (Nurse Samantha)

The patient did not accept her offering of empathy, perhaps because it was not consistent with his conscious perspective of illness. Samantha understood that in the patient's rejection of her interpretation, she needed to establish herself as one who was involved, and who was, first and foremost, interested and committed to more than mere involvement. Perhaps this patient took Samantha's constancy as evidence of that commitment, and was able to develop an understanding that there was a possibility his suffering could be relieved, and that possibility was situated in a more engaged relationship. I also discovered this idea in a nurse's perspective of a patient's experience:

> Can you imagine being trapped and these voices are telling you to kill yourself or to harm somebody...inside you know it's wrong, but these voices are torturing you and telling you those things. It calms him down a bit, "Hey, finally, I am being heard". Yes, they still may need a PRN because of the voices and that, and there still might be a little anxiety up there, but somebody listened. (Nurse Joy)

Joy's projected understanding of the experience of the patient revealed that she valued being with the patient more than any standard measure of treatment outcome. This nurse characterized presence as "listening", which implied moving toward and taking in the essential experience of the other. Despite the fact that hallucinations and anxiety were standard targets for intervention, and they may not have been eradicated, Joy placed a value on being with the person suffering these symptoms, not so much to increase the possibility of cure, but to create the possibility that the person would learn his own worth in relationship with Joy and other nurses.

The temporal nature of presence was articulated by a patient's description of the difference between her comfort interacting with nurses when and her comfort interacting with psychiatrists.

> I would be more comfortable talking to my nurse (rather than psychiatrist) because they see the big picture, like I may only see my psychiatrist for once or twice during the course of the day, whereas I'm with my nurse all day long. They might not put as much relevance to some stupid statement; they're going to take what they see all day. (Patient Laura)

While it would have been easy to assume that the everyday realities of social roles and perceptions of power may have accounted for the patient's perspective, this patient identifies the ongoing presence of nurses as important. Nurses were present with the patient over chronological time and this passage of time created more possibilities for authentic knowing. This patient sensed their interest and commitment throughout the day; an expressed thought in a moment of time became only one of many expressions of interest. Nurses' presence created an ongoing sense of safety in relationship, and presence was not one moment of knowing, but many moments of knowing.

Abiding: Friending. I learned that many patients sought and valued experiences in which their identities as patients receded to the background and their identities as persons came to the foreground. Many patients enacted these relational encounters as friendships. A person who meets another in friendship holds certain private understandings of the other and the expected nature of the encounter; the rules for sharing these private understandings are governed by the history and nature of the friendship, the time and place of meeting, and prevailing socio-cultural norms. In friendship, each

person possesses a genuinely warm and affirming attitude toward the other. Friendships transcend the immediate context of the encounter; friendships endure. I created the term "friending" to illustrate that patients interpreted these encounters as friendship-like, that is, they possessed many of the qualities of friendship. The term helps to illuminate the enormous value that patients place on the qualities of friendship in the nurse-patient encounter.

A patient recounted an experience in which the nurse intervened in a supportive way to prevent her from taking an ill-advised action:

> I was going to make a decision to call someone that wouldn't have been in my best interests because of my heightened emotions and my mania, and everything because I was manic and depressed and angry at the same time. I told her what I was going to do, and she totally talked me down... I said thank you very much for preventing me from making a mistake...she was quick-thinking, she knew enough about me, it was good, as it was supposed to be...it wasn't intimate, it wasn't a big secret, I just came out of my room flailing and freaking out and she dealt with it...and it was appropriate and it was awesome...I didn't have to teach somebody...they don't have to sit there and learn about me. (Patient Marie)

When Marie first shared this experience with me, I interpreted it to mean that the nurse had skillfully enacted her professional role. I reflected further on the anecdote, and the phrases "it wasn't intimate, it wasn't a big secret", "I didn't have to teach somebody…they don't have to sit there and learn about me" eventually revealed a different meaning. To Marie, this encounter did not resemble a professional encounter. The exchange took place in a public area of the unit, and the nurse did not take her to an

interviewing room to have a discrete and private interaction. There was no requirement to interpret or reflect. To Marie, the encounter was free of the burden of having to explain herself, and therefore she was free to be herself. She had not sought out the nurse's support. In Marie's view, the nurse based her actions on what she knew about Marie, but she did so without seeking a particular result. Further, Marie interpreted the nurse's action as spontaneous and altruistic, and not governed by a plan of care or psychiatrist's orders.

In the following account, Patient Marta stated that the perspectives of nurses were more than helpful: they were "the most important thing". Further, the patient characterized this "important thing" as a "friendship":

> The most important thing for me really has been the perspective that I get from the nurses…there is a friendship there, a genuine, sincere interest in your well-being. (Patient Marta)

Marta understood her nurses to be "genuine" and "sincere"; she directly associated these qualities with friendship, and not with a nurse's professional way of being. Her interpretation suggested that Marta attributed nurses' intention to be helpful as friendship-like, rather than nurse-like. She continued:

> I just felt that the gestures and talks that we've had, they were distinctly made for me…One of the nurses brought me some Vim and a sponge so that I can like, totally clean like I would at home, and it was so sweet, so thoughtful of her to do that. Also, brought me in books or things that I can talk to them about, just interests, like hobbies or something like that…pick out articles or relevant books that would just be of interest to me. (Patient Marta)

The nurse recognized Marta's discomfort with her physical environment and brought her cleaning materials. To Marta, the nurse took this action because the nurse had taken time to understand Marta's needs in a way that was different from how a nurse normally understood a patient. The nurse brought the patient books from home: not books about stress, coping, or mental illness, but books about general life interests. Marta understood these encounters as person-to-person, not nurse-to-patient; temporarily stripped of her identity as patient, she temporarily stripped the nurse of her professional identity, and experienced her as a friend. Similarly, another patient gave an account in which she articulated the significance of an encounter with one nurse in particular:

> The male nurse, when we tormented each other in the hall, that was more of a joke. I felt more connected with that joke than anything I was connected with here. He's a happy-go-lucky person and that's what I like; down to earth…you can always tell, the ones that can joke, will take a joke and go along with it right?...you know, it's just something that we have that it makes you laugh. (Patient Elsie)

For Elsie, being able to engage in light-hearted verbal exchanges with a nurse helped to build a meaningful connection with that nurse. While Elsie reported a general disengagement with this nurse and other nurses, she came to regard her friendship-like relationship with this nurse as one of her most significant relationships in the current hospitalization. She was unable to articulate the precise relational practice that brought her to interpret the experience in this way, but she hinted at its idiosyncratic, almost supernatural quality when she said, "It's just something that we have…"

The theme of engagement helps us understand that as nurses and patients move toward each other and sense the nature of the other, conscious knowing of the other moves to the foreground of awareness. In some experiences, patients and nurses are able to reveal their perspectives and intentions, recognize compatible interests, and create a shared and enduring understanding. In other experiences, nurses and patients appeared to meet in a relational space where potential for knowing was not yet fulfilled, but not yet discounted; likewise, the potential for intimacy and common purpose existed, but was not yet actualized.

Withdrawal

I didn't want to be talking to every nurse, because then things get messed up, and they do, because one nurse can interpret it that way but this nurse can interpret it that way. (Patient Elsie)

It is easy to contemplate the relational practices of nurses and patients engaging with one another. As a nurse, I have worked with hundreds of patients over the years, and I have observed my colleagues work with hundreds more. Nurses and patients seem to move toward each other in search of an engaged relationship as naturally as old friends rush toward each other in greeting after a long absence. In the words of Benner (1994), "nursing has earned the right to understand itself as a caring profession" (p.141). In my own experience, and in this inquiry, I have learned that for some nurses and patients, engagement is difficult to achieve. The connection becomes frayed and the link becomes broken, or nurse and patient never make the connection at all.

Taylor (1995) stated, "Our perception of the world is essentially that of an embodied agent, engaged with or at grips with the world" (p.23). While Taylor's words

point us toward much more than the experience of patients and nurses in relationship, it is reasonable to understand that an engaged relationship is a knowing relationship. The following excerpt illuminates this point. A patient used language that showed me that she understood that each nurse could interpret her words and behaviour in a unique way. She understood that mental health nurses did more than observe; they interpreted, and in her view, interpretation presented some risk:

> I said, don't be sending every nurse to me because every nurse is gonna go writing them notes, a different interpretation... I didn't want another nurse, because that happened, right, I had one nurse, then another nurse come, and I said "OK, here we go". Everybody's going to get my thought process mixed up and like everybody interprets things their way... (Patient Elsie)

For Elsie, having many informal and incidental encounters with many nurses rather than just one nurse over a period of time made it difficult for her to make herself understood. Many nurses created multiple possible interpretations, which Elsie characterized as nurses getting things "messed up". There is a sense in Elsie's language that she experienced little engagement with individual nurses, and that she had to work hard to ensure that she was being understood in the way she wanted to be. In conversation with this patient, I had noted that she expected little of nurses, because she always expected to be misunderstood, or misinterpreted:

> If someone misinterprets me, I'll know. Because I can say things the wrong way, not meaning it to come out that way and if someone takes it the wrong way and it comes off as an issue, I don't like that type of behavior. I just think you are off, you know. (Patient Elsie)

Elsie was not arguing that she was healthy, wrongfully hospitalized a victim of being misunderstood. She was humble in her self-appraisal, noting that she "can say things the wrong way". Because of her vulnerabilities, she valued nurses who sought to understand her, whom she could trust to get it right. Elsie's viewpoint shifted little during her hospitalization experience; her relationships with nurses were always, she maintained, somewhat detached. Understanding that nurses always "messed up" in their assessment of her, she withdrew to a less engaged, perhaps more superficial relational space.

Even a relationship that a patient and nurse would understand to be an engaged relationship, a patient expressed frustration with a nurse's apparent unknowing. A patient described a situation in which in which nurses failed to understand her:

> When I first came in here, I was extremely raw about what I was coping with and it didn't feel good to have somebody kind of tell me, it was intimidating to have somebody tell me what was wrong with me or say they understood when they weren't really listening. Even though it was true…I'm sick of hearing I'm textbook. (Patient Marta)

Marta was not dismissing the accuracy of clinical labels, but she clearly disliked them, firstly because nurses seemed to be "not listening" and secondly because she interpreted nurses' labeling practices as discounting her lived experience. For Marta, it was one thing to be ignored and another to be misunderstood. This gap in understanding seemed to move in both directions, as Marta described how her perception of the nurse in an encounter was strongly linked to how well she could understand the message, communicated and sensed in a fully embodied way:

> I have a harder time interacting with somebody that I can't read. I understand that a person who offers psychiatric counseling and that kind of stuff, you know they're supposed to be non-judgmental, but I gauge a lot of how much I can say with somebody based on how they're reacting to me. I read body language and if I feel that they look like they're rushed or they're not interested or that they're judging me then of course I am going to clam up…it's more comfortable to have somebody nodding and smiling than the blank face, cause I take that as criticism or judgment. (Patient Marta)

Just as nurses often expressed frustration with patients who were non-communicative, Marta identified the difficulties of non-expressiveness in nurses. Although Marta understood that a nurse's clinical role could explain a lack of emotional expression, when Marta was unable to read the "blank face", she interpreted the nurses" expression as a sign of non-approval. In these types of encounters, Marta would fill in the "blanks" with her own self-understanding; neither she nor the nurse made any movement toward the other, and neither uncovered any new understanding. Neither *knew* the other.

The person not seen. Nurses articulated relational withdrawal in a variety of ways. One particular way of unknowing came forward as nurses referred to *countertransference* in their relational practice. Emerging from Freud's psychoanalytic theory, countertransference in nursing has come to be "an umbrella term for a wide range of feelings" experienced by a nurse toward a patient (Ens, 1998, p.279), and it has been said to create "circular dissonance between a nurse and a patient" (Ens, p. 279). The experience that nurses identified as countertransference seemed to help them interpret their reactions to patients, when such reactions were, at first, little understood and where

they struggled to engage with patients. Nurses variously experienced countertransference feelings as "difficult", "a barrier", "not doing a good job". Nurse Hilary identified countertransference as something to be noticed, to be brought into the foreground, because if it were not, she would not be able to understand the patient: "Even though we watch for countertransference, maybe they've reminded me of someone in my past, where I'll say, "I know what YOU are like"." In labeling the countertransference experience, she sensed the potential for an inauthentic encounter, whereby she would have responded to the patient as if the patient were another person, previously known by the nurse. In this kind of encounter, the nurse would not know the patient. The nurse would be physically present with her patient but connection would be fragmentary, and shared understandings would be few. Hilary qualified these experiences as unsatisfactory and unintentional, but at the same time, she characterized them as common.

Similarly, Nurse Charles accepted (counter) transference as "normal" and I came to understand that most of his colleagues consciously acknowledged the potential for this kind of experience in relational practice. Usually in the background of Charles' relationships with patients, it was very much foreground in certain circumstances, and when it entered his awareness it required conscious articulation and special attention. Charles related his experience with (counter) transference:

> There was a young male on the floor and a much older female. The young male was completely incompetent at this point, first episode psychosis and the female is competent, fifty or close to fifty, much older, and she kind of lured him from what I found out, into going over to the shower with the door open to come in. We've had this whole things where obviously I've had this duty, most nurses, we

> have this, but I could see my own children and if that would actually happen to my own kids, so at one point I might have had a little bit more transference than normal. (Nurse Charles)

Charles qualified pre-determined clinical assessments: competent became "very much" competent and incompetent became "completely" incompetent. In this set of encounters, Charles oriented himself to protecting the younger patient as if he were Charles' child, and setting limits on the older patient as if she were a sexual predator. In situating himself as a parent, the younger patient was situated as his child; but he was not his child. Charles enactment of his nursing "duty" protected the young patient from harm but his counter-transference experience, not conscious to him at the time, created a place of unknowing that lingered even after the experience became conscious.

The following anecdote provides another illustration of the patient not seen, but from the perspective of a patient. Laura recounted her experience with a nurse in which she felt as if she were invisible:

> Last night I wanted my meds at 8:30 because I was tired and wanted to go to bed. She said it was too early…I am tired. I was ready to go to bed. I want to be able to get up at a half decent time. The nurse was chitchatting in her nursing station and it would only have taken two seconds for me to get my meds and go to bed...Just two pills, blue and yellow. I would have taken them and went right off to bed and she could have gone back to chat. I stood there and waited for like 10 minutes, and it was the security guard who said "somebody is waiting patiently for you." (Patient Laura)

In this encounter, Laura was quite literally the "person not seen". Laura sensed that the nurse was actively ignoring her for reasons that she did not understand. The nurse knew the patient was waiting for her medication but she placed little value on the patient's request. In Laura's experience, the nurse not only ignored her request but she did not understand her request. The nurse did not explore the reason why Laura had asked for her bedtime medication, and Laura had struggled to find an opportunity to explain. After failing to be acknowledged by the nurse, Laura sensed that the nurse had little regard for her as a person, and that the nurse did not understand her need or her suffering. Later, after reflecting on her own anger, Laura rejected the nurse's action, considering it to be incongruent with reasonable expectations for nursing practice, and was able to uncover what really mattered to her: a determination to ensure that the incident would never recur. Laura made sure that the nurse would never care for her again; she and the nurse remained disengaged, and had few encounters.

No room. When a nurse struggled to move toward the patient, and the patient withdrew from the nurse, the nurse was unable to uncover critical meanings emerging from the encounter. Struggling to make sense of patient behaviour, some nurses called forward traditional nursing practices to bring the patient closer. These traditional nursing practices involved carefully formulated verbal responses and reassurance. A nurse described an encounter in which the patient's emotional state seemed to create a barrier, a kind of relational "no fly zone", and the potential for engagement diminished with each attempt to move forward.

> Angry personality disorders are difficult…you can't really get through. I can remember this person was admitted and very angry…I can remember trying hard

> to watch what I said to this person, but kind of screwing up at the same time. Like I should have used fewer words than I did. I can't quite remember what I said, but I felt like I didn't do as good a job as I could have. Maybe some hooks, some comments were put out that I should have completely left alone, but maybe I was trying to reassure the patient. It's like getting involved with a few comments that I should have completely ignored, and just said one or two words that I had to say and left, that's what I should have done. The barrier was the patient, there was no room for me to do any good in that situation, the patient was very angry at the circumstances. (Nurse Colleen)

Colleen evaluated herself harshly in this situation. She clearly intended to "do good" in this situation, despite the patient's emotional intensity. She attempted to enact what she understood to be her moral responsibility. This nurse continued, however, to interpret the encounter beyond the actual moment in which she had experienced it. In ongoing personal reflection, even before her conversation with me, its meaning became clearer. As she concluded that there had been "no room to do good", the nurse recognized the disengaged nature of the encounter, her inability to move toward the patient, and ultimately, the mystery of the patient's experience.

Colleen perceived a disengaged relationship, prompted by barriers created by the patient.

In the following story, a nurse recounts her discomfort with the possibility of an engaged relationship with a person who she had known outside of the professional context.

> I have known this particular patient for several years…I was surprised when I came to work yesterday to see that she was a patient...I don't ever want to have

> her as a patient, I think I am going to make that clear. I have a boat and this patient used to spend a lot of time down at the wharf and the first time I realized that she was there, I was outside the boat and she came along and you know just talking that she never came on the boat but she was always sort of, she was there a lot. Sometimes when I'd see her coming I'd go inside, you know. I got the feeling that she was seeing me more as a friend or somebody, not a nurse, but just an ordinary person and then you come to work and have this person as a patient, there's that conflict that you just can't have. It's uncomfortable. She keeps coming to me if she's having any problems and she keeps coming to me and I keep saying you'll have to go, I'll let your nurse know about that or you better tell your nurse about that. I feel like she feels I'm not paying much attention to her. And it's not the type of thing where you can sit down and say "really look we have a problem", I can t explain it to her, you know because she is a patient. She's only just come here two days ago and she's ill and she's not ready to cope with any kind of discussion like that...you keep your distance, your psychological distance. (Nurse Lydia)

Lydia was the person who avoided any kind of intimacy; Lydia established the barriers. Lydia anticipated encounters with this patient that would challenge Lydia's ability to respond within the social matrix of nursing action. By articulating that she kept a "psychological distance", she seemed to imply that she could act just as responsibly by maintaining physical proximity. This assertion seemed to contradict her earlier account of telling the patient to "go" away whenever the patient approached her on the unit. In this situation, the "conflict" referred to by the nurse is just as much a conflict within her

own expectations of herself as it is the patient's expectations of her. The nurse uncovered no understanding of the situation that would allow her to reconcile the conflict, and the relationship remained distant and unengaged. I did not have the opportunity to ask the patient any questions about the relationship, but when faced with repeated rebuffs from Lydia, the patient stopped approaching. This nurse withdrew from other kinds of encounters as well. She explained, "I find the people I shy away from or am really nervous to work with are usually people who are experiencing a manic episode, hypo-manic, irritable. I don't want to push any buttons". In these situations, Lydia perceived these patients to be unpredictable and potentially threatening; Lydia valued a relational space without conflict and emotional intensity. Lydia's fear of "pushing buttons" revealed her fear of initiating emotionally-laden discourse. After this conversation, I contemplated the possibility of relational experiences so filled with the projections of the nurse or the patient, that there could be no room to create shared experience, or uncover shared meaning.

Absence. A relational space crowded with the projections of either nurse or patient can be contrasted with patients' accounts of unfulfilled relational experiences in the form of the absence of the nurse. At times, a patient experienced an absence of relationship with nurses:

> Last week I didn't know who my nurse was. I knew her by name, but I don't know all the nurses by faces. I mean, I am a frequent flyer, but not that frequent. I didn't know who she was until 2 o'clock when she came at me with clonazepam. I didn't know who she was. It is not enough for her to know me. It's not enough. What if I was freakin' out? What if I am having a panic attack? Who will I go

> to? It's unsafe. I didn't feel safe...It takes two seconds to poke your head in and say "I am your nurse". My world could have fallen apart around me and I would have found somebody else...I feel like a nuisance, and I feel like I am being ignored. I think, well, I could sit at home and be ignored. (Patient Laura)

Laura was acutely aware that as a patient with a severe mental disorder on a psychiatric unit, there would be moments in time when she would need to engage with a nurse. She understood the potential for experiencing illness-related anxiety and distress, and could not rely on her nurse's knowingness or expertise to support her in those painful moments. Because her nurse did not identify herself, Laura experienced much uncertainty and interpreted the nurse's absence as passive disinterest or active disparagement; she stated, "It's dignity and respect and it's a two way street". Because she experienced disregard from her nurse, Laura's self-worth suffered a blow, and withdrew her respect for the nurse. Instead of moving toward each other, they moved apart, and remnants of that day's experience endured throughout Laura's hospitalization. Although Laura later recounted moments of engaged relationship, she learned that nursing support and nursing presence were inconstant features of this hospitalization, and that while she tried to convince herself that she didn't deserve to be abandoned, she found it difficult to shake the feeling that her nurse did not find her to be worthy of care.

Patient Elsie also recounted her experience of absent nurses, although to Elsie, nurses' absence meant something quite different than Laura's experience had meant to her:

> Nurses really never had a lot of time with me. Since I've been in here, I haven't really sat with any number of nurses. I think that they spend more time with the

> patients who really have to have it…they have to spend time with the ones who are talking up their time. See, I'm not taking up their time. (Patient Elsie)

While Laura interpreted her nurse's absence to mean that she was personally unworthy of care, Elsie articulated the view that nurses "spend more time with patients who really have to have it". In other words, she read nurses' absence as a commentary on her general self-sufficiency; she did not need constant attention. As I considered Elsie's experience more closely, it became clear to me that there were certain aspects of her illness that may have supported her need for distance: she was generally suspicious of intense inquiry and she had few family members and friends with whom she shared her intimate concerns. That being said, in order to understand Elsie's perspective, it is useful to understand that Elsie had a psychotic illness, and while her basic self-care abilities required little nursing support, she was certainly a patient who, in the view of most professionals, temporary required hospitalization and nursing care. She qualified nurses' apparent disinterest as a function of role overload:

> When I go for my medication or something, you and I can see that they're trying to do something else and they can't do two things at the same time. So I would wait. But my nurses always seem to be busy. They're never there…I am not one of the ones that need full attention. (Patient Elsie)

My conversations with Elsie revealed that her relationships with nurses were primarily instrumental (for example, medication administration or activity regulation) and superficial. Elsie did not actively seek an extensive type of engagement with individual nurses; by virtue of her own self-appraisal, she did not require it. On the other hand, nurses did not seek to engage with Elsie. Nurses knew Elsie only by what was revealed

to them through a distanced vantage point, and Elsie's ability to safely and competently meet her basic needs in her day-to-day world did not compel nurses to move closer to gain a clearer understanding. Having interpreted her relationships with nurses as being unrelated to her own self-worth, Elsie herself expressed satisfaction with this distance, but the absence of nurses removed any possibility of learning more about Elsie or helping Elsie learn more about herself.

The theme of absence also emerged from an experience that Patient Laura recounted. Laura knew that nurses had been assigned to care for her, but she found it difficult to connect with any of them because of her mental status. She stated:

> I wish we had one or two nurses that were ours and that we knew…It is confusing for me. There are so many staff, and so many shifts. They work 12 hour days, and they have a couple of days on, and a couple of days off, and the new ones come in and you have never seen them before, and that can be confusing...my head isn't 100% clear yet...it would be less confusing for me if it was the same faces every day. (Patient Laura)

Laura understood that in the inpatient setting, many nurses would be assigned to care for her. For Laura, encounters with these nurses became part of the ever-changing and confusing background noise of the inpatient unit. Laura yearned for more satisfying encounters in which she could confidently interpret nurses' intentions and develop a clearer understanding of her own situation. In Laura's experience, only one nurse had been able to emerge from the background noise and help Laura organize her thoughts and feel safe in her environment, but this nurse had been rarely on duty. Perhaps because she was cognitively disorganized, Laura was unable to interpret the actions of most nurses as

relevant to her own needs, and experienced these encounters as confusing, not helpful, and distant.

Both nurses and patients recounted moments in which one or the other considered it almost impossible to know the other in any kind of intimate way. Nurses often characterized this non-engagement as countertransference, using knowledge from the discipline of psychiatry as a framework for interpreting the experience. Patients gave accounts in which they were unable to approach nurses, understand them clearly, or make themselves understood. In all of these experiences, the possibility of mutual knowing was either hidden by complicated layers of misunderstanding, or left undeveloped due to ongoing relational distance.

Mindful Approach

"There is a certain kind of conscious outreach, it's often, "What does that mean for you?" (Nurse Charles)

While contemporary nursing wisdom holds that a key focus of nursing practice is the development of a nurse-patient relationship, PMH nurses seem to have a unique view of the possibilities of such a relationship. While it is true that like almost all nurses, PMH nurses attend to patients' corporal needs, these nurses most frequently engage patients in discourse emerging from the patient's psychosocial experiences, and do so in a manner that encourages and values patients' willingness to work, authenticity and openness. I observed that nurses created encounters that helped patients focus on assigning meaning to their feelings and behaviours that prevented healthy living, or their unacknowledged areas of strength. I assigned the label "mindful approach" to this kind of discourse. To be mindful is to "take thought or care", to be "heedful"; a more ancient

definition is to be "intending or inclined to do something" (Oxford University Press, 2010). Within the theme of mindful approach, I identified three sub-themes: "the frontline", "the common ground", and "the shift".

The frontline. Nurses who work in inpatient psychiatry are immersed in a culture that has been highly stigmatized by its association with centuries of inhumane treatment of the mentally ill and a modern society in which people with severe and persistent mental illness struggle for access to timely treatment, supportive housing, and sustained improvement in quality of life. A prominent component of the stigma of mental illness is its supposed association with unpredictable and violent behaviour. In this inquiry, I learned that for nurses attempting to engage in mindful approach, patient unpredictability and threat of violence posed constant challenges. Both nurses and patients reported that there were incidents of violent behavior. As a participant-observer on the unit, I saw no physical violence, but on several occasions I observed patients experiencing severe anxiety and escalating anger. These experiences were an example of non-violent conflict that could escalate into violence if left unexplored. I noted that these conflicts could arise early in the relationship, when neither nurse nor patient understood the expectations of the other, or later in the relationship, when nurses and patients were unable to maintain any sense of common goal or common understanding. I understood conflict between the nurse and the patient as expression of differences in understanding that were yet to be reconciled, but that needed to be reconciled before patient and nurse could work relationally. I employed the metaphor of the frontline to signify these experiences. A frontline is a place where advancing parties meet; it is a place of courage

and confrontation. Above all, a frontline is a place of possibilities, where each party meets the other halfway, and conflicts eventually dissipate.

In the following anecdote, a nurse recounts a frontline experience that occurred early in a relationship.

> One patient who was very highly educated, fairly wealthy background, and his attitude was "I don't need to be here"...I went in to relate to this person, and I'm just a nurse on board so he didn't really want to have anything to do with me other than get me this, get me that, do this, do that. I stopped him for a moment and I said, "OK, listen, sit down, this is what I'm here for, this is my role as a nurse, to help you out here, but you have to work with me too". So we talked and I didn't sit with him, I sat where we were eye to eye, I didn't stand above him, I didn't. So I sat in a relaxed manner and just said, "Let's get together, I can get to know you better and you can get to know me too, so we can work." (Nurse Diane)

This anecdote illustrated a conflict in which the patient attempted to establish himself in a position of control wherein the nurse would respond to his demands without demur. The nurse's intention was to engage, but the patient's understanding of the nurse's role or his need to express his status meant that there was little shared understanding. Initially, the patient did not get that the nurse was there to "relate", perhaps because he did not understand the nurse to be the clinician who would adopt that role. The nurse consciously used her body to communicate the value of power-sharing, and chose language that invited the patient into a mutual exchange ("you can get to know me too").

Nurse Deborah gave an account of another experience that characterizes the notion of the frontline. Because Nurse Deborah does not work full time on the nursing unit, she often situated herself as a both a nurse and a stranger. In the following encounter, a patient approached Deborah, who was standing behind the nursing desk, to make a simple request:

> I had a man ask me a question this morning, he, said, "Can you check in the book and see when plastics is coming to see me. I said, "Yes, and I'll get back to you on that, and I checked the appointment, there wasn't any. I personally felt it was something fictitious or maybe not fictitious but something that, you know, they just wanted you to work for them, to get you to run for them, and have possibly asked this question of somebody else and already had the answer to this question...I knew that I had to be matter-of-fact and right to the point...From the report I got he was quite a menace around the nursing station, and obnoxious, I guess, some people were saying at report…I was glad to be aware of that because had I not, then, I knew the possibility for him becoming obnoxious or irritable could be quite great. (Nurse Deborah)

Initially, Deborah knew the patient only as other nurses had come to know him: as a person who could become "obnoxious or irritable". As she and the patient participated in the exchange, the nurse's preconception of his identity receded into the background, and his current demeanor and demands moved into the foreground. She constructed her response carefully, always mindful of the background material, which cast its shadow over the encounter. As a participant in a frontline exchange, the nurse recognized the potential for unpleasant confrontation, and created a relational space in which the

patient's intentions were sensed but not brought to the foreground. The nurse avoided an intimate, in-depth exchange, in part because of her stranger status, and in part because she did not want to incite conflict.

Patients expressed anger in both words and actions. The nurse in the following situation described an encounter in which the patient was enacting anger in a physical manner. In the face of an escalated risk of physical harm, Nurse Joy attempted to engage the patient by openly communicating care and concern. Joy's response was framed by her understanding that the patient needed to vent his feelings safely, her language was patient-centered, and she did not attempt to situate herself in a position of power. Joy's verbal message communicated her expectations clearly and concisely:

> If the person's really slamming things around, looks like he could be a threat...the first thing I would do is sit with him if I can to explain that I am really concerned about him and how he's going to hurt himself or hurt somebody else... he will kind of settle down and say "OK, all right, I'll listen for a minute"...there's that window to get in. "Ok, let's talk a minute". I only take a few minutes. I don't continue on and on and one, just explain to him that maybe a PRN might help, if he's familiar with one of the medications. "Let's just try that and see. And then maybe another hour or so once the medications calm you down a bit we can sit and talk." (Nurse Joy)

In this encounter, the patient created the space wherein the nurse could move toward him; in other words, the patient declared a temporary truce. The nurse sensed that the patient's temporary receptivity created the possibility of mutual understanding. The nurse gathered all of her background knowledge and awareness of prior similar experiences and

assembled it for the patient, in that moment in time, but still pointing toward future engaged relationship, which she characterized as a time when she and the patient can "sit and talk". Similarly, in the following anecdote, Nurse Joy describes the moment where the patient "starts to stop" by turning his attention toward the nurse so that he can take in the nurse's expectation for the encounter:

> Where I get a chance to have a little more rapport…you gotta sense that. When someone actually starts to stop instead of talking continually and lets me talk, they're actually stopping and when someone stops for that even if it's ten seconds, they're starting to listen...I have to find a window, that quiet moment or pause: "OK, now it's my turn, you've had your turn, give me two minutes". It won't work for most people, not for long, but if we can get that quiet time between the two of us that she is listening to me. (Nurse Joy)

Joy understood that the possibility for this moment was intuitive, initiated by the nurse but only possible if the patient opened a "window" or a "pause", perhaps to allow herself to breathe, reconsider, or listen to the other. Whatever the patient's intention, Joy recognized that she had only a moment to help the person understand the nurse's point of view.

The nurse in the following exchange looked for an opening that would create an opportunity to establish a moment of mutual understanding, but had experienced situations in which that moment was difficult to find:

> There was no break in the conversation for me to get in. It was unleashed anger continually. Venting about anybody that in this patient's life, at that time. How you know that a conversation is going to go anywhere or get anywhere positive is

> if there is an opportunity to speak and if they have stopped and listened for a moment, and then maybe get back to us. But you know you are getting in there. But there is this sense that with certain people, that they won't hear you. (Nurse Diane)

At times, the frontline filled with unanticipated and unknowable enemies. Nurse Samantha recounted an experience in which a patient surprised her with his threatening actions:

> I had my chair in the doorway and he came over the chair to get out of the room because he thought somebody was coming to kill him. I didn't expect that, he just sat right up out of his bed and bolted for the door but I learned I shouldn't have had my chair right in the door. I knew that he had this fear of people coming to kill him and also his wife too, when his wife would come in to visit, he was really worried when she would leave and he would watch her get in the elevator because he thought somebody was going to grab her and kill her. So I should have known not to have my chair totally blocking the door, but I just hadn't thought about it...he came to the point where he recognized me...I was able to redirect him and do some reality orientation...I didn't really know what to do for him at first. (Nurse Samantha).

This experience highlights different qualities of the frontline encounter. This patient experienced hallucinations and delusions, and acted out a scenario that the nurse only partially understood. For Samantha to establish shared meaning with the patient would have required Samantha to uncover the patient's own internal narrative, and in this situation, only a portion of the story had been revealed to clinicians previously. In this

encounter, the potential for de-escalation became apparent when "he came to a point where he recognized me". Either the patient gained awareness and stepped outside of the drama he was experiencing, or he understood the nurse's place in the experience. Samantha's response was to help the patient situate himself and the nurse in the immediate environment and help him shed light on his own fear and rage and the battle was over quickly. Patients, too, experienced unexpected rage that put them into a position of conflict with nurses. Patient Marie stated: "I was agitated and for some reason I picked up the jar of beads and I threw them. I don't know why to this day. I was totally fine...there's the difference." For this patient, her demonstration of rage had consequences that endured beyond the event. The nurse made little attempt to help her understand the meaning of the outburst, and Marie spent two days in seclusion. At the time of our conversations, Marie still did not comprehend the experience, and she had made little progress in working with her nurse in a more engaged manner.

Nurses situated themselves at the frontline even as threats to their personal safety moved from background to foreground. I found it remarkable to listen to the experiences of these nurses who constantly searched for a place and time of connection even when they themselves were experiencing anxiety and fear in response to the patient's anger and threatening behavior:

> You can't show anxiety. You can't show that. Sometimes I can be a little bit "Oh, this person might not listen, maybe I just better back off and get them into TQ now. It's kind of a feeling you get that you know you can't show your anxiety… I would admit there are times that you don't know what they are going to do, so I kind of back off a little bit, but never show and I always have to show

> the professionalism because they will remember that long after they are gone. (Nurse Diane)

In the following anecdote, Nurse Samantha appears to understand that as she senses a threat to her personal safety, she may need to reposition herself in the frontline encounter:

> There is always something going on in the back of my head that's distracting for my nursing interaction with the client...Am I taking this person down the road where they're going to get really agitated, then I'm going to need to act on an emergency basis? (Nurse Samantha)

Even though Samantha valued the emergence of any possibility of common ground, she held her position and reconsidered her approach. Samantha's language points toward the changeability of relational space; here, a value such as personal safety came into the foreground and Samantha questioned the route she was taking. As Samantha reflected on this experience, she noted that one particular contextual factor often played an important role in how she chose to proceed: the presence of a security guard. The security guard was present on the unit at all times and Samantha had discovered that she could often dismiss questions of personal safety because she was no longer enacting the work of a nurse and a security guard:

> Before they were there, if I saw any hint of agitation it would be like "Maybe I will come back later. Would you like a PRN?" Now I can take it further.... With them present or nearby, I can just be a nurse. (Nurse Samantha)

The presence of the security guard was liberating. Samantha was able to change the boundaries of her role so that she could create more possibilities for achieving common understanding: “now I can take it further”.

So far, the nurses in these frontline exchanges have responded in a fully embodied way, by positioning their anxiety-infused bodies in supportive positions and directing their minds toward creating a healing space for possible resolution of the patient’s distress. Nurse Hilary could recall moments of anxiety, but she had learned to merge intuitive knowing with knowing rooted in professional values. Because she perceived the encounter to have an enduring temporality, she worked hard to uncover the possibility of a more engaged relationship in the future. Other nurses recounted experiences in which they were confronted by angry patients and responded in a manner that they later regretted:

> This patient has a propensity for...getting people angry at her, you know, inciting anger. I forget what I said to her, I thought afterwards I could have handled it differently...she made some kind of a remark about me, and I said no, no, no, that’s not true. (Nurse Hilary)

This exchange revealed the complexity of mindful approach. After experiencing the patient’s hostility, the nurse responded intuitively to present her own truth, moving toward the patient in a defensive posture. At the same time, the nurse rejected her own initial interpretation of the exchange, understanding that the patient’s hostility was misdirected and part of a more complex array of patient’s feelings. She adjusted her response to create the possibility of a more authentic exchange, less focused on the patient’s battle tactics and more focused on discovering the patient’s actual need:

> I thought, just let her say it...she needs to vent and even if it isn't true, don't come back with that response because maybe that's what she's looking for to further engage this type of banter. (Nurse Hilary)

In the following confrontation, Nurse Lydia and the patient were unable to find a space where the confrontation could be defused.

> She was saying things like, "Oh, you're so stupid, you are the stupidest nurse I've ever met. Why aren't you dead? I could kill you". This woman was very, very angry; it just really got to me and I thought, how much is too much? I think in psychiatry we are used to a little bit of verbal abuse because nobody wants to be here and they don't think they are ill. So there are those conflicts, right? I think it comes to a point where it is really over the top and you have to sort of say somebody else has got to take this because it's really getting to me…It got to the point where I thought if I don't stop this I'm going to say something that isn't very nice. (Nurse Lydia)

Lydia interpreted the patient's verbal attack as personal, reaching to the core of her self-worth as a nurse. There was no truce; in fact, Lydia needed to create distance in order to prevent herself from launching her own defensive verbal attack. Upon later reflection, Lydia recognized that her response did not conform to her own professional standards; she understood that in the social matrix of nursing practice, nurses do not always act in their own defense:

> We have to maintain this sort of professionalism and sort of blank all this out because it's not real. It is real, but it isn't real in our personal lives...you have to say, this is a person who is ill, this is not a personal attack. (Nurse Lydia)

For Lydia, a nurse who had many years of nursing experience, the frontline was not a place where the personal merged with the professional. She articulated an expectation of herself that she found difficult to enact; she stated that she preferred to create distance between herself and the patient by choosing to "blank all this out". As conversation with Lydia unfolded, I noted that just as Lydia created distance between herself and the patient, she created distance between her personal and professional self: "I've had people say to me, 'I don't know how you could work there, in a place where there's all this violence.' And I don't know either." For Lydia, the struggle to understand the patient in this encounter was as much a conflict within herself as it was a conflict with the other.

In conversations with nurses and patients, I learned that "frontline" relational work resembles a battleground even in the absence of conscious confrontation. Many nurses highly value the kind of formal relational experience that facilitates intense exploration of patients' emotional suffering and helps patients identify pathways to psychological health and healing. Nurses variously labeled these experiences as "one-to-ones" or "talk time", although a few Registered Nurses labeled their work as psychotherapy. Nurse Tim, who viewed much of his relational work as psychodynamic psychotherapy, understood that when patients uncover thoughts and feelings previously hidden, patients often experience anxiety:

> You will see immediately they say, "Gee, you are getting too close"… "I feel like I can talk to you so easily"… the anxiety wells up. I check and make sure, "Where is the anxiety?" I just pull back. Some patients will say "I would like to expose more" and some patients say, "That's enough." (Nurse Tim).

Through his use of language, Tim expressed an understanding of the patient's apparent insecurity, shifting his strategy accordingly. In this experience, both Tim and the patient attuned themselves to the potential harm associated with intimacy and revelation, and moved toward and away from exploring the patient's core feelings. Nurse Colleen used language that illustrated the movement of nurse and patient in this shared relational space: "I push until I get resistance and I stop". Most commonly, it seemed that nurses in the encounter guided this approach and retreat; I understood these nurses to be highly sensitive to the patient's reaction in the moment. Like Tim and Colleen, Nurse Charles created opportunities for intense exploration, and was prepared to see the patient retreat. Charles, who identified himself as a humanist, explained his strategy this way: "There is a certain kind of conscious outreach, it's often, "What does that mean for you?" These nurses understood these kind of relational experiences as being filled with motion; at once a place of possible convergence and a place of disjuncture whereby participants constantly approached, held position, retreated, and encircled.

Common ground. As nurses and patients shared their experiences of formal encounters with each other, it became evident to me that each sought to establish some kind of shared understanding in which each was able to talk about a concern without a constant need to seek clarity, explain one's feelings or defend one's position. While nurses and patients understood this experience differently, each highlighted moments when the shifting frontline of uncovering, confrontation and explanation was replaced by the emergence of a common aim. Patient Laura stated:

> When I talked to my nurse in one of these rooms about (a treatment decision) … she was good and supportive and she was treating me as intelligent. It was a

> connecting conversation, we were engaging and we were on the same page. I didn't feel like an idiot, she was talking to me properly…She was listening to me … and she gave me an intelligent answer back. (Patient Laura)

For Laura, the physical location of this encounter—an interview room—helped to qualify its nature. In these units, encounters between nurses and patients in interview rooms were generally reserved for engaging in ongoing therapeutic work: nurses almost always had specific objectives for "talk time" in an interview room. Patients, too, recognized that interview room encounters carried specific expectations related to active participation and engagement in a therapeutic process. The nurse in this exchange worked with Laura in a way that communicated respect. Any preconception of the expectations associated with a formal encounter receded into the background as Laura experienced a "connecting conversation". Patient Elsie also noted the value of this kind of conversation, "It makes you feel better about yourself that they can relate to what you're going through."

It is reasonable to question the "commonness" of common ground. Is it really possible for nurses and patients to be "on the same page"? How could and patients to create any kind of shared understanding when their worldviews appeared to be so different? Nurse Tim stated, "It comes down to bringing the patient into the room where you are, instead of this psychotic state, so that they actually can start to be grounded in some type of reality." Tim wanted to bring patients into his "room", which suggested to me that he was not trying to find a new place of understanding; he was trying to bring the patient to *his* place of understanding. Tim articulated a very specific intention to "ground" the patient, which suggested to me that he understood the patient to be in need

of a solid connection, a new foundation, but the question remained, did the patient need to abandon his place to find connection? Tim's later conversation helped me understand his perspective more clearly:

> You got to have some kind of shared experience with a patient…he'd already become very defensive around words he felt were derogatory, like psychosis or illness, so I had to try to ease him into that idea…I'll test some words to see which words are going to work so we will not be adversaries that we will have an agreement on which word is going to frame this experience for him, because if I start putting the words on him without him agreeing to the words, then of course it could become a battleground, or it can be lots of interpretations…I had already picked up the fact that psychosis was not going to fit and anxiety was not going to fit and stress was not going to fit. I just tossed it out there (the word disturbance) and I just watch and see what word he will attend to…it has to be a non-threatening word that he can start to get some frame around the experience of coming to hospital. (Nurse Tim)

In this encounter, Tim expressed his understanding of the patient's experience in a tentative and respectful way, recognizing that the patient self-understanding was somewhat blurry and below the surface. Tim invited the patient to consider different truths, and attempted to help the patient to understand more fully a confusing experience. The point here is that Tim and the patient did arrive at a place of shared or common understanding; each adopted the label and both the patient and his nurse were "on the same page". In this situation, Tim created many of conditions for shared understanding, but in the end, both the patient and the nurse arrived at the same place.

Nurse Charles recounted his experience with a patient in which each party uncovered "common ground" in a very different way than the participants in the above anecdote.

> A gentleman who is very schizophrenic and we were having a hard time to get him to his baseline that we knew of him before. But at the same time, when you do approach him, the big thing was right away, he had this thing that was important to him and he had a chain on it…He takes out this old pocket watch that he had…he remembers it's his grandfather's. And one of the things that on the pocket watch itself it says "rest in peace" and he got his grandfather's name on the other side of it, so I said "Obviously this means a lot to you, so what do you use it for?" He says, "Anytime that I start remembering like this, I get angry real easy"… "One of the greatest things that I've learned to do" (he came up with this by himself, although we've had a few conversations before along those lines), he said, "Every time I get frustrated and angry now, I will look at this watch and it says, rest in peace, and right away I think nothing really matters much more than that." One of the great things that was there right off the bat is that I had a deep connection to my own grandfather who used to carry a pocket watch all the time. So obviously there was that commonality that I can see how much his grandfather meant to him and right away made that little bit of extra connect, people connection. (Nurse Charles)

In characterizing their connection as "extra connect" or "people connect", Charles understood that they had uncovered common ground in an almost accidental way,

unrelated to therapeutic aims. Once each discovered the common ground, however, each understood its value.

The following story presents an encounter in which the nurse and the patient, actively engaged in a conversation with therapeutic aims:

> He was very anxious, nothing was working for him...I had approached him (before) and he had already gone through the day treatment program and somebody had already talked about mindfulness and right away he said, "I don't want any of that", so I left it at that point. So today, after looking closer at the assessment I noticed that he had put in the boxes that he had a strong faith… I just told him that I noticed what he put in his assessment--strong faith. "What does that mean for you? What does that connect with?" He told me that he does pray every night. I asked him, "In that prayer, do you often pray to God to allow all these difficulties that you are going through, just allow them to be what they are and see how they transform you?" He said, "Gee, I didn't think to see it that way". He was thinking about praying more to take it away. He said, "I never thought of just giving it thought for just a while". We started talking about it and one of the quotes I came up with was from King Solomon "this too shall pass". The whole conversation came around to that direction. It comes down to the same thing--how creatively are you going to use whatever language that person is going to bring...sometimes it is not a matter of mindfulness, it is that ability to go wherever they are at and you are there. (Nurse Tim)

The nurse in this scenario understood that the patient's strong spiritual values seemed to have prevented him from exploring other ways of managing his pain and suffering. The

nurse had an equally strong belief, rooted in his own spiritual practices and emerging research evidence, that a particular approach had the potential to be helpful. In searching for a common ground, the nurse invited the patient to find areas of congruence between the proposed new practice and his religious faith. The nurse understood that the connection could be shaped with goods that each brought to the encounter; he also understood that each person's use of language constituted much of what mattered.

Natural alliance. One component of the theme of the common ground is the experience of a natural alliance that emerged from participants' accounts of relationships that achieved a degree of easiness and intimacy. Nurse Colleen described this alliance as "an organic kind of thing that happens… not as contrived". Although she found the experience difficult to explain, she knew that it had unique characteristics. Elsie, a patient who suffered from disorganized thought processes, could not articulate its specific nature, but in the following account she seemed to be pointing toward the idea of a natural alliance:

> When I first came in, I was very disoriented. I have over circuit on my mind...I was probably talking any which way but loose. You've got so much on your mind, you want to spit it out all at the same time, but it's all coming out in funny little words, you know, this word this way and this word that way and that's why I want (always) wanted (one nurse) so she could better understand that I was in over circuit. (Patient Elsie)

Another patient seemed to suggest that a natural alliance was only possible if the nurse expressed sincere interest in the patient and the work. While the patient initially identified that his relationship with the nurse was "comfortable", he further noted that

other nurses did not "seem to be paying attention" or did not "really listen"; the patient stated, "They seem to be doing it because they are getting paid." In other words, the patient needed to experience a nurse's motivation in a particular way in order to sense this kind of easy intimacy. Nurse Tim tried to enact this kind of sincere interest; he stated, "I do distance myself from the perception of me being just another person in this industry". In saying this, Tim was situating himself not only as a person *of* the health care profession, but as a caring person; he was interested in the patient not only because he was a nurse, but because he cared. Still, Tim clearly situated the encounter in the nurse-patient relationship, stating, " The patient will often say 'nobody cares' so they are already looking for care…I have to make sure they identify me as possessing care…it's part of the relationship, that I must care."

Tim illustrated the generative qualities of this kind of connection as he stated, "He said thank you very much for validating me a new way. Basically taking the label off and seeing (himself) as other than the label". Nurse Colleen stated, "I spent a lot of evenings just talking to (a patient) and at the end of one conversation, I realized, OK, what I am doing is actually doing some good." Nurse Heather illustrated the generative qualities of an "easy" and "comfortable" alliance:

> I can think of a young girl who was very delusional about spaceships, and being taken up and examined and that sort of thing. I spent a lot of time with her listening to her experiences and asking her questions, being a little bit challenging but not too much because she couldn't really take much challenge; I kind of felt that I had a connection with her in a way and that it was easy. It was comfortable.

> She sought me out. She was very open, maybe revealing more very personal things than she would to other people. (Nurse Heather)

This nurse understood that a patient's intimate revelations could serve the patient's desire to become healthier and she recognized that the patient privileged their conversations above those she had with other nurses.

In order to unearth common ground, nurses were willing to "go wherever they (the patients) are." Nurse Colleen seemed to go beyond the common ground by positioning herself "on her (the patient's) side". Colleen stated, "She knew that I was somebody that was on her side, and wanted to help her". As nurses shared these experiences, I thought about the almost constant exhortations about professional boundaries that are so prominent in the discourse of professional nursing, especially psychiatric mental health nursing. It became clear to me, however, that the possibility of unearthing common ground was linked to each person's sense of his/her own potential as a human agent. To achieve an intimate, caring, and natural alliance, both the nurse and the patient needed to understand and respect the human qualities of the other. Patient Laura stated, "she treated me like I was intelligent". Another patient stated,

> "I've seen lots of psychologists and psychiatrists over the last few years…That's always made a difference to me, coming into a situation where you feel somebody's talking to *you* …I can't receive it when I feel like they're (just) fascinated." (Patient Marta)

In an earlier story, Nurse Charles illustrated how he explored his own intentions and motivations, and accepted that his perspective was only one constituent of shared understanding. In mindful approach, the nurse and the patient can approach and closely

inhabit a shared, inter-subjective space, and remain situated in that space for a long period without losing their respective identities as patient and nurse, if each is able to understand what is worthwhile and important in the relationship, and value and respect the other.

The shift. As I spoke with nurses and patients who had arrived at a place of mutual understanding, I learned that their relationships continued to undergo change and transformation. I used the term "shift" to signify those changes that participants experienced as turning points in their relationships with the other, in which the relationship moved beyond engagement, and patients sought deep understanding of their illness experience, demonstrating a willingness to move away from their confusion and suffering and toward a more healthy way of being. Nurse Charles recounted the following:

> We'd probably call him a sociopath…By giving him his space and I think leaving him enough time to see what he probably hadn't noticed over time--what I was really like with everybody else that was around--I think that finally for him somehow there was something, I don't know how, what opened up but he finally one day he said "Let's have a chat." The first thing was he asked me "What's so different about you from the rest of the people I know?" and that was a long conversation. (Nurse Charles)

Prior to this relational shift, Charles and the patient had arrived at a place of mutual understanding; the understanding was one in which each party maintained a distance from the other, with little requirement for intimate knowledge of the other. Charles understood that the patient did not yet trust him, and yet he continued to create potential a

shift by "allowing" the patient to remain in his comfortable space. Charles recognized that the patient was keenly observing him from a distance and learning about him through Charles' interactions with other patients. The patient, having satisfied himself that Charles was safe and trustworthy, approached him with curiosity and the relationship changed.

Nurse Joy gave an account of a relationship in which a shift occurred, despite struggles to engage and ongoing conflict:

> There was a young fellow; he was having an identity crisis along with other things too…So he had a hard go of it and it didn't go well for quite a while with him and me. So we didn't have a good rapport and I had a very hard time getting to him because he basically didn't want to talk to me…So with patience and I mean patience, not the patients on the unit but the patience in your body, I slowly got through to him. Slowly, it took a while. He would say, "I don't want you to be my nurse today." "Unfortunately for you, I happen to be assigned to you so you are going to have to put up with me today. I will try to back off. I have to talk to you this afternoon because that's my job, but you have to carry on and if you need me I am here." We actually had a great conversation about his situation, and how he was feeling …then he said, "You know, honey, you are not that bad." I said, "No, I'm not." (Nurse Joy)

Carefully and in a fully embodied way, Joy approached the patient, made manifest her intentions, affirmed the patient's human dignity, and allowed room for the patient to understand what he needed in the situation. Given his space and allowed to choose the time and place for the encounter, the patient's initial rejection moved into the background

and the nurse and patient were able to explore his situation in an intimate way, and the patient could safely expose his perspective to the nurse.

Both nurses and patients seemed to experience this relational shift. Patient Marta noted both change in nurses' interactional demeanor and her own feelings, "I find that they have changed how they interact with me…I am less tearful when I spill my guts and a bit more comfortable". Nurse Joy stated that "You could see when he was relaxed, his arms weren't folded anymore, he didn't seem like he was standing off, he was kind of slouching...There were the facial features." Joy interpreted the patient's body language as the patient decoding her own behavior and saying, "I'm not being threatened by her, she's actually letting me have my way; I have control so maybe I can talk to her". In the following account, Nurse Samantha noted that both patient and nurse experienced the shift, although each experienced it differently:

> When I was treating him almost as a child it was, "why don't we do this?" It was always my suggestion whereas once he started to feel a little bit better and we were able to link better to each other, I was able to ask him more, "What's on your mind today, what's important to you today?" I remember a picture on his windowsill, he had a picture of his family and another picture of his brand new grandson and I remember when I was treating him more like a child, it was, "Oh, how beautiful, your grandson" and it was all my value judgment placed on these pictures. Like, "That must be so nice. It looks like you have a nice big verandah on the front of your house." When we were speaking more as adults, it was "I see your grandson there and when was he born? Do you get to visit him often? How do you feel after these visits? What's it like for you? It looks

> like you have family gatherings--what is that like for you? Are you still able to do that?" I didn't put words in his mouth. (Nurse Samantha)

From Samantha's perspective, as the patient's experience changed ("once he started to feel a little better"), the relationship changed ("we were able to link better to each other"). Samantha abandoned the "adult" role, in which she enacted most of the decisions, in favor of a more collaborative role, in which she encouraged the patient to explore the meaning of his experiences. The patient learned to articulate his story and Samantha recognized that she did not need to control the conversational exchange in order to help the patient find meaning.

For some nurses and patients, the shift seemed to relate to exposure of the patient's vulnerability. Tim exposed his psychoanalytic framework as he commented that, "Shifting, it's quite consistent, they start to feel vulnerable, they start to feel their defenses crashing then they get trapped. Should they let their defenses down or should they put them back up?" Tim constructed his relational practice so that patient vulnerability was exposed, and in Tim's view, the patient would make the choice between remaining stationary or creating the shift. Tim's intention was to help the patient experience a willingness to move forward. Tim stated, "The chaos will drop. The person will say, "'I feel better, I am more relaxed'". Some professionals hold that the dogma of psychoanalytic theory is one of unequal power between professional and patient. Tim's intention to expose vulnerability and force a choice appeared to be consistent with this paradigm: Tim consistently and actively sought to create the conditions whereby a shift would occur. He acknowledged the power imbalance in this practice but understood that the balance of power would shift if the patient made a conscious decision to move

forward. Patient Marie described how she experienced this kind of vulnerability as being on a pathway to recovery, "I used to come into hospital and my Mom would say, "Oh my God you've got worse...you are worse than when you left (home)". It is the first step to wellness really." Marie appeared to accept an intensification of her own vulnerability if it pointed toward a more healthy state. At one point I observed a nurse and a patient operating within this space of shifting vulnerability. A sad and angry patient expressed puzzlement at a question the nurse posed, and then his eyes filled with tears. "You don't know me", stated the patient, with a hint of anger. "Tell me, then", replied the nurse. In the ensuing conversation, the patient recounted specific aspects of his story that were clearly uncomfortable and anxiety-provoking, and formerly not a focus of their conversation. At the end of the conversation, the nurse understood the patient in a different way. The patient had both articulated and argued for his vision of his future. Although he did not commit to a follow-up conversation, the patient continued on his own reflective journey, questioning how he had handled a particular situation, and the nurse considered the experience to signify a change in their relationship.

The theme of mind-work emerged from the accounts of both nurses and patients. In their accounts of mindful approach, nurses and patients appeared to be expressing an understanding that certain relational experiences were more focused on finding meaning, responding to a particular challenge or revealing particular strengths in the patient. The three sub-themes may be particularly useful in understanding the temporal nature of relational experience; the language of frontline, common ground and shift helps us to visualize nurses and patients moving in space and time, constant repositioning, each seeking a position of relative security. Nurse Charles stated, "The experience is now",

but in mindful approach, the "now" appears to be always moving toward another place to achieve another purpose and a different way of being.

Keeping Safe

You know, even in the touch, I tried to convey that I cared. (Nurse Colleen)

Nurses understood that patients often struggled to maintain a normal existence, in which they could nourish and clean their bodies, connect with those outside of the unit, and feel safe from harm. The theme of "keeping safe" illustrates the perspectives of nurses as they care for patients expressing a basic need for ontological security, and the experiences of patients who are sometimes so ill that they struggle to articulate their needs at all. The theme of keeping safe embraces the following sub-themes: "acts of caring", "directing", and "protecting".

Acts of caring. Some nurses gave accounts of caring for patients that clearly stood apart from the everyday, specialized work of the PMH nurse. As I listened to these accounts, it seemed to me that these encounters were characterized by a unique purpose. Instead of exploring the patient's feelings or helping the patient manage anxiety, nurses responded in an easy, gentle manner, made few demands on the patient, and understood the patient's request to be an authentic representation of her need. This was illustrated in the following account:

> She would be asking where the towels were, "I want to use the phone" and you might say, "It's right there" … questions that seem very simple, and she should know the answer to, but you know where they're coming from, a heart that's very innocent and a heart that's very genuine, and just needs some guidance. (Nurse Hilary)

In this encounter, Hilary offered guidance rather than challenge. She characterized the patient in this account as "innocent" and "genuine"; she understood the patient's need for security, and restrained herself from undertaking a more complex exploration of symptoms. Hilary described another encounter in which she understood that the patient sought something elemental from the nurse, and Hilary responded with what she termed "basic nursing":

> I had a patient who came in depressed. She had literally been just lying on her bed. I went right back to doing basic nursing, that made me feel really good. I came on one day and she was lying in her bed; her period had started during the night. She needed to have her bed changed and I thought, when was this patient last in the bath? So I encouraged her, she at first didn't want to get in the bath. I ran the water for it and said, come on, and I escorted her up to the bath and washed her hair, she got her bath, I changed her bed, and I remember feeling very good at that time...she thanked me, very much. (Nurse Hilary)

As I listened to Hilary tell this story, I noted her characterization of this encounter as "basic" nursing. In the culture of nursing, care of the body is usually characterized as basic nursing, and for many, it is the purest expression of caring. Hilary experienced great satisfaction in being able to care for the patient in this way. Perhaps this satisfaction was linked to being able to enact nursing in its most basic form, thus giving Hilary the opportunity to express unfettered care, uncomplicated by the demands of mindful approach. Hilary's response was very skillful; by encouraging the patient to bathe, Hilary initiated a patient action that would have been simple, even intuitive, for most adults, but was beyond the range of possibility for this patient at this time. In this

quiet exchange, Hilary responded to patient's unmet need to tend to her body, recognizing possibilities in the yet-to-be relationship.

In the following account, Nurse Colleen illustrates how she transformed her caring intention to a caring action:

> I said to this patient, in a loving manner, "I am going to run a bath for you"...In a gentle warm way, in the way I spoke to her...the way that I used my hand gestures, even in the way I helped, I helped wash her hair, and making sure that the water was at the right temperature to the way I poured the water over her, over her head in washing her hair, to the way I applied the shampoo, to the way I washed her back. You know, even in the touch, I tried to convey that I cared. (Nurse Colleen)

As I contemplated the image of the nurse pouring water over the patient's head, I was struck by what seemed to me to be an almost ritualized act of service. I first considered whether the nurse's action was like a Christian baptism, but then I understood that the act was an act of service. Like a maidservant caring for her mistress, the nurse was more than an intellectual partner who would help the patient to overcome the challenge of bathing. The nurse was doing *for* the patient, not because she controlled the patient, but because she cared for the patient. The core intention in the nurse's action was not to make the person clean; it was to communicate care and respect.

Nurse Hilary used the mothering metaphor in the following account of physical caring:

> I liken it to a mother taking care of her child. When they are infants, it is just that total care and the satisfaction your get connecting with them, caring for them in a

> loving way. Do for them. There is nothing else you can do when somebody is psychotic and they come out of TQ and they either have feces or saturated with whatever. (Nurse Hilary)

Hilary, the guardian, carefully and safely chose how to cleanse the person, who was, at that moment unable to cleanse herself. Hilary knew that the patient was in need of cleansing, and she framed it as an act of love.

Nurse Colleen recounted an experience in which she felt driven to offer to help the patient care for his body, even though circumstances made it challenging to do so. The patient was in locked seclusion, behaviorally unpredictable and verbally abusive. Many of her colleagues would not have attempted to offer hygiene care in this situation; most would have considered such a move to hold too much risk. Colleen, however, held a different view:

> There was a fellow in TQ for a long period of time. I wanted him to get out and have a shower. And, the person I was on with absolutely objected to it…So, what I did was, I waited until he went off the floor, and I got all the commissionaires and we got this patient out of TQ, cleaned it, he had a shower with the commissionaires there…and it was all said and done, and no incident happened, but an incident could have happened. I just felt it was almost a human rights thing…the patient wanted a shower. So the patient was very appreciative. But cursing and loud, and you know, kind of, you know, what looks disrespectful. But, I mean, it, it was the illness and his lack of control and his impulsivity and that stuff. (Nurse Colleen)

Colleen's actions were shaped by her determination to bridge the physical barrier of a locked seclusion room and enact a caring intention. That intention was rooted in her understanding of the human dignity of the patient and her identity as a nurse with the moral and professional requirement to care. In this situation, Colleen's caring action was also an act of bravery. Just as practices of hygiene care are well-embedded in the culture of nursing, so are values related to team work and mutually supportive collegial relationships. Colleen acted without the support of her nursing colleague; instead, she asked security staff to assist her. In the end, Colleen minimized the issue of peer relationships as "in the background", and pointed toward her moral reasoning: " I felt like I was doing the right thing, so I, you know, I just went ahead and did it and it all really worked out very well." In this situation, Colleen valued the relational over the practical, and understood the patient's need for a particular kind of caring action.

Protecting. When patients were admitted to the inpatient unit, many experienced feelings of extreme anxiety, sometimes transforming to actual terror. When patients felt overwhelmed by these fears, and were unable to make sense of the experience, they sought protection and comfort in relationship with a nurse. Patient Laura recalled how a nurse responded to her fear:

> I am remembering when I first came in, (the nurse) would have been sitting right here (points to her side) and if I had a question or if I was scared I would look at her and she would make me feel better. (Patient Laura)

In this encounter, the patient needed only to look at the nurse to communicate fear and seek reassurance. There was little exchange of words, little exploration of feelings; the nurse shaped the encounter in a manner that would create a safe space and shield the

patient from the confusion and danger of her immediate environment and her inner experience. When Patient Raha reflected back on her admission to the inpatient unit, she recounted the fear and terror that she experienced:

> I was terrified when I came in. I had a nervous breakdown. I didn't know who the nurses were and weren't...I wasn't sure if I was dying or what was going on. It was a really scary time and she took me under her wing...She was just like a mother to me and just like a nurse. (Patient Raha)

Raha used the metaphor of being "taken under wing" to express her sense of being protected by the nurse, in the way a mother bird would protect its offspring. Her use of this mothering metaphor points to her openness to receiving protection, and her understanding of the nurse's intention to provide it. Raha made a direct link between being "just like a mother" and "just like a nurse", perhaps indicating that she expected that a nurse would protect her patient as a mother would protect her child. Raha continued:

> She (the nurse) was with me every step of the way. When I asked her to be there, she was there...she mothered me, almost. Because I hadn't slept in days, I was hallucinating and I didn't know who was real and who wasn't ...having her there made me feel a lot better. (Patient Raha)

Because of her illness, Raha experienced the terror of being unable to make sense of her environment. She sought out the nurse's presence and took comfort in having someone who could provide a sense security in her confusing world. By characterizing these experiences as "almost" mothering, Raha illustrated that she was not experiencing the nurse *as* her mother, but *as if* she were mother. These encounters were enacted over a

period of time, on demand and without condition, allowing Raha to interpret these actions as authentic and caring. In recounting the following, another patient illustrated a similar understanding of the nurse's role as mother-protector:

> I had a bit of a problem with one of the nurses last night. She wasn't particularly friendly and she was actually kind of rude to my room-mate's friend, and I mentioned to (my nurse) this morning and she had it resolved by noon. She is awesome...I think she is a Mom, too, which helps. (Patient Laura)

In addition to feeling protected from inner distress, patients recounted how nurses offered support and protection from the social environment of the nursing unit. Patient Laura stated:

> There is one patient that I am afraid of. (The nurse) understands that I don't feel safe. I told her that I was scared of him and she said that's OK, eat in your room. She even brought me my tray. (Patient Laura)

It is important to understand that in general, most patients on an inpatient psychiatric unit are not physically disabled and are expected to eat in a common dining area and attend group activities. While there is no real private space in an inpatient psychiatric unit, the nurse recognized that the patient needed to create one in order to feel safe. In this anecdote, the fact that the nurse offered a patient this opportunity illustrated that she received and understood the patient's sense of insecurity, validated her fear, and supported her decision to withdraw.

Directing. Up to this point, I have highlighted relational experiences that illustrate the theme of keeping safe in encounters in which nurses enact caring and protection in a fully embodied way, and patients have used the mothering metaphor to

find meaning in these exchanges. The theme of keeping safe also emerged from experiences in which nurses responded to patients who were angry or in danger of losing control; I labeled this kind of keeping safe as "directing", in which nurses approached with the intention of restricting or limiting patient behaviour. In the following example, Nurse Colleen communicated an expectation of compliance, but did so in a respectful manner:

> Make it positive, not "Well, I don't care, if you are not going to do this then were are going to throw you in TQ, that's it, case closed, you are not going to listen to me you can go into TQ". If someone said that to you, wouldn't that be a little like "You want to see what I can do? You just watch me." And they will, they will act out. (Nurse Colleen)

Colleen's self-reflections illustrated that she wanted to avoid using power and intimidation. Her stance was in part a practical one, governed by her moral stance of protecting human dignity and her professional knowledge of which action would most likely yield a safe outcome. She believed that any obvious use of power would prevent her from reaching any shared understanding with the patient. In another encounter, Nurse Hilary shared her experience of enforcing a no-smoking rule on the unit. Hilary found it difficult to reconcile her understanding of the patient's right to autonomy and her directive response:

> I really would say that sometimes, it's punitive. And who am I to really tell a person that they can't smoke? I'm taking their rights away, what right do I have to do that? So you know, you're constantly the sergeant-major, telling people "No,

> you can't". You are taking charge of someone's life. Who am I to have the right to do that? (Nurse Hilary)

Hilary's use of the metaphor of "sergeant-major" pointed toward her distress at enacting a paternalistic role with patients and perhaps even her ongoing struggle with enacting the directive role. Even though most health professionals would understand a smoking ban as a means of promoting health, Hilary understood that to act as the enforcer was somehow incompatible with what she valued in her relationships with patients. In the context of a nurse-patient encounter, Hilary placed a higher priority on communicating respect than enforcing the no-smoking rule; indeed, she seemed to recognize that this kind of directive encounter was unlikely to create meaningful engagement.

It is common for PMH nurses to respond in a directive manner to patients whose anger is mounting and whose ability to regulate their emotions and behaviour appears to be eroding. In the following anecdote, Nurse Colleen renders an account of an interaction with a patient who was angry and freely expressing that anger to all who were near.

> Because she was making such a scene, she was so angry and escalated…I ended up saying "Go to your room", doing the firm, authoritative thing. I felt that if I didn't step in and do that, somebody on the team would and she would have ended up in TQ. I said "You need to go to your room right now. This is not the place, calm yourself down in your room and we can try to talk later".

As she interpreted this situation through the lens of a skilled PMH nurse, Colleen was conscious of her directive stance. She referred to her response as the "authoritative thing", appearing to understand it as a somewhat objectified, perhaps even technical action. Colleen sensed that she chose the right course of action, not because it

communicated respect or led to a deeper understanding of the patient but because it minimized harm. Her intentions were conscious; she clearly identified with the prescribed nursing action in this situation. She experienced little moral distress.

The theme of keeping safe illuminates the encounters between nurses and patients as nurses responded to patients who sought or in the nurses' view, required basic comfort and protection. "Acts of caring" and "directing" emerged primarily from nurses' accounts, and "protecting" emerged primarily from patients' accounts. It is true that the theme of keeping safe highlights relational practices that are in some manner also point toward engagement, mindful approach and some aspects of withdrawal-unknowing. It is possible that this portion of the analysis in particular suffers from the "lack of language" (Benner, 2007) available to describe relational care. Given that "the person is always embedded in a specific set of circumstances with certain concerns" (Benner), I understand that this theme amplifies modes of being that are particular to nurse-patient encounters in specific contexts, and that its inclusion adds an important dimension to my exploration of the relational experiences of nurses and patients.

Reflections on this Analysis

While immersing myself in storied accounts and participant-observation, I came to understand that moments in nurse-patient relationship were meaningful not just for the "now", but that meaning extended forward in time, to achieve a hoped-for and valued endpoint. These encounters were enacted in a moral space, whereby nurses were oriented to professional caring and patients commanded respect for their suffering, their personhood, and as individuals who matter. In conversation, observation, and reflection,

I was exposed to participants who tried to understand the intentions of the other and attempted to discover meaning with the other.

The first theme, the theme of engagement, illuminates the moments in which nurses and patients move toward each other in a journey of discovery. The practice of engagement, well articulated in nursing and human relations discourse, is revealed to be first and foremost a practice of knowing, in part by actively searching for understanding and in part by patiently waiting for the moment in which patients allowed themselves to receive the wondering gaze of the nurse. The second theme, withdrawal, brings into our awareness how the absence of common purpose or common meaning yields relational emptiness. The third theme, mindful approach, may find particular resonance with PMH nurses, who seek to understand their own unique healing practices but for whom meaningful language to describe mindful approach encounters seems difficult to achieve. The last theme, keeping safe, subsumes many of the traditional caring actions so commonly expressed in professional nursing's community of practice. For the PMH nurses, many of these caring actions are extraordinary and challenging; for patients, many of these caring actions are highly valued affirmation of their human dignity. As for me, these stories allow me to dismantle my previous understandings of the relational experiences of nurses and patients, bringing into view a wide expanse of meaning, which I am only beginning to explore. At this juncture, it is helpful to recall the words of Benner (1994):

> It is a tenet of this kind of research that there can always be another, deeper and perhaps more persuasive interpretation of a phenomenon. The forestructure of the study may be quite different from one study to the next and will therefore produce

quite different accounts of the same phenomenon. Competing accounts do not negative each other. Rather, they set up a conversation.

CHAPTER FIVE

Discussion

In this section, I discuss the key findings of this inquiry, highlighting each of the four themes and comparing the findings with knowledge derived from relevant literature. I situate these findings in a wider theoretical context by linking certain thematic elements to relevant nursing theory. I use carefully selected and previously presented examples from the text to highlight these linkages. I employ particular theoretical lenses to illuminate particular themes, but in doing so I do not intend to imply that a particular theoretical lens is only relevant to one particular theme. I conclude with a discussion of the strengths and limitations of this inquiry, implications of the findings to the discipline of nursing, and implications for future practice, education and research.

I began this inquiry in order to understand the experiences of mental health nurses and their patients as they relate to each other during the patient's hospitalization in an acute inpatient psychiatry unit. Although the concept of nurse-patient relationship has been an important focus of interest in mental health nursing theory and practice, it is my contention that much of the work on nurse-patient relationship in psychiatric-mental health nursing has not yielded a full account of the experiences of nurses and patients in acute inpatient psychiatric units. My conversations with nurses and patients have confirmed, to a large extent, my earlier assessment that we still have much to learn about relational experience in this context.

The key findings are as follows:

- PMH nurses enacted a moral and caring intention by seeking engagement, creating presence, committing to mind-work, and keeping the patient safe.

- Patients in acute inpatient psychiatric settings used relational experiences with nurses to create meaning related to their illness, their environment, and their own humanity.
- PMH nurses and their patients desired to make connections with each other, and actively sought out and moved toward each other; at times, nurses and patients moved toward each other in a measured, careful pace, awaiting an opportunity to find common ground.
- PMH nurses and their patients experienced encounters in which neither came to know the other and in which each found it difficult to achieve relational intimacy.

Some of these findings are consistent with findings of current and past research and some of these findings create the possibility that old ideas can be understood in a different way. Some of these findings create the possibility for completely novel understanding of relational experiences in acute inpatient psychiatric unit.

Discussion of Findings

Engagement. The theme of engagement-knowing helps us understand that as nurses and patients move toward each other and sense the nature of the other, conscious knowing of the other moves to the foreground of awareness.

Engagement, non-engagement and relational experience. Morse and colleagues argued that "the essence of the nurse-patient relationship is the engagement: the identification of the nurse with the patient" (Morse, Bottorf, Anderson, O'Brien & Solberg, 1992, p.819). These authors also suggested that the nature of engaged involvement is variable, ranging from "detached and disembodied", to active fighting

against involvement, to "professional" use of empathy, or "pseudo-engagement" (Morse, et al., 1992, p.820). Schultz and Carnevale (1996) stated, "modernist forms of caregiving not only involve but require disengagement of the caregiver as a human person or self from the patient's situation of illness" (Schultz & Carnevale, 1996, p.193). Themes emerging from this inquiry illuminate experiences that both challenge and support the notion that disengagement is a dominant value; nonetheless, many stories point toward engagement as a highly valued and meaningful experience in the nurse-patient relation.

Gadow (1999) stated that, "The valuing of persons requires perception of each other's uniqueness and perception involves engagement" (p. 63). Hess (2003), who was interpreting Gadow, stated that if "engagement of patient and nurse assumes the moral agency of both" (p.143), then "understanding that comes from dialogue between patient and nurse supports their engagement" (Hess, 2003, p.144). Many nurses in this inquiry enacted what might be understood as radical PMH nursing practice (Barker, 2001), in which the nurse's professional responsibility is to create possibilities for "dialogue or conversation between both parties" (Schultz & Carnevale, 1996, p.196). Relational work is an embodied, involved experience. In this inquiry, nurses and patients shared stories in which each was engaged with the "other's existential, subjective and embodied being" (Hess, 2003, p.145), enacting "personal responsiveness to the particular other" (Gadow, 1999, p. 63). These were examples of *clinical phronesis* (Schultz & Carnevale, 1996, p.193). Both nurse and patient become involved in interpreting the illness experience, and nurses were open to experiencing their own suffering. In responding to different dimensions of suffering, including physical discomfort, nurses in this setting, understood and "embraced vulnerability, the patient's and the nurse's own" (Hess, 2003, p.145).

When Nurse Joy approached a paranoid patient and said "I don't know how it feels", she may have been carefully shifting her position from that of an empathic, knowing nurse to that of a not-yet-knowing nurse. She did not altogether disassociate herself from her nursing role but she moved closer to the patient's world in order to engage in respectful and authentic interaction. In that instance, her willingness to be one of two vulnerable persons separated her from the detached and professional posture that clinicians learn to adopt in relationship with patients.

Seeking. Engagement as a process of emerging understanding is related to the work of Peplau (1952) as interpreted by Forchuk (1992, 1994, 1995) in her work on the orientation phase of the therapeutic relationship. Coatsworth-Puspoky, Forchuk, and Ward-Griffin (2006) used an ethnonursing methodology to explore mental health patients' perceptions of nurse-client relationships, and suggested, "Each type of relationship contained three phases, a beginning, a middle and an end. Each phase was unique and built on the previous one" (p.350). These authors stated that the beginning phase was one in which the patients were looking for a nurse who was "trustworthy, genuine, caring…" (p.350). Coatsworth-Puspoky et al. reported that a patient stated:

> Remember when you were a child and you were lost and desperately looking for your Mom…you're out in this public place, you're crying, you're scared…this is very much what it felt like in the hospital, looking for that sense of security and safety, and being convinced that you're not going to find it…(p.350).

The above text was an example of a patient finding "a glimmer of help" (p.350). In reading the text, the following anecdote from this inquiry, came to mind. I interpreted the anecdote as a patient seeking to know her nurse: "It's hard for a person like me to come

in here and to trust that someone actually does care about you and it took me a while to really believe that". In both studies, patients entered the care context and experienced difficulties trusting the nurse. In the Coatsworth-Puspoky et al. study, a patient stated that the nurse was "a source of anchor" (p.350), and when she felt comfortable with a nurse's personality and behaviour, the relationship could progress to a more exploratory level. In this inquiry, a patient discovered that she could trust the nurse once she understood how the nurse was offering care; in this regard, the findings of each study are comparable. The relevance of these findings is also supported by a study in which it was reported, "Trust is created when the professional's attitude makes it possible for the patient to accept help" (Piippo & Aaltonen 2008, p. 2870). Further, Johanson and Eklund (2004) reported, "The relationship between patient and therapist must be one of trust and stability" (p.520). Hem, Heggen, and Ruyter's (2008) ethnography of an acute inpatient psychiatric unit linked "working to achieve contact" as "making efforts to achieve trust". In this inquiry, a patient seems to be pointing toward a similar understanding:

> When you first meet these people, they don't know me, all I am is someone that's trying to dispel their beliefs. So I come on board saying, "Hi, I'm Joy, how are you today?"…"OK when you are ready I can come and talk to you about your situation" and get to know them. (Nurse Joy)

It appears then, that the work of seeking out the other compares with findings of other studies of patients and nurses in the acute psychiatric setting. Unlike this inquiry, however, most studies frame the early relational experience as one of trust-building. In this inquiry, patients and nurses did not commonly declare the notion of trust to be an explicit component of the getting-to-know experience: trust came to the foreground only

rarely. Rather, I understood that the experience of moving toward the other in order to know the other better was a more prominent feature of the experience.

The sub-theme of noticing-the-now resonates with Johnson and Hauser's (2001) theme of "noticing the patient" (p.656). Noticing the patient is a pattern of action that PMH nurses employed when patients displayed signs of escalating anger and agitation. To Johnson and Hauser, noticing included nurses' interpretation of behavioural cues and linking their observations to their knowledge of psychopathology. Significantly, the authors suggested that "expert psychiatric nurses' actions are not decontextualized and isolated interventions, but ways of intervening that are dependent on the individuality of the patient and the nurse's understanding of the evolving situation" (p.656). Johnson and Hauser's perspective amplifies the theme of noticing the now that emerged from this inquiry. Although the context of noticing the now is broader in this inquiry, both the nurse's understanding of the patient's need for contact and the patient's search for engagement mirrored many aspects of participants' experience in the Johnson and Hauser study. The sub-theme of noticing-the-now goes beyond the act of noticing, however: it suggests that meaningful nurse-patient encounters do not need a prolonged arc of time, and that the momentary recognition of feelings or behaviours establishes a connection that may transcend time. In some encounters, noticing-the-now was one moment and quickly over; in other encounters, the noticing generated a more prolonged, engaged relationship.

Most of the nurses in this inquiry situated themselves as eager to receive the stories that patients wanted to tell, and actively engaged with patients to uncover meaning in their as yet to be understood experiences. A nurse recounted that she was "getting

inside and I'm also listening to what the voices, what the delusions are. Then down the road I can say ... the person over there, in my eyes, there's no one there, but you see them and that's your brain telling you that it's there…I want to get into their minds and find out what they are actually thinking." Coatsworth-Puspoky, Forchuk and Ward-Griffin (2006) identified a "middle" phase of exploring and problem solving in which patients disclosed their problems. In the Coastworth-Puspoky et al. study, the notion of exploring emerged from the clients' perspective, and nurses were valued for their supportive attitude. In this inquiry, the theme of uncovering emerged only from nurses' experiences or nurses' reports of patients' experiences. There is a conceptual difference between the theme of uncovering and the concept of a middle phase of relationship. Uncovering appeared as an experience that illustrated engagement, or moving towards, but it was not situated in a chronology of relationship development and only subtly reflected nurses' interest in the yet-to-be or known. The experience of uncovering may bear some relationship to Johansson and Eklund's (2004) finding that a "supportive and stable (inpatient) milieu has to be complemented with an…explorative ingredient" (p.520); these authors framed the "explorative ingredient" as therapeutic. In this inquiry, however, the therapeutic, or health promoting aim of uncovering appeared to be only tacitly experienced; in fact, nurses appeared to understand uncovering as creating the *possibility* for an engaged, health promoting relationship, rather than as a healthy action in and of itself.

Abiding. In this inquiry, the experience of abiding subsumed the experiences of presence and friending. Both nurses and patients contributed stories that yielded sub-

themes of presence and friending, but presence emerged primarily from nurses' conversations and friending emerged primarily from patients' conversations.

In nursing literature, the concepts of presence and caring are often linked; it has been suggested that these two concepts may be redundant (Finfgeld-Connett, 2008a, 2008b). Watson (1997) associated the concept of caring with the concept of presence when she articulated her "caritas" processes, one of which is "Promote and accept positive and negative feelings as you authentically listen to another's story" (Watson, 1997, "Caring Science-Caritas Processes Refined"). Presence has been defined as "an intersubjective encounter between a nurse and a patient in which the nurse encounters the patient as a unique human being in a unique situation and chooses to spend herself on his behalf" (Doona, Haggerty & Chase, 1997, p.3). Doona et al. (1997) suggested that nursing presence implies that the nurse recognizes the patient's vulnerability, needing "reassurance and safety" (p.277). In this inquiry, presence was linked to patients' and nurses' accounts of safety related to the nurse's proximity, calmness, listening, "just being there", and patient empowerment as experienced over a period of time and with an expectation of more intimate knowing at some time in the future. The experience of presence manifested itself in the patient's understanding of the nurse's undemanding and abiding way of being and in a nurse's sensitivity to a patient's desire for connection. These expressions of presence are consistent with an understanding of presence that includes spatial and temporal aspects (Iseminger, Levitt, & Kirk, 2009) and whereby nursing presence creates the possibility of a "caring interaction" (Iseminger et al., p.448), with someone "who is willing to give themselves, not just in fragments, but wholeheartedly…" (Hessel, 2009, p.277). Like Finfgeld-Connett (2008), nurses in this

study understood presence as a skilled, authentic practice, and one patient highly valued nurses' presence as a sustaining force. In their accounts of presence, nurses used language that was consistent with a caring intention, and occasionally used the word "caring" when telling their stories. Care and caring emerged into the light and receded into the background in almost every conversation. I do not agree with Finfgeld-Connett (2008) that presence and caring are "substantively similar" (p.113); rather, I understand presence to be a caring way of being, the expression of a caring intention.

In friending experiences, patients identified encounters in which they interpreted nurses' behaviours as resembling peer relationships. In this inquiry, some patients valued experience in which there was "friendship". They appreciated it when nurses appeared to go out of their way to perform special kindnesses or respond in a genuine manner. Patients interpreted these encounters as "sincere", "genuine", and "down to earth"; they experienced connectedness and grounding.

The sub-theme of friending did not emerge from nurses' accounts, and I did not understand nurses in this inquiry to associate friendliness with relationship building in a conscious way. This finding differs from Scanlon's (2006) research, in which she reported that psychiatric nurses used humour to "enable the relationship to be more inclined toward the friendly relationship as opposed to the professional relationship." (p.325); she also reported that nurses used friendliness and humour as ways of achieving therapeutic relationships. Other investigator described findings that support the findings of this inquiry. Forchuk and Reynolds (2001) found that **"**participants described closeness, genuine liking, and trust with the nurse…" (p.47). Coatsworth-Puspoky, Forchuk and Ward-Griffin (2006) reported that, "Clients said they sought a nurse who

was “nice” “friendly” “genuine” and “caring” (p.350). The authors noted, however, that a “friendly” relationship was not the same as a friendship, because it was non-symmetrical; the nurse was always free to ask things of the patient but the patient was not as free to ask things of the nurse. Similarly, I understood that patient-participants in this inquiry appreciated certain friendship-like qualities in some of their encounters such as “gestures distinctly made for me”, “genuine, sincere interest”, and “down-to-earth” gestures, but did not expect to act as a friend to nurses.

Shattell, McAllister, Hogan, et al. (2006) found that patients valued the experience of being treated as an equal. A study participant stated, “You’re like a neighbour or like a friend. Don’t talk to me like you’re a counselor. Talk to me like a human being” (p.238). For a person admitted to an inpatient psychiatric unit, one of the most difficult challenges is coping with a loss of identity as a person; patients have stated that they experienced their psychiatric inpatient care as “being seen as a disease” (Lilja & Hellzén, 2008, p.281). It is possible that patients find meaning in friendship-like encounters because these number among the few times that their illness recedes into the background. The patients in this inquiry maintained an awareness of their illness state, but in understanding the nurse to be enacting friendship-like qualities, they felt worthy of attention, not because they were patients, but because they were human.

The theme of abiding subsumes both presence (which predominantly emerged from nurses’ stories) and friending (which emerged from patients’ stories only). It is possible that these are interpretations of similar experiences, as seen through different lenses. Perhaps nurses interpreted their own “gentleness”, “patience”, “calmness” and “listening” as highly valued nursing ways of being, whereas patients interpreted nurses’

characteristics of genuineness, sincerity, and being "down-to-earth" as highly valued human ways of being. This may be a specific example of how the situated selves of nurses and patients each interpreted nurses' responsiveness as being worthy and good, evaluating the nature of nurses actions through their own "inescapable frameworks" (Taylor, 1989, p.31).

Withdrawal. Nurses and patients in this inquiry sometimes struggled to achieve a knowing, engaged relationship. At times, nurses and patients were physically absent from one another, and at times nurses and patients were physically within reach but disengaged, without opportunity to create shared meaning. Some patients recounted experiences of being misunderstood. These findings are similar to the findings of Forchuk and Reynolds (2001) who also reported that psychiatric patients did not always feel understood: in the words of a patient-participant, "She failed to understand how I felt about my condition. I felt she did not care" (p.49). Shattell et al. (2006) also reported that patients valued being understood.

In this inquiry, the theme of withdrawal showed itself as experiences framed by nurses as countertransference; these were experiences in which the relational space was filled with intense emotions that transcended the actual relational encounter; there was no room for uncovering new meaning. The experience of countertransference refers to "attitudes and emotions evoked in the mental health practitioner representing unresolved personal conflicts" and which are "noticeably intense with the mentally ill" (Cameron, Kapur, & Campbell, 2005, p.69). In this inquiry, countertransference experiences were very meaningful. Nurses who articulated these experiences noted that countertransference was common and could be non-productive. Although not fully

conscious of the experience at every moment of every encounter, they knew the challenge that countertransference experiences posed in fully understanding the other. Nurses who "directed themselves toward" (Heidegger, 1962, p.260) the possibility of countertransference came to understand it as something to be avoided. Even though Cameron et al. suggested that countertransference "may open up possibilities for understanding" (p.69), nurses in this inquiry did not experience countertransference as an opportunity for self-reflection and a potent source of relational knowledge. They experienced it as an inauthentic enactment of their relational work, rendering the patient's experience less visible.

In a study by Coatsworth-Puspoky et al. (2006) clients referred to "the dark side" of the nurse-client relationship as "withholding, avoiding and ignoring and struggling with making sense of" (p.350). In this inquiry, participants told me stories of unknowing-withdrawal in which nurses interpreted aspects of their behaviour as emotionally distant, and patients interpreted relational distance as an indicator of the relative importance of their health needs or as a failure of nurses to understand their needs. Some patients interpreted nurses as withholding support; as a result they were hurt, angry and confused. Similarly, Coatsworth-Puspoky et al. reported that clients "experienced feelings of hopelessness and frustration as a result of the lack of support they had received" (2006, p.352). Nurses' behaviours that were interpreted as authoritarian and controlling were seen as primary reasons for disengagement.

In this inquiry, nurses and patients experienced gaps in understanding, the sources of which were difficult to discern. Coatsworth- Puspoky et al. (2006) suggested the need to explore "cultural and contextual factors that influenced the development and

deterioration of the nurse-patient relationship" (p.352). Iseminger, Levitt, and Kirk (2009) hinted at one possible contextual factor, and speculated that "nurses' peers may discourage healing presence…when others observe their colleagues spending too much time with patients, they may think the nurse is struggling with time management" (p.450). In what appears to be a reference to individual, rather than contextual factors, Watson suggested that the nurse is largely accountable for the effectiveness of the caring relationship (LaSala, 2009). It is Finfgeld-Connett's (2008) position is that "both parties take an active role in co-creating an intimate partnership" (p.533). Assuming that caring relationships are intimate partnerships, and intimate partnerships are created by the intentions of both parties, can it be said that the nurse is largely accountable for the effectiveness of the caring relationship? The key idea may be the notion of "effective" caring, which suggests that nurses and patients work to achieve a specific effect. But what is that effect? Further, Hessel (2009) stated that presence is a "reciprocal and healing relationship" (p.277). In this inquiry, the stories of nurses and patients suggested that in many encounters, both nurses and patients interpreted their experiences similarly. Both nurses and patients framed encounters in terms of their impact: for example, a patient "felt good", or a nurse experienced satisfaction that she was able to "get through" to the patient. Patients and nurses also experienced encounters in which one or the other retreated, and in which one or the other was rebuffed, despite patients' expressions of need and in most cases, the nurses' intentions to approach. I suggest, then, that ideas such as reciprocity, presence and effective caring are useful in drawing an outline of certain relational experiences; I speculate that they render only partial understanding of the meaning of the experience to the person. I am not convinced that the experiences

such as relational distance and "the person not seen" are examples of non-reciprocity, non-presence, or non-caring. In other words, it may be just as reasonable to understand a gap in knowing between nurses and patients as an imperfect expression of caring as it is to understand a gap in knowing as an expression of non-caring.

Patients with mental illness are often "highly sensitive to the mood, demeanor and subtle communications emanating from professionals", and "if they feel distant from and unsafe with the nurse, service users may….keep their fears to themselves" (Horsfall, 1997, p.62). Further, PMH nurses practice in an atmosphere of control (Handly & Stocks, 2009; Johansson, Skärsäter, & Danielson, 2006) and use relational detachment as a way of maintaining relational boundaries between nurses and patients (Scanlon, 2006). Scanlon reported that PMH nurses experience confusion over how to locate themselves within the therapeutic relationship and Horsfall (1997) posited that PMH nurses "can replicate their own experiences of oppression in interactions with psychiatric service users" (p.62). Lilja and Hellzén (2008) concluded that psychiatric patients are often transformed from "a unique person to a disease" (p.284), which "justifies staff's continued exercise of power" (p.284). According to Horsfall:

> These negative uses of power work against the interest of patients and do not uncover the structured causes of impediments to therapeutic nursing agency. Such mechanisms prevent the possibility of recognizing that psychiatric nurses and patients have interests in common. (p.62)

These ideas relate to Schultz and Carnevale's (1996) notion of *disengaged care*, in which clinicians approach patients without attention to "the morally relevant particulars of the situation to determine the goals or directions" (Schultz & Carnevale, 1996, p. 193). In

other words, in disengaged care, nurses abandon their responsibility to "appreciate the intersubjective or common meanings of illness" (Schultz & Carnevale, 1996, p. 194). I speculate that there is unresolved tension between values situated in the PMH nursing community of practice and nurses consideration of patients' interests; I have outlined some the reasons. This points toward diminished agency of PMH nurses and their patients (Horsfall, 2006). I further speculate that diminished self-agency and associated loss of human dignity make it difficult for nurses and patients to command the respect of the other, creating the conditions for relational distance and lack of knowing.

Mindful approach. Within the context of patients' intense experiences of anxiety, agitation, anger, and other expressions of distress, PMH nurses and patients engaged in the mindful approach: a dynamic set of actions aimed at discovering to a patient's strengths in order to create a calmer and healthier life experience. Of all the themes that emerged from these stories, the theme of mindful approach is the most illustrative of the special nature relational work of PMH nurses and their patients. Mindful approach refers to nurses' actions directed toward creating the possibility for patients' relief from distress, patients' unfolding awareness of nurses' healing intentions, and the resulting shift from internal chaos and distress to calm awareness. I use the word "mind" as building block in this theme as a reference to the authentic manner in which nurses and patients focused their gaze on each other, and the intense and often rapidly unfolding process of meaning-making that occurs in this kind of encounter. Referring to the work of PMH nurses with distressed patients, Johnson and Hauser (2001) stated that "expert psychiatric nurse actions are not decontextualized and isolated interventions…but

ways of intervening that depend on the individuality of the patient and the nurse's understanding of the evolving situation" (p.659).

Mindful approach and nursing theory. One might be tempted to interpret mindful approach as an illustration of linear relational process ending in an engaged and productive nurse-patient relationship, but I did not understand mindful approach to be a linear process. Hagerty and Patusky (2003) questioned the assumption of "linearity of the nurse-patient relationship" (p.146) after a broad analysis of nursing literature and practice. Peplau's (1952) use of the term "phases" to describe the nurse-patient relationship (NPR) leads one to assume that these phases are distinct, and that one must end before the other begins. Peplau acknowledged that the phases in her framework overlapped (Hagerty & Patusky, 2003) when she stated, "The phase under discussion represents all prior ones and an extension of the self of the patient onto the future. It is characterized by an intermingling of needs and a shuttling back and forth" (p. 39). The fact that Peplau's NPR phases have porous boundaries does not free them from being characterized as linear.

Aside from the barrier of linearity, some aspects of Peplau's (1952) work on the phases of the NPR are relevant to this discussion of mindful approach. For example, Peplau states that patients that a patient in the *orientation phase* "provides leads on how he visualizes the difficulty, providing opportunities for a nurse to recognize gaps in information and understanding" (p.20). In this inquiry, patients made statements such as "I don't need to be here", leading the nurse to respond with an explanation of her role, or "I don't want any of that", leading the nurse to retreat from his initial suggestion for an approach to relaxation. In the sub-theme named "the shift", a nurse gave an account of a

turning point in his relationship with a patient, stating that, "there was something…that opened up" when the patient said, "Let's have a chat". This relates to Peplau's *identification phase* of the NPR, in which the patient's feelings of threat to self are "minimized as the patient identifies with persons who help him to feel less threatened" (p.31).

Other aspects of Peplau's (1952) work, such as her framework for understanding and working with anxiety, resonate with mindful approach experiences. For example, a nurse attempted to guide a patient to the point of anxiety before allowing the patient to decide if he wanted to press forward and risk more anxiety or stay at his current level; he discussed the challenge of transforming the patient's anxiety by discovering shared experience, or common ground. This encounter lends itself to comparison with Peplau's discussion of how PMH nurses respond to patients with "unexplained discomfort" or anxiety (p.119). Peplau stated, "Anxiety is a potent force in interpersonal relations and the energy it provides is converted into destructive or constructive action depending on the perception and understanding of all parties in the situation" (1952, p.156). Further, "Nurses can recognize the anxiety factor inherent in doubt and permit expression of feelings, aiding the patient to see what the situation means to him" (Peplau, 1952, p.143). Peplau referred to the importance of remaining with an anxious patient, in order to provide a point of reference or focus for the person. In this inquiry, Nurse Samantha told a story about being surprised by the aggressive actions of a patient and initially unable to find a response within herself. She held her ground, and the situation resolved after a moment in which the patient recognized the nurse and stopped his advance.

Peplau's (1952) description of the nurse as counselor is highly relevant to this discussion of mindful approach. MacNeela et al. (2007) suggested that PMH nurses tend to distance themselves from formally associating their therapeutic work with a counseling model and in this inquiry, most nurses did not apply formal names such as psychotherapy or counseling to their work. The theme of mindful approach exposed the intentions and actions of nurses as they "expand(ed) experiences dimly intelligible to the patient at first, so that they become better understood by patient and nurse" (MacNeela et al. 2007, p.63). At first glance, it is counterintuitive to uncover the notion of nurse as counselor in the theme of mindful approach, where so many nurse-patient encounters were enacted in moments of acute distress. Counseling is conventionally understood to take place over a longer time period, within the context of a formally contracted therapeutic relationship with specific goals. Peplau, however, stated:

> Counseling in nursing has to do with helping the patient to remember and to understand fully what is happening to him in the present situation, so that the experience can be integrated with, rather than dissociated from, other experiences in life (p.64)

In Peplau's view, the nurse's counseling function is not the same as that of a psychotherapist; rather, the nurse works with the patient to explore "how he feels about what is happening to him" in his illness state (p.63).

I do not mean to imply that the theme of mindful approach is a full representation of Peplau's (1952) framework, nor that Peplau's framework fully articulates the theme of mindful approach. Peplau's framework is psychodynamic, and as such makes clear reference to the nurse's role in responding to the patient's ego defense mechanisms,

anxiety and transference, the nurse's self-awareness and countertransference, and identifying patient readiness for problem resolution. Psychiatric nurses have included many of these ideas in the canon of nursing practice, and many of these concepts are expressed in mindful approach sub-themes of frontline and shift. It is important to note that this framework illuminates more than mindful approach: aspects of Peplau's framework relate to the theme of knowing-engagement and sub-themes such as uncovering and noticing-the-now, and the theme of unknowing-withdrawal and its subtheme of the person not seen. It is also important to note that although she was a PMH nurse and psychotherapist, Peplau developed her framework to guide nursing practice in all settings, not just PMH nursing. As a middle-range nursing theory (Howk, 2002) with reference to specific elements of the NPR (McCamont, 2006), the framework can be used to shed light on the theme of mindful approach and other relational themes, but it does not provide a complete perspective.

The theme of mindful approach subsumed three sub-themes: the frontline, the common ground, and the shift. The theme of frontline, with its strong evocation of the idea of place, bears some relationship to Barker's transmutation of the term *coal face*, which is the place where miners actively dig coal from the seam, to *care face.* The *care face* is the place where PMH nurses are directly engaged with patients for aims unique to nursing practice (Barker, Jackson, & Stevenson, 1999). The frontline is one expression of the care face. In this inquiry, the frontline was a place of active approach and exchange of perspectives, in which patients and nurses seemed to jostle for position, sometimes to seek advantage or exercise power, and sometimes to open a window of opportunity or declare a temporary truce. On an acute inpatient psychiatry unit, nurses

are highly engaged in responding to patients' rapidly changing feelings and behaviours, in fact, they are the clinicians who are primarily responsible for responding to patients in these circumstances; on their part, patients want nurses to recognize and anticipate their needs (Barker, Jackson, & Stevenson, 1999).

Initially, Barker developed the Tidal Model (Barker, 2002) for acute inpatient psychiatry (Barker, 2003). Barker used Peplau's (1952) work as a foundation for a model which "incorporated… a discrete model of empowerment" in the nurse-patient relationship and at the same time explore the "lived experience of the person in care" (Barker, 2003, p.99), with few assumptions about "the proper course of life" (Barker, 2001, p.217). Barker (2001) made specific reference to enacting a rescue of people in crisis. In this inquiry, the frontline was almost always a place of courage where nurses and patients met in a moment of extreme patient need. As nurses encountered patients in a place of anger, distress or other form of need they were able to suspend their assumptions about a patient's choices or goals. Barker (2001) abandoned any attempt to uncover a "causative course of the person's present problems of living" and instead focused on a joint exploration of the person's experience, which resulted in a "co-created narrative" (Barker, 2001, p.219). Similarly, in this inquiry, the common ground was a place for "connecting conversation", with little attention paid to using clinical language or diagnostic labels. In an anecdote that generated the theme of the shift, Nurse Samantha said, "when I was treating him almost as a child, it was 'why don't we do this?' … once we were able to link better to each other, I was able to ask him, 'what's on your mind today, what's important to you today?'" This encounter is congruent with Barker's perspective of a radical psychiatric nursing practice, in which "the caring response,

expressed by nursing, needs to flow with the person, adapting itself to the person's changing needs" (Barker, 2001, p.235), for the simple aim of "understanding the present situation of the person" (Barker, 2001, p.236). In Barker's Tidal Model, language of movement and journey evokes images of mindful approach: nurses and patients moving toward each other, retreating, setting up camp on common ground, and repositioning. The Tidal Model points toward a less complicated view of mindful approach, one in which nurses and patients place the language of illness aside and adopt a simpler language of personhood, courage and human dignity.

Keeping safe. Like all nurses, PMH nurses attend to patients' safety and security needs, and both PMH nurses and patients recounted these kinds of relational experiences. In this study setting, patients and nurses had a unique perspective on what constitutes safety and the role of nurses in protecting patients from harm. These unique perspectives relate to the role of the PMH nurse in supporting psychological and physical health, psychiatric patients' safety fears and rapidly changing mental status, physical characteristics of psychiatric units and their space limitations, and psychiatric nurses' exercise of power and control.

Acts of caring. On these study units, most PMH nurses understood their work to be focused predominantly on patients' psychosocial needs, but they also understood that as nurses they were called to respond when patients needed assistance to meet basic daily living needs and more complex physical health and illness needs. In a study by Pitkanen, Hätonen, Kuosmanen, and Välimäki (2008), patients stated that they valued interventions "supporting physical health" (p.1602); these interventions included medication administration, vital signs measurement and promoting rest. In this discussion, acts of

caring refers to nursing actions such as assisting with meals, hygiene, and other activities of daily living. With the exception of a study by Engqvist, Nilsson, Nilsson, and Sjöström (2007) who explored strategies for working with women with post-partum psychosis, there is little research on acute inpatient PMH nurses' response to patients requiring this kind of nursing care.

Spatial dynamics and caring acts. Malone's (2003) understanding of the "spatial dynamics of the nurse-patient relationship" (p.2003) and its relationship to nurses' work illuminates this discussion of acts of caring. Malone suggested that hospitalized patients experience "displacement" from the actions of their normal lives:

> Leaving behind the place of home and entering into the unfamiliar institutional spaces of the hospital, our understandings of intimacy and distance are challenged by intrusive examinations, loss of private space, the threatened foreshortening of our life horizons, and the need to depend upon the kindness of strangers as we seek not only wellness, but re-emplacement in our bodies and our lives. In hospitals, nurses are among the strangers to whom we turn. (p.2317)

In general, persons hospitalized for the treatment of psychiatric illness experience displacement from familiar routines; in some respects, patients with severe mental illness experience displacement from their own identities and their ability to interpret an unfamiliar environment. For example, in this inquiry, Patient Raha stated, "I didn't know who was real and who wasn't". Even though Malone's work frames Registered Nurse practice in all hospital settings (p.2318), I speculate that hospitalized patients with severe mental illness are "seek(ing) re-emplacement in their bodies" (Malone, p.2317). These

patients may be unable to discern their own bodily needs, or they may not be able to determine how to meet those needs in the unfamiliar and public place of the nursing unit.

Malone defined three types of proximity: physical, narrative and moral. In Malone's view, a nurse's nearness to the patient's body creates the possibility for "hearing and trying to understand" (p.2318) the patient's story; understanding the patient's story is necessary for the nurse to "encounter the patient as the other, recognize (ing) that a moral concern to 'be for' exists" (p. 2318). If "proximity beckons moral agents to act" (Peter & Liaschenko, 2004, p. 219), then the PMH nurse, who is the most physically proximate clinician to encounter psychiatric patients, is compelled to act, even if a patient's expressed physical need is one which is outside of usual psychiatric treatment and nursing care practices. Indeed, the patient's expressed need may be in conflict with prescribed psychiatric treatment and nursing care practices such as geographic restriction or behaviour management strategies.

The nurse's moral horizon and caring acts. I understand acts of caring and kindness as part of a nurse's moral horizon, in which a nurse's awareness of a patient's need for basic assistance represents what is "good" (Rodney, Varcoe, Storch, McPherson, Mahoney, Brown, et al., 2002, p.298). Rodney and colleagues identified commonly negotiated features of the moral horizon; these included "physical and psychological safety and prevention and minimization of harm" (p.300). In this inquiry, as nurses focused on psychosocial needs, they were confronted with other kinds of needs; this is consistent with the notion that "the horizon was not necessarily set as an objective, but rather, emerged in the context of treatment and care" (Rodney et al., 2002, p.299). At times, PMH nurses openly negotiated this changing moral horizon with patients; at other

times, there was no obvious negotiation. When Nurse Colleen told a patient, "I am going to run a bath for you", she did not negotiate this act of caring; she did, however, experience it as a moral imperative.

Rodney, Varcoe, Storch and colleagues (2002) observed that nurses, "often experienced a great deal of difficulty navigating" (p.307) as moral agents. When Nurse Colleen removed a patient from seclusion to help him to have a bath, she understood that her colleagues would object. In order to make it possible for the patient to bathe, Colleen waited until the objecting colleague left the unit and then summoned assistance from elsewhere to facilitate the process. Rodney and colleagues suggested that "supportive colleagues" (p.304) facilitated successful navigation toward a moral horizon; in this situation, Colleen was forced to hide this ethical practice from non-supportive colleagues. In this particular nurse-patient encounter, Colleen exercised her moral agency, but the social dynamics of the work team was a constraining factor.

PMH nurses in this inquiry did not universally enact caring and kindness related to patients' basic health and daily living needs. There are many possibly ways to understand this phenomenon: personal, contextual, organizational, regulatory, and sociopolitical (Trobec, Hersbt, & Zvanut, 2009). In the context of a discussion of nurses' moral horizon, I speculate that because PMH nurses do not commonly experience close physical proximity to patients, they find it difficult to understand a person's needs beyond those directly related to the treatment of mental illness. In this inquiry, a patient reported that a nurse would not help another patient re-make a soiled bed, and this patient was distressed by the nurse's lack of sensitivity to the other patient's need. It may be that PMH nurses, in their relationally-focused practice, privilege a concern for the patient's

psychiatric disorder, leaving other problems in living unacknowledged. If this is the case, then PMH nurses may be experiencing moral ambiguity in the presence of this kind of patient need; further, they may need to consider the conditions that are preventing them from successfully navigating toward a moral horizon.

Protecting and directing. It was evident from their stories that patients on an acute inpatient psychiatric unit experience intense vulnerability and that experience of vulnerability is a focus of concern in their relationships with nurses. In this inquiry, some patients experienced the nurse-patient relationship as a protective space. Engqvist, Nilsson, Nilsson and Sjöström (2007) found that PMH nurses understood the importance of creating a secure environment, and Walsh and Boyle (2009) found that patients with psychiatric illness saw the hospital as a "haven from the pressures of the outside world" (p.35). It has also been reported that hospitalized patients with mental illness sometimes saw fellow patients as "frightening" (Pitkanen, Hätonen, Kuosmanen, & Välimäki, 2008, p. 1603). In the lifeworld of patients, safety in relationship was an experience of physical security and projection of emotional safety: a space where the future is trusted.

In this inquiry, the experience of trust remained hidden. The theme of keeping safe points toward the experience of vulnerability, and it is in a future examination of this experience that the notion of trust may emerge. Carter (2009) suggested "there has been a surprising lack of scholarship in the nursing literature on the nature of interpersonal trust" (p.395). Carter referred to the philosophy of Baier (1986), who stated that it is important to explore trust in relationships between "the powerful and less powerful, especially in those in which there is trust between them" (p.253). Baier also maintained that an individual experience of trust is constrained by all of their other trust experiences.

Baier's view is of particular note to those who practice of nursing, as it suggests that a patient's decision to trust a nurse is not informed solely by a patient's experience in relationship with a particular nurse. In this inquiry, most patients alluded to trust in the context of a relationship with a specific nurse, but as I previously stated, the concept did not emerge from my conversations with participants and their experiences of trust were not fully explored. Because "trust often flourishes in a climate of familiarity" (Carter, 2009, p.397), Carter questioned the possibility of establishing a trusting relationship in health care when "interactions are frequently episodic" (p.397). In this inquiry, participants did not qualify their positive encounters in relation to their length of time in relationship, but all of the patients had been patients on the inpatient unit for several weeks.

Carter (2008) suggested that health care providers have adopted a parent-child model of trust with paternalistic models of interaction aimed at establishing compliance. Barker, Jackson, and Stevenson (1999) suggested that the "mother figure could be seen to nurture…at the same time offering protection" (p.107). In this inquiry, both nurses and patients used a mothering metaphor to articulate their experience of keeping safe; some patients articulated experiences similar to those reported by Barker and colleagues (1999), in which "some people were more than happy to hand themselves over to the nurse" (p.107).

Nurses and patients looking toward each other in the manner of a mother and child create an image of caring, but the mother-child relation also creates an image of power. Because of the inherent imbalance in power between patients and nurses and a patient's experience of vulnerability, a nurse holds special responsibility for

understanding power and limiting its use in the nurse-patient relationship. It has been reported that patients value PMH nurses' ability to manage behavioural disturbances, but that they also value nurses who do not abuse their formal power (Beech & Norman, 1995, p. 121); those nurses were described as responding to the patient "as a person" (p.121). Cutcliffe and Happell (2009) reported that PMH nurses employed relatively invisible strategies to enforce their power, such as privileging biopsychiatric treatment, controlling conversational content, or making decisions for patients. Cleary (2004) has reported that PMH nurses are often intimately involved in negotiating "contradictory expectations and conflicting demands" (p.57) related to following organizational rules and enacting treatment decisions. PMH nurses have been understood to be "enforcers of rules" (Müller & Poggenpoel, 1996, p.147; Walsh & Boyle, 2009); this has been found to "maintain distance" between staff and patients (Lilja & Hellzén, 2008, p.282). The practice of PMH nursing is intimately connected with the discipline of psychiatry, which has been shown to have "very clear links to social exclusion and control" (Cutcliffe & Happell, 2009, p.117). If Brimblecombe (2005) was right when he stated that "psychiatry still has tremendous influence over nursing…through direct influence at the clinical level" (p.350) then it is reasonable to accept that PMH nurses are agents of social control. This kind of power relation is clearly in conflict with many ideals of PMH nursing practice, particularly engaged relational practice.

In PMH nursing, there is a tension between patients' experiences of vulnerability, the challenge that nurses face to "fulfill their claim to be trustworthy" (Austin, 2007, p.81), patients' need for safety and security, and nurses' ability to "honour the patient's need" (Carter, 2009, p.403). In this inquiry, nurses and patients gave accounts of power,

recognizing how it created relational distance. One nurse experienced what I understood to be moral distress at assuming a role in which she "took charge of someone's life", while another nurse experienced no moral distress when she took a clearly authoritative action to minimize harm to the patient. On a daily basis, PMH nurses and their hospitalized patients are engaged in a relational space, attempting to meet the other in spite of the background noise of institutionalized power and control. The theme of safe keeping, with its related concepts of nurses' use of power and nurses' moral horizon, illuminates the obstacles to creating this kind of relational experience, and points toward an understanding of PMH nursing as a moral experience.

Contribution to the Discipline of Nursing

The major contributions of this study to the discipline of nursing are as follows:

- an exploration of engagement practices as lived by PMH nurses and patients, who may or may not have experienced a traditional, evolving therapeutic nurse-patient relationship;
- the detailed exploration of the experience of mindful approach in PMH nursing practice;
- uncovering the ethical challenges inherent in PMH nurses enacting caring practices related to activities of daily living in PMH;
- presenting the experiences of hospitalized patients with acute mental illness, who have so often in have been rendered invisible and voiceless.

Engagement practices. Since the advent of the text *Interpersonal Relations in Nursing* (Peplau, 1952), the nurse-patient relationship has been the subject of much research by nurse-scholars, particularly in PMH nursing. In the modern world of health

care, it has proven increasingly difficult to sustain nursing care environments in which nurses and patients have the opportunity to develop health-promoting, therapeutic relationships. In this inquiry, PMH nurses and patients stories of knowing the other, even in brief encounters, demonstrates nurses' commitment to one aspect of the therapeutic relationship, that is, understanding the patient. Even when the development of a long-term relationship was uncertain, nurses and patients moved toward each other, seeking engagement. I do not suggest that PMH nurses and patients do not experience challenges in establishing relationships; what I do suggest is that the theme of engagement was a dominant one, which points toward the meaning that patients and nurses attach to knowledge of the other.

The experience of mindful approach in PMH nursing practice. This inquiry revealed that despite the increasing pressure to maintain short lengths of stay and focus on biomedical intervention, PMH nurses and their hospitalized patients engage with each other in relational work that in some ways resembles traditional psychodynamic or humanistic frameworks, using language emanating from psychology or nursing communities of practice. That is not to deny that that nurses sometimes find it challenging to create place for relational practices in acute inpatient psychiatric settings. The fact that biomedical treatment occupies a privileged position in these settings influences how nurses set priorities. In their encounters with patients, nurses may feel pressured to focus on symptom assessment or treatment compliance, and abandon more patient-centered approaches. Funders are mandating shorter lengths of stay, and clinicians are being asked to help patients meet certain treatment goals within specific periods of time. For nurses whose work is focused on engagement, finding common

ground and facilitating transformation, these objective outcome measures hold little meaning.

The actual experience of mindful approach showed itself to be a kind of existential journey, in which patients and nurses moved about a field of understanding until each could comfortably meet with the other; private meanings became shared, and patients showed themselves as transformative beings, willing to move toward health. Stories that generated the theme of mindful approach made manifest the usually private experiences of PMH nurses as they helped patients find meaning in their illness experience. The emergence of the theme of mindful approach is a counterbalance to a vast array of PMH nursing research literature, in which the therapeutic nurse-patient relationship is both esteemed and elegized. The theme of mindful approach points toward the possibility that relational work, however imperfectly enacted, is still highly valued in PMH practice.

Keeping the patient safe: a moral horizon. Eminent nurse researchers in the field of PMH nursing and beyond have built a substantial body of literature related to the legal, ethical and moral dimensions of PMH practice. The social construction of power continues to be present in the discourse of nursing and other social science disciplines. I do not pretend that the findings from this inquiry will make a substantial contribution to the extant literature, with the exception of an understanding of caring practices related to the basic and bodily needs of the patient hospitalized with acute mental illness. Many have examined the challenge of providing psychosocial care to patients with physical illness, but few have explored the nursing work of providing physical care and support for basic activities of living to patients with acute mental illness. In this inquiry, patients

either sought or were understood to need this kind of care, and a patient's expressed need for protection "under the wing" of a nurse led to an exploration of the relationship of safe keeping to the concept of trust and power in the nurse-patient relationship. To a greater or lesser degree and faced with the moral imperative to respond to patients' basic needs, some nurses articulated a level of uncertainty. Only a few of the study participants articulated this theme and much of the meaning in these actions remains hidden. It is perhaps paradoxical that I assert the importance of these findings at the same time I acknowledge their limitations. I highlight these limitations in order to draw attention to the emergent question, and identify a direction for future inquiry.

The voices of hospitalized patients with acute mental illness. It has long been my hope to raise a platform so that nurses and other clinicians will hear the voices of hospitalized PMH patients on matters relating to the hospitalization experience. Much PMH nursing research has attempted to understand patients' experiences from patients' perspectives, but most researchers report on interviews that have taken place with patients in community or rehabilitation settings, or after the patient's hospitalization period has ended. It was my intention to focus the spotlight on the experiences of patients in an acute setting, and to understand these experiences as contemporaneously as possible, given ethical and practical considerations. Despite the practical barriers to recruiting patients into this study, the patients who participated all initiated their participation during their admission to the inpatient unit. Experiences were fresh, context was accessible, and conversations were lively. The nature of this contribution, then, is that it is full of possibility. Nurse researchers need to find courage, look beyond the barriers, and make connections with patients who are navigating the experience of psychiatric

hospitalization, for these are the most important sources of knowledge for the PMH nurse.

CHAPTER SIX

Strengths, Limitations, and Implications of this Research

Strengths and Limitations

Methodological rigour in interpretive inquiry. I am eager to demonstrate that I engaged in this inquiry competently and with integrity, which are significant hallmarks of rigour (Tobin & Begley, 2004). According to Laverty (2003), "Issues of rigour in interpretive inquiry are confusing to discuss…as there is not an agreed upon language used to describe it" (p.31). It has been suggested that the use of "generic" (deWitt & Ploeg, 2006, p.217) qualitative criteria to comment on interpretive phenomenology poses a problem because of the possibility of philosophical inconsistencies. It has also been suggested that these generic criteria may "create obstacles to full expression of rigour" (deWitt & Ploeg, 2006, p. 223) or miss threats to rigour that are unique to a particular methodology (Armour, Rivaux, & Bell, 2009). Laverty (2006) asserted that there is no "universal set of criteria" (p.31) and suggested concepts related to rigour in phenomenological inquiry were still evolving. Armour, Rivaux and Bell (2009) offered a corresponding view when they stated, "qualitative inquiry has been plagued by a lack of agreement about criteria for judging the adequacy" (p.102) of interpretive phenomenology.

Patton (2002) stated that choice of criteria for assessing rigour in qualitative inquiry should depend on the methodological and philosophical orientation of the researcher and the perspective of the research audience. It is likely that the audience for this research will situate themselves in many different philosophical, research, and professional backgrounds; therefore, I will discuss the limitations and strengths of this

work using a framework consisting of criteria of merit that reflect the nature of qualitative inquiry in general and its distinctness from a positivist paradigm. I will use Lincoln and Guba's (1985) framework, which Sandelowski (1986) interpreted for nursing research (deWitt & Ploeg, 2006, p.221). Lincoln and Guba's (1985) framework highlights credibility, transferability, dependability, and confirmability. Although deWitt and Ploeg (2006) stated that aspects of the Lincoln and Guba (1985) framework were not appropriate for evaluating interpretive research, Creswell and Miller (2000) noted that the language used in the framework reflected the "interpretive position" (p.125) that emerged during the last quarter of the 20th century. Creswell and Miller (2000) concluded that the framework is still an appropriate way of expressing the relationship between validity and interpretive inquiry. Beck, Keddy, and Cohen (1994) also suggested that Lincoln and Guba's (1985) framework was appropriate for interpretive phenomenology. In later work, Lincoln and Guba (1994) stated that it was more appropriate to comment on authenticity than credibility when discussing rigour in studies that fall within a relativist paradigm. An inquiry is said to be authentic if a) the researcher collects data from multiple sources, b) different worldviews are represented, and c) the voices of the researcher and the participants are clear to the reader. I will comment on authenticity in my discussion of credibility. Mindful of the debate surrounding particular criteria of merit in evaluating interpretive phenomenology, I will use Shenton's (2004) work to enrich the discussion, and I will comment on particular aspects of criteria that I understand to be inconsistent with the philosophical and methodological underpinnings of interpretive phenomenology.

Credibility and trustworthiness. Koch and Harrington (1998) stated that a study is credible if phenomena are faithfully rendered. The notion of truth is

philosophically complex, and in this phenomenological inquiry, I did not seek to establish an objective truth. Taylor (1985) asked: "How does one know if the interpretation is correct?" (p.17). Taylor suggested that the interpretion is correct if it helps "to make sense of the text", and if the text "appeals to our understanding of the language of expression" (p.17), with an inescapable "ultimate appeal to a common understanding of the expressions, of the language involved" (p.17). In interpretive inquiry, success is actualized through ongoing exploration of the relation of the part to the whole, entering into the circle of meaning-making known as the hermeneutic circle (Shleiermacher, in Ormiston & Schrift, 1990). According to Ast (1990), "no individual inspection of a work ever exhausts its meaning…interpretation can always be rectified. Even the best is only an approximation of the meaning" (p.97). In order to be credible, my analysis should be a fitting representation of a) my conversations with participants, and b) the meanings that emerged from my experiences and those of the study participants. In order to promote confidence in the credibility of this research, I will comment according to criteria from Shenton (2004).

Familiarity with the research context. I interpret the fact that I was extremely familiar with the study units, having worked as a Clinical Nurse Specialist on all study units for an extended period of time (which ended approximately three years before I began the study) as a strength of this inquiry. In anticipation of commencing the study, I connected with clinical nursing leaders and nursing staff, and sought to familiarize myself with changes in programming, personnel, and patient population. In relation to two of the study units, I had little difficulty gaining access.

One of the limitations of this study is that on one study unit, a physician team member initially objected to the study being conducted on the unit without his prior approval, and in the end, the person who had acted as gatekeeper had only partial success in securing his cooperation. The challenges on this particular unit were unique to that unit; on no other unit did I encounter resistance from psychiatrists. In fact, psychiatrists on other units became important sources of information regarding potentially appropriate patient-participants. On another study unit, nursing leadership changed shortly before study initiation and staff seemed to find it more difficult to accept my presence as researcher on their unit, even though I had worked on the unit only a few years before.

There was an additional limitation related to the research setting: in the two years prior to study initiation, two of the four study units experienced significant re-organization and mission change, a fact which had originally prompted me to limit recruitment to participants from two units that had not undergone change. When patient recruitment on the first two units proved to be a challenge, I sought permission to recruit from the two remaining units. These units were still in transition, and it is reasonable to assume that I was less familiar with them. As the unit programs were continually changing, the context within which I conducted interviews and observations was continually changing, and I found it difficult to develop an effective working relationship with the personnel on these units. I was able to recruit only three of fifteen participants from these units.

Prolonged engagement with a research setting may lead to some undesirable effects; in particular, researchers may "become so enmeshed with the subjects that investigators have difficulty separating their own experiences from their subjects"

(Sandelowski, 1986, p.30). In phenomenological inquiry, it is expected that researcher and participant become intensely engaged with the other, with an aim to build a shared understanding of the participant's experiences. At the same time, researchers must be able to maintain some distance so that they remain open to and curious about experiences as lived, articulated and interpreted by the participant. In this inquiry, I minimized any undesirable effects of long-term engagement. I maintained a degree of interpersonal distance by conducting semi-structured interviews in a formal, quiet interview room on the inpatient unit. In addition, I was constantly mindful of the interview guide when interacting with patient-participants, and brought the interview to close if I sensed that the patient was seeking a therapeutic encounter, rather than engaging in a research interview. I actively reviewed the accounts of patients and nurses before engaging in secondary interviews, so that I could focus my attention on emerging themes and questions for discussion that arose from the accounts of patients and nurses. I engaged in reflective writing, which helped me to clarify my own perspective on my research experiences.

Sampling. Shenton (2004) suggested, "A random (sampling) approach negates charges of researcher bias" and contributes to credibility in qualitative inquiry (p.65). Random sampling is not an appropriate criterion for credibility in interpretive phenomenology; randomness does not alter or enrich the meaning of an individual's experience. In this phenomenological study, I used purposive sampling to engage participants who met specific criteria and were willing and able to share their stories. A particular limitation related to sampling in this study is that patient-participants were required to be capable of consenting to treatment. This reduced the potential patient-participant pool, and eliminated the possibility of speaking directly with patients who

were not capable of consenting to treatment. During the period of the study, on any given day, there were more patients on the study units who were certified as incapable of consenting than were certified as capable of consenting, and therefore a majority of patients on the study units were excluded from the study. This challenged the study's authenticity, as I could only hear the stories of patients who met the study criteria. That being said, almost all of the patients had been certified as incapable of consenting at some point in their hospitalization; almost certainly, many gave accounts of experiences that occurred when they had been deemed incapable of consenting. Further, it is important to note that the authenticity of the study was strengthened by the fact that both nurses and patients were invited to share their experiences of relationship. In this way, I was able to uncover differing worldviews: those held by nurses and those held by patients. It is possible that some readers may interpret my sampling method to be a threat to both credibility and authenticity, and a limitation of the study.

Sample size is a sampling-related limitation in this inquiry. While "sample sizes in qualitative research are typically small because of the large amount of verbal data that must be analyzed" (Sandelowski, 1986, p.31), in this inquiry, the sample size was both small and unevenly distributed. Over a period of 13 months I was only able to recruit six patient participants, while I was able to recruit nine nurse-participants. This imbalance created a situation whereby the volume of accounts created by nurse-participants was significantly greater than the volume created by patient-participants. Although rich and meaningful texts emerged from conversations with both nurses and patients, there is no doubt that the nurse perspective has at times, overwhelmed the patient perspective.

It is possible that the sample suffered from the problem of "elite bias" (Miles and

Huberman, 1994, p.410). Elite bias occurs when study volunteers are "the most articulate, accessible or high status members of their groups" (Sandelowski, 1986, p.32). While all were accessible and most were articulate, of all fifteen participants, only one participant seemed to hold high status in her group (a Registered Nurse who acted in the position of clinical leader). All other nurses were staff nurses of various skill levels and years of experience. Of the six patient participants, two had active psychotic symptoms (but were cognitively organized) and the remaining four were well into their recovery phase. It is possible to characterize this sample as reflecting an "elite bias", although I hold that the stories themselves are true to the experiences of the participants and beyond the fact that the participants were articulate, I see no evidence that the participants held a narrow or privileged world view.

Triangulation. Triangulation involves the use of multiple sources of data or multiple strategies for collecting data (Shenton, 2004). In this inquiry, I used interviews and participant-observation to help me fully understand participants' experiences. Participant-observation gave me the opportunity to explore participants' experiences in real time and clarify individual perceptions of the unit environment. In addition, I explored participants' relational experiences by interviewing both nurses and patients, and using information from individual interviews, I created questions for other participants in follow-up interviews. In this way, over the course of the research, I maintained an ongoing awareness of participants' accounts and my interpretation of those accounts, and used my emerging understanding of the phenomena under study as a foundation for further enquiry. It is important to recognize that in this inquiry, triangulation was not used as a means of "confirming existing data, but as a means of

enlarging the landscape of the inquiry, offering a deeper and more comprehensive picture" (Tobin and Begley, 2004, p.393). Participant-observation also strengthens the study's authenticity by using different sources for data and honouring different worldviews.

Participant honesty. When I approached potential participants, I created many opportunities for participation refusal; according to Shenton (2004), this ensures that "data collection sessions involve only those who are genuinely willing to take part and prepared to offer data freely" (p.66). I attempted to establish rapport with each participant, and although I asked specific questions, I encouraged a free flow of ideas. I ensured that participants knew that I was not connected in any formal way with their clinical decision-making team or their nursing supervisors. I informed participants that they had the right to withdraw from the study at any time, and therefore they shared information at their pleasure.

Iterative questioning. Shenton (2004) suggested that it is important to "incorporate specific ploys to…uncover deliberate lies" (p.67). I did not approach participants with the expectation that participants would offer lies. In order to engage participants in experiences that created the possibility for uncovering and sharing meaning, I used a form of iterative questioning, whereby I relied on earlier information to suggest and create new lines of questioning.

Other approaches to ensuring credibility. Shenton (2004) suggested other approaches to ensuring credibility, such as negative case analysis (Miles & Huberman, 1994), peer scrutiny of the research project, reflective journaling, and member checks (Guba & Lincoln, 1989). Negative case analysis, with its focus on category confirmation,

is more suited to grounded theory methodology than interpretive phenomenology. In a form of peer scrutiny, I presented some anecdotes from this study to a national conference of PMH nurses and at a seminar of graduate students in my home institution. Significantly, two study participants were also in the conference audience. After the presentations, I had the opportunity to discuss the premise of the research, my assumptions, and some early interpretive writing. These activities helped strengthen the inquiry by giving me an opportunity to view the data through the lens of others. I also engaged in reflective journaling, which helped me to uncover both my own previously unacknowledged responses to conversations with participants, and gain deeper insight into the accounts of patients and nurses and the meanings that were revealed to me.

Guba and Lincoln (1989) defined member checking as "the process of testing hypotheses, data, preliminary categories and instruments with members of the stakeholding group" (p.239). While Guba and Lincoln (1989) maintained that member checking is "the single most crucial technique for establishing credibility" (p.239), I am hesitant to apply this criterion in its strictest sense to this inquiry. As defined by Guba and Lincoln (1989), member-checking is consistent with a post-positivist paradigm, as it "corrects errors of fact or interpretation" (p.240). Because interpretive phenomenology seeks to uncover meaning through exploration of the life world of the participant, it is philosophically inconsistent to contemplate an "error of fact" emerging from this exploration. It can be said, however, that in so much as phenomenology involves perceiving and grasping meaning (Benner & Wrubel, 1989), the researcher may struggle to grasp the narrator's meaning. Given that "the person is seen as attuned to and concerned with a world of significance" (Benner & Wrubel, 1989, p.97), the researcher

must respect the meaning that the person creates and seek to understand it as completely as possible. In this inquiry, I sought to understand the person's "world of significance" by carefully listening to participants as they recounted their stories, asking questions based on what I interpreted to be matters of significance to the person, reviewing transcripts after the completion of the interview, and scheduling follow-up interviews to create opportunities for clarifying possible misinterpretations and uncovering new meaning.

Transferability. Transferability in qualitative inquiry is related to the concept of generalizability (Tobin & Begley, 2004). According to Sandelowski (1986), "generalizability is something of an illusion since every research situation is ultimately about a particular researcher in interaction with a particular subject in a particular context" (p. 31). Taking the opposite position, Stake (1994) suggested that it is possible to demonstrate that a single case in a qualitative inquiry is an example from the study group, and that it is possible to cautiously apply the findings of one study to other contexts. While I do not hold that the results of this study are transferable or generalizable in the post-positivist sense, and some may assess this as a study limitation, I attempted to make first-hand accounts the centerpiece of this work, so that readers can understand both the context of the inquiry and how participants interpreted the phenomena. Further, by explaining the study context and offering my interpretation of participants' experiences, I am encouraging researchers to engage in further enquiry in similar or different settings, and encouraging readers to reflect on these experiences themselves.

Dependability. Dependability relates to the concept of reliability in quantitative research but "qualitative research emphasize the uniqueness of human situations and the importance of experiences that are not necessarily accessible to validation through the senses" (Sandelowski, 1986, p.33). It has been recommended, "The processes within the study should be reported in detail" (Shenton, 2004, p.71). In this respect, this inquiry strongly meets the criterion of dependability in relation to the description of the research design and the description of the data collection process. Earlier in this paper, I have discussed particular problems associated with patient recruitment, therefore offering an appraisal of the effectiveness of this part of the data collection process, which also supports my claim to the dependability of this work.

Confirmabilty. Confirmability is related to the concept of "freedom from bias" in quantitative research (Sandelowski, 1986, p.33, Shenton, 2004). The process of triangulation, described in an earlier section, contributes to confirmability. Confirmability is also achieved when the researcher explains her own perspective in reflective commentary. Considering the extensive reflective material at the beginning of this paper and the weaving of reflective material throughout the interpretive commentary, this inquiry meets this aspect of the criterion of confirmability. The lack of a clear audit trail may be interpreted as a weakness in this inquiry, although I have presented an explanation of my approach to data collection and the interpretive process.

Implications for PMH nursing practice

PMH nurses have found themselves experiencing tension in clinical practice as they attempt to work relationally within a biomedical treatment paradigm. This research has uncovered some aspects of that struggle, but more importantly, nurses and patients

revealed that in a psychiatric inpatient setting, it is possible for nurses and patients to create a knowing encounter in a chaotic and unpredictable environment if each is looking toward the other.

This inquiry challenges clinical nursing leaders and PMH nurses in acute settings to create conditions for practice in which nurses can expertly respond to multiple demands in varied encounters in the same way that PMH nurses have developed expertise in traditional relationship development. Horsfall, Cleary, and Hunt (2010) stated, "what happens on a unit depends on who is there, how they got there, and where else they could be under other circumstances" (p.275); an expert PMH nurse is highly flexible and responsive to rapidly changing patient experiences and expectations. Despite patients' challenges associated with hospitalization in an acute inpatient psychiatric care setting, such as nursing availability and disconfirming and depersonalizing experiences, patients value encounters with nurses. Perhaps nurses need to rethink approaches to nursing care delivery such as primary nursing, where a patient-nurse dyad is formed on admission and the patient is considered part of a nurse's continuing caseload; perhaps a system of primary nursing actually restricts nurses and patients from moving toward each other when the need arises. Primary nursing was instituted so that nurses and patients can develop effective, therapeutic and traditional working relationships. This inquiry suggests that relational work does not necessarily follow a traditional path.

This research suggests that the tradition of nurse-patient relationship is not dead, but the character of the relation is changing. Nurses in this inquiry pointed toward the value of being fully responsive in the moment that the patient's need presented itself. In inpatient psychiatric nursing practice, nurses were called to approach patients with the

intention of creating a highly intimate interpersonal space, even when they were uncertain of the potential for intimacy and long-term engagement. This inquiry suggests that the highly idealized nurse-patient relationship in acute inpatient psychiatry does not always exist in reality; nurses and patients do not always move unremittingly toward achievement of mutually determined health goals. Perhaps the nurse-patient relationship would be better characterized as a cycle of approach and withdrawal, commitment and disconnection, presence and absence, the nature of which depends on the emerging needs of the patient and the willingness of nurse and patient to move toward each other at a particular moment in time; in other words, each moment could be understood to hold the potential for moving toward or moving away from engagement. In these moments, as in all relational moments, the person interprets the context and creates a response based on the meaning derived. By understanding relationship in this way, nurses in acute inpatient psychiatry may be able to free themselves from the burden of a tradition of relational practice that depends on prolonged nurse-patient contact, continuity, and a system of organizing nursing care that may soon become extinct.

This inquiry challenges nurses to examine their understanding of the scope of psychiatric-mental health nursing in an acute inpatient psychiatric unit. Patients needed support in all dimensions of distress, and not just those commonly categorized as psychological. Nurses enacted caring responses to those needs, but interpreted caring for the body and activities of daily living as "basic" nursing; in doing so, they seemed to be privileging work traditionally viewed as psychiatric nursing, such as responding to safety and security needs, assessing mental status, administering medications, engaging in emotional support. I suggest that PMH nursing practice is one of the few settings for

hospital-based nursing practice where there is potential for enactment of whole person care. Some may question whether PMH nursing expertise encompasses care of the body and responding to physical discomfort. In PMH nursing practice, truly engaged relational experiences create awareness of issues such as problems of everyday living, emotional suffering, social isolation and physical discomfort, all considered to be within the scope of nursing practice.

Implications for nursing education

This inquiry creates questions for those charged with the education of nurses. Education in the specialty of PMH nursing and sometimes advanced practice nursing commonly focuses on helping nurses become experts in cognitive-behavioural therapy, solution-focused therapy, family therapy, and other forms of psychologically based therapies. This inquiry revealed that on occasion PMH nurses in acute inpatient settings experience their encounters through the lens of psychological knowledge, but significantly, these nurses seemed to be seeking a deeper understanding of their patients; importantly, patients did not state that they sought out nurses because they were skilled in counseling or psychotherapy. Perhaps educators should help PMH nurses develop knowledge of nurse-patient relationship in the context of PMH practice before helping them explore the tools from the discipline of psychology, and when PMH nurses consider using these tools, they need to make them meaningful and consistent with a nursing paradigm. Curriculum planners may need to consider how to help PMH nurses can understand relational ways of knowing before they present students with psychology practices that may not be consistent with relational values.

It is true that many nursing curricula are rich with content related to nurse-patient communication and nurse-patient relationship, but this content is often presented in a theoretical and decontextualized way. Like many other professional disciplines, nursing has experienced an explosion of knowledge for practice, and student nurses often find themselves buried in a sea of facts (Horton-Deutsch & Sherwood, 2008). While students must understand the rich tradition of nurse-patient relationship and knowledge arising from associated scientific inquiry, I suggest that in order for students to create meaningful relational practice, whether as PMH nurses or nurses in another specialty, they must develop self-understanding in the context of their relationships with patients. In nursing curricula, clinical practice is often understood to be an opportunity for development of technical skill, and is often matched with corresponding theoretical course work. If "being engaged with patients encompasses what probably is the most important tool available to the nurse, the self in its entirety" (Hess, 2003, p. 146), educators need to consider how to create clinical practice opportunities focused on self exploration and reflection: that is, helping learners to know what it means to be a nurse-in-relation,

Horton-Deutsch and Sherwood (2008) stated that reflective learning helps students develop awareness of their thoughts, feelings, experiences, worldview, and the influence of these on their nursing work, and that nurse educators should facilitate reflective learning to help students "manage the intense emotional labour of nursing" (Horton-Deutsch & Sherwood, 2008, p.947). I contend, however, that reflective practice is more than just a strategy for uncovering and articulating understandings, previously tacit or otherwise, in order to manage a clinical encounter. Rather, "reflection-in-action" (Schön, 1982, p.49) is, as Schön (1982) puts it, "a legitimate way of professional

knowing" (p. 69). Nurses need to be open to the uncertainty of discovering the particular nature of each nurse-patient relationship as it is being experienced; in other words, reflection-in-action is the "core of practice" (Schön, 1983, p.69) and not just a tool for managing the practice situation. Reflective practice is an experience of meaning-making within the nurse-patient relationship. Nursing faculty need to accept the uncertainty that this kind of reflective experience creates, and be prepared to help learners exploit this uncertainty for valuable learning.

Implications for future nursing research

In terms of understanding patient experience, this inquiry suggests that patients who are admitted to an acute psychiatric inpatient unit can interpret and articulate their relational experiences in ways that create meaning for PMH nurses. The challenges in recruitment of patient-participants serve as a caution for nurse-researchers, but it is clear, from this inquiry and others, that patients in this setting have much to say about their illness and hospitalization. Further inquiry should, where possible, seek the perspective of both patients and nurses.

The themes that emerged in this inquiry create many new questions about relational experience in PMH nursing; these questions can be explored using an interpretive lens. Future research questions include the following:

- Some PMH nurses articulated an understanding of the relational process as viewed through the lens of psychotherapeutic relationship. Given the unique and highly particularistic view that this lens allows, what nurse-patient relational practices are enriched in this view? What aspects are constrained? What is the significance to PMH nursing practice?

- Are PMH nurses really uncertain about their responsibility to care for psychiatric patients' physical needs? What is the source of that uncertainty? Is it related to awareness of shared vulnerability that emerges from intimate and knowing relational practices?
- Understanding that relational experiences between nurses and patients do not always follow a predictable path, what constitutes an end to the PMH nurse-patient relation? How do patients and nurses experience "ending"?
- At times, relations between PMH nurses and patients appeared to generate transformative experiences for patients. What is the nature of this transformation? How is transformation reflected in the narrative of mental illness as it unfolds beyond hospitalization? How does personal transformation relate to illness experience and health outcomes?
- PMH nurses and patients sometimes understood their relationships with each other as protective and maternal. What is a PMH nurse's experience of nurturing in an acute inpatient setting when a patient does not experienced nurturing? Are patients who feel controlled and traumatized by virtue of experiences such as locked seclusion or involuntary medication open to a nurturing experience? What is the relationship between the gender of the nurse or patient and their experiences of nurturing in this context?
- What is the nature of trust in a nurse-patient relational experience that is incidental or informal? How do a patient's trust experiences with other

health care providers inform, influence, or change a patient's trust experience in a particular nurse-patient relation?

- The culture in acute inpatient psychiatric units is often rich with a tradition of social control. Given that nurses and patients in this inquiry articulated the potential for engaged relational practice, how might the tradition of control continue to show itself? How might engaged practice show itself in an evolving unit culture?

End Note

As a Registered Nurse, I understand that my colleagues in other health care disciplines may look at this research and note similarities or differences between these findings and their own experience as caring professionals. In my view, each discipline must explore its own relational practices, in the context of providing clinical care and as members of interprofessional teams. In the acute inpatient psychiatric setting, some may find it more challenging than others to explore the notion of "engaged care" (Schultz & Carnevale, 1996, p. 198) and understand its place in professional practice. All clinicians work within practice paradigms that frame their relational experiences, and these paradigms need to be uncovered and explored.

In acute inpatient psychiatric units, nurse-patient relationships are profound experiences for both patients and nurses. Patients continue to approach clinicians, seeking more engaged ways of being. Nurses are called to listen to patients' stories, so that they can envision their own moral horizons, reconcile tensions arising from competing worldviews, and work with patients to create safe, affirming, and healing places for recovery from acute mental illness.

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Appendix A
Nurse-Participant Consent Form

Consent to Take Part in a Research Study

Nurse-Participant Information

STUDY TITLE: The relationships of hospitalized persons with acute mental illness and their nurses: an interpretive inquiry

PRINCIPAL INVESTIGATOR:
Catherine Thibeault, RN, MN, PhD (c)
School of Nursing
Dalhousie University
5869 University Avenue, Halifax, Nova Scotia, B3H 3J5
Telephone: _____.

PART A
RESEARCH STUDIES

Introduction

You are invited to take part in a research study. The study is taking place at _____. We are doing this study to find out better ways of caring for people with problems like yours. This information will help you decide if you want to be part of the study or not.

I am a Registered Nurse and faculty member of the School of Nursing, Dalhousie University. I am doing this research as part of my Doctor of Philosophy program at the School of Nursing, McGill University. The study involves asking patients and staff to meet with me and talk about their experiences in the acute care psychiatric inpatient unit. I will use this information to learn more about how nurses and people with mental illness work together while patients are in hospital.

Taking part in the study is voluntary. The information in this consent form will help you decide if you want to be part of the study or not. Participating in this study may not benefit you, but information gained may benefit others in your situation. The quality of your health care will not be affected by whether you participate or not.

What will I learn from reading this?

I will explain why I am doing the study, and what you will be asked to do. I will tell you about what will happen, and about inconveniences, discomforts or risks. Please read this consent form carefully. Take as much time as you like. Mark anything you don't understand, or want me to explain better. After you have read it, please ask questions about anything that is not clear.

What is a research study?

A research study is a way of finding out new information about the best way to care for people. In this study, we want to find out what it is like for nurses and patients to interact on an inpatient psychiatric unit.

Do I have to take part in this study?

No. It is completely up to you. Whether you take part or not is for you to decide. You may want to show this to your family or friends before you make up your mind. Please feel free to get other opinions any time.

No matter what you decide, no one will be upset with you if you decide not to take part or change your mind.

If you do decide to take part, you can still change your mind and stop participating at any time. If you decide to stop participating in the study, please talk to me first. I can answer any questions you may have.

Will the study help me?

It is very likely that there will be no direct benefit to you. In this study, I want to learn about the experiences of patients and nurses who are working together while the patient is in an acute inpatient psychiatric unit. I may gain knowledge that will help nurses like you who work in inpatient psychiatric settings and their patients.

PART B

EXPLAINING THIS STUDY

Why is this study being done?

I want to understand your experiences of interacting and working with patients on the inpatient unit, so I can learn more about how nurses and patients work together in this setting.

Are there other choices?

You do not have to be in this study in order to be employed as an RN or LPN on the inpatient psychiatric unit. If you would like to talk to someone about your interactions with patients, but you do not want to participate in this study, I encourage you to talk with your manager, your nurse educator, or your colleagues.

Why am I being asked to join the study?

You are being asked to join this study because you are a nurse on an acute inpatient psychiatric unit. Because you work on one of these units, and have interactions with patients, your perspective about those interactions is important.

Who can take part in this study?

If you are a nurse, you may take part in this study if the answer to the following is "yes":
Are you are a Registered Nurse or Licensed Practical Nurse on _____?
Do you work in a part-time or full time position?
Are you are able to talk with me about your experiences working with patients?
Will you give informed consent to participate in this study?

How long will I be in the study?

If you agree to participate in this study, we will meet at least three times. If you continue to participate in the study, you will be enrolled in the study for three to six months.

How many people will be taking part in this study?

This study is taking place only in _____. About 10 patients and 10 nurses will participate in this study.

How is this study being done?

In this study, I will learn about your experiences in two ways. The first way is by talking with you. Together, you and I will meet and talk about your experiences interacting with patients on the inpatient unit. During our conversations, our voices will be taped. The second way I will learn about your experiences is by observing you when you are interacting with patients. I will be on the inpatient unit at certain times, and I will observe patients and nurses who have given their permission to be observed. I may take notes to help me remember what I observe. At times, I may ask to observe a meeting between you and a patient. At other times I will be present in open areas on the unit, observing many patients and nurses all at once.

A person (who does not know you) will listen to the recordings and put your words onto paper. I will read the written records of all of our conversations so that I can learn what it is like for nurses and patients to interact on the inpatient psychiatric unit. I will think about what you and other nurses have said and identify ideas that seem to have some importance. I will identify words and stories that best describe nurses' and patients'

experiences. I will write those words and stories down in a way that helps me understand what nurses are experiencing. I will use these words and stories to ask nurses even more questions in the second and third interviews. Finally, I will summarize and analyze nurses' experiences, so other people can learn from them.

Your name will not be recorded in any research data. A code will be used to label any written record of our conversations, or my observations.

What will happen if I take part in this study?

If you decide to participate in the study, you will first be asked to sign this consent form. You will be given a copy of the consent form to keep for your own records. You and I will agree on a time when we can meet for the first interview.

After the first interview, together we will decide when we will be able to meet next. You can decide where you would like to meet with me. We can meet in an office at the hospital, or we can meet at my office at _____. It is up to you. Meetings may last up to 1 ½ to 2 hours. I would like to talk with you at least three times in total. Each time we meet, I will ask you if you continue to give consent to participate in this study. If you do not wish to continue meeting with me, you may stop at any time. After the third interview, your participation in the study will end. In the same way, if there is any time that you do not want to be observed while I am on the unit, please tell me and I will not continue the observation and I will not take any notes.

At no time will your name be recorded on any paper containing interview or observation data, or any research report. A special code will be used to label any record of our conversations or my observations. From example, if you are the first nurse in the study, and we have our first talk on August 3, 2008, your code might be 3-08-08-01N. After the third interview, your participation in the study will end.

Are there risks to the study?

Although sometimes people may find it helpful to talk about their experiences, there is a chance that you will find it upsetting to answer questions about your interactions with patients. You only have to answer the questions that you want to answer. If you find the interview distressing, you can stop the interview. There is also a chance that you will find it upsetting to be observed when you are a nurse on the unit. You may decide when you want to be observed and when you don't want to be observed. If you find it distressing to be observed, you can tell me to stop observing you. If it is necessary, I will help you connect with another professional person, available through the Employee Assistance Program, who will help you feel better.

You may also find that when you talk to me and answer questions about your interactions with patients, you will think about things that you wouldn't normally think about. You may share events and conversations with patients that you had placed at the back of your mind. Talking about these events and conversations may cause you to think differently

about the patients on the unit. Talking about these memories may affect your relationships with patients on the unit. If you find that our conversations are making your relationships with patients uncomfortable, you can choose to stop participating in the study.

I will do everything I can to maintain your right to privacy, but there is a chance that someone reading quotations from our conversations in a research report of this study may be able to identify you by your words. Neither your status as an employee of Capital Health nor your job performance will be affected by your choice to participate or not participate in this study.

Are there other choices?

Yes. You do not have to participate in this study to be employed as a Registered Nurse or Licensed Practical Nurse on your unit.

What are my responsibilities?

As a study participant, you will be required to:
Renew informed consent at every interview
Tell me if you feel upset and need help while you and I are talking, or while I am observing you

Can I be taken out of the study without my consent?

Yes. You may be taken out of the study at any time if:
There is new information that shows that being in this study is not in your best interests
The _____ Research Ethics Board or Principal Investigator decides to stop this study
You will be told about reasons that you might need to come out of the study.

What about new information?

You will be told about any new information that might affect your health, welfare, or willingness to stay in the study.

Will it cost me anything?

<u>Compensation</u>
You will not be paid to be in the study.

<u>Research Related Injury</u>
If you become ill or you are injured because you are in the study, necessary medical treatment will be available at no additional cost to you. Your signature on this form only indicates that you have understood to your satisfaction the information regarding your

participation in this study and agree to participate in this study. In no way does this waive your legal rights, nor release the Principal Investigator or involved institutions from their legal and professional responsibilities.

As a Registered Nurse and a researcher, I have a responsibility to inform you of any risks as they arise, and to help you get appropriate care if you suffer any distress or worsening of your illness as a result of participating in this study. The research team and the hospital also have their usual legal and professional responsibilities. Signing this form does not alter any of that. .

What about my right to privacy?

Protecting your privacy is an important part of this study. A copy of this consent will be put in your health record.

When you sign this consent form you give us permission to:

Collect information from you
Share information with the people conducting the study
Share information with the people responsible for protecting your safety

Access to records

As the researcher, I will see health and study records that identify you by name. Other people may need to look at the health and study records that identify you by name. These might include the _____ Research Ethics Board and Research Quality Associate, the person who is supervising my research and my research assistant.

Use of records

The research team will collect and use only the information they need to complete the study. This information will only be used for the purposes of this study.

This information will include your:
Sex
Information from study interviews

Your name and contact information will be kept secure by the research team in _____. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study. Information collected for this study will kept as long as required by law. This could be 7 years or more.

If you decide to withdraw from the study, the information collected up to that time will continue to be used by the research team. It may not be removed.

Information collected and used by the research team will be stored by the researcher at the _____. The researcher is the person responsible for keeping it secure.

You may also be contacted personally by Research Auditors for quality assurance purposes.

Your access to records

You may ask the researcher to see the information that has been collected about you.

What if I want to quit the study?

If you chose to participate in this study and later change your mind, you can say no and stop the research at any time. All data collected up to the date you withdraw your consent will remain in study records. Your decision to stop being in the study will not affect your status as an employee.

Declaration of financial interest

No one conducting this study has any financial interest in this study. No one conducting this study will receive any money, other than their usual salary, for conducting this study.

What about questions or problems?

For further information about the study call Catherine Thibeault at _____.

What are my rights?

After you have signed this consent form you will be given a copy.
If you have any questions about your rights as a *research participant*, contact your unit manager or union representative.

PART C

Consent Form and Signatures

I have read all the information about this study, which is called: "The relationships of hospitalized persons with mental illness and their nurses: an interpretive inquiry"

I have been given the opportunity to discuss it. All my questions have been answered. I am satisfied with the answers.

My signature on this consent form means that I agree to take part in this study.

_____	_____	___/_____ /___
SIGNATURE OF PARTICIPANT	NAME (PRINTED)	day month year*
_____	_____	____/_____ /____
WITNESS TO PARTICIPANT'S SIGNATURE	NAME (PRINTED)	day month year*
_____	_____	____/_____ /____
SIGNATURE OF INVESTIGATOR	NAME (PRINTED)	day month year*
_____	_____	____/_____ /____
SIGNATURE OF PERSON CONDUCTING CONSENT DISCUSSION	NAME (PRINTED)	day month year*

I WILL BE GIVEN A SIGNED COPY OF THIS CONSENT FORM.

Thank you for your time and patience.

Appendix B
Patient-Participant Consent Form

Consent to Take Part in a Research Study

Patient Information

PART A
RESEARCH STUDIES

STUDY TITLE: The relationships of hospitalized persons with acute mental illness and their nurses: an interpretive inquiry

PRINCIPAL INVESTIGATOR:
Catherine Thibeault, RN, MN, PhD (c)
School of Nursing
Dalhousie University
5869 University Avenue, Halifax, Nova Scotia, B3H 3J5
Telephone: _____.

1. Introduction

You are invited to take part in a research study. The study is taking place at _____. I am doing this study to find out better ways of caring for people with problems like yours. This information will help you decide if you want to be part of the study or not.

I am a Registered Nurse and faculty member of the School of Nursing, Dalhousie University. It is likely that I am not known to you. I am doing this research as part of my Doctor of Philosophy program at the School of Nursing, McGill University. The study involves asking patients and nurses to meet with me and talk about their experiences in the acute care psychiatric inpatient unit. I will use this information to learn more about how nurses and people with mental illness work together while patients are in hospital.

Taking part in the study is voluntary. The information in this consent form will help you decide if you want to be part of the study or not. Participating in this study may not benefit you, but information gained may benefit others in your situation. The quality of your health care will not be affected by whether you participate or not.

2. What will I learn from reading this?

I will explain why I am doing the study, and what you will be asked to do. I will tell you about what will happen, and about inconveniences, discomforts or risks. There is a

complete description of the study and the procedures that the study involves. Please read this consent form carefully. Take as much time as you like. Mark anything you don't understand, or want me to explain better. After you have read it, please ask questions about anything that is not clear.

3. What is a research study?

A research study is different from normal or standard care. It is a way of finding out new information about the best way to care for people in your situation. In this study we want to find out what it is like for nurses and patients to interact on an inpatient psychiatric unit.

4. Do I have to take part in this study?

No. It is completely up to you. Whether you take part or not is for you to decide. You may want to show this to your family, friends or your doctor, before you make up your mind. Please feel free to get other opinions any time.

No matter what you decide, the people in charge of your care support your decision. No one will be upset with you if you decide not to take part or change your mind.

If you do decide to take part, you can still change your mind and stop participating at any time. If you decide to stop participating in the study, please talk to me first. I can answer any questions you may have about continuing your usual care.

5. Will the study help me?

I do not know. It is very likely that there will be no direct benefit to you. In this study, I want to learn about the experiences of patients and nurses who are working together while the patient is in an acute inpatient psychiatric unit. We might learn something that will help people with similar problems to yours, or who are in similar situations.

PART B

EXPLAINING THIS STUDY

6. Why is this study being done?

I am trying to understand what it is like for you to interact and work with nurses on the inpatient unit. I want to learn more about how nurses and patients work together in this setting.

7. Are there other choices?

If you are a patient, you do not have to be in this study to get care for your problems. You will continue to receive all usual treatment and care. If you would like to talk to someone about your interactions with nurses, but you do not want to participate in this study, I encourage you to talk to the patient representative.

8. Why am I being asked to join the study?

You are being asked to join this study because you are or have until very recently been a patient in an acute inpatient psychiatric unit. Because you have stayed on one of these units, and had interactions with nurses, your feelings about those interactions are important.

9. Who can take part in this study?

If you are a patient, you **may** take part in this study if the answer to the following is "yes":

- ✓ Are you are an inpatient on _____ or you have recently (within one week) been discharged from either of those units?
  Or
  Are you an inpatient on _____ being actively treated for a mental disorder?
  Or
  Are you an inpatient on _____ and have recently (within one week been discharged from _____?
- ✓ Can your psychiatrist or his/her delegate determine that your health will not get worse if you take part in this study?
- ✓ Are you are able to talk with me about your experiences without becoming distressed, or without your illness becoming worse?
- ✓ Are you capable of giving consent to treatment?
- ✓ Are you willing to take part in this study?
- ✓ Have you carefully read this form?
- ✓ Are you willing to sign this form?

If you are a patient, you **may not** take part in this study if the answer to the following is "yes":

- ✓ Has your psychiatrist found you to be not capable of consenting to treatment at this time?
- ✓ If you are still a patient on _____, to the best of your knowledge, will you still be an inpatient two weeks after today's date?

10. How long will I be in the study?

If you agree to participate in this study, you will meet with me three times. At least one of those times will take place during or very near to the time when you were in hospital. The other two times will take place after you leave hospital. If you continue to participate in the study, you will be enrolled in the study for three to six months.

11. How many people will take part in this study?

This study is taking place only in _____. About 10 patients and 10 nurses will participate in this study.

12. How is this study being done?

In this study, I will learn about your experiences in two ways. The first way is by talking with you. Together, you and I will meet and talk about your experiences interacting with nurses on the inpatient unit. During our conversations, our voices will be taped using a simple audiocassette tape recorder. The second way I will learn about your experiences is by observing you when you are interacting with nurses. I will be on the inpatient unit at certain times, and I will observe patients and nurses who have given their permission to be observed. At times, I may ask to observe a meeting between you and your nurse. At other times I will be present in open areas on the unit, observing many patients and nurses all at once. I may take notes to help me remember what I observe. A person (who does not know you) will listen to the tape recordings and put our words onto paper.

After I talk to you I will read the written record of the conversations. I will also review what I have observed on the units. I will think about what you and other patients have said and identify ideas that seem to have some importance. I will identify words and stories that best describe patients' experiences. I will write those words and stories down in a way that helps me understand what patients are experiencing. I will use these words and stories to ask patients even more questions in the second and third interviews. Finally, I will summarize and analyze patients' experiences, so that other people can learn from them.

13. What will happen if I take part in this study?

If you decide to participate in the study, you will first be asked to sign this consent form. You will be given a copy of the consent form to keep for your own records.

After our first interview, you and I will decide when we will be able to meet and talk again. Our conversations will take place while you are in hospital and/or up to six months following your discharge. I will ask you questions like:

1. Tell me about the interactions you have with nurses while you have been a patient here on this unit. What is it like to be with nurses on this unit?

2. When have you been with a nurse in a way that you have found to be helpful? Tell me more about it.

3. When have you been with a nurse that you have not found to be helpful? Tell me more about it.

Meetings may take place while you are in hospital or after you have been discharged from the hospital. You can decide where you would like to meet with me. We can meet in an office at the hospital, or we can meet in my office at _____. It is up to you. Meetings may last up to 1 ½ to 2 hours. I would like to talk with you at least three times in total. If you prefer, we can talk in several short sessions rather than three long ones. Each time we meet, I will ask you if you continue to give consent to participate in this study. If you do not wish to continue meeting with me, you may stop at any time.

This study also involves observation. Over a period of several days, I will be on the inpatient unit and observe you when you are talking with nurses. I expect that I will observe you talking with your nurse for approximately four hours in total, but not all in one day. If there is any time that you do not want to be observed by me while you are on the inpatient unit, please tell me and I will not continue the observation and I will not take any notes.

After your sign your consent, your name will not appear in any research data. A special code will be used to label any written record of our conversations, or my observations. For example, if you are the first patient in the study, and we have our first talk on August 1, 2008, your code might 1-08-08-01P, which means August 1, 2008 patient number one. After the third interview, your participation in the study will end.

It is possible that you will decide that you want to participate in this study, but that you do not want to sign this consent form. If you clearly state that you would like to participate, you can give your consent on audiotape at the beginning of each of our conversations. If you audiotape your consent, I will record your name, and the date and time of your taped consent, on a separate piece of paper, to be kept with the study records.

14. Are there risks to the study?

Although sometimes people may find it helpful to talk about their experiences of being a patient, there is a chance that you will find it upsetting to answer questions about your interactions with nurses. This means that, as a result of talking to me, you may feel more worried or anxious. You only have to answer the questions that you want to answer. If you find the interview upsetting, you can stop the interview.

There is also a chance that you will find it upsetting to be observed when you are a patient on the unit. You may decide when you want to be observed and when you don't

want to be observed. If you find it upsetting to be observed, you can tell me to stop observing you, or tell your nurse and she/he will let me know of your wishes. If it is necessary, I will help you meet with another professional person, such as a member of your care team, who will meet with you in order to help you feel better.

You may also find that when you talk to me and answer questions about your interactions with nurses, you will think about things that you wouldn't normally think about. You may tell me about events and conversations with nurses that you had placed at the back of your mind. These events and conversations may cause you to feel more worried and anxious than you would feel had you not talked to me. Some of these events and conversations may be pleasant memories, but some may not be. Talking about these memories may affect your relationships with nurses on the unit. Talking about these memories may cause you to think differently about the nurses on the unit. You may even find it harder to talk to your nurse about your illness. If you find that our conversations are making your relationships with nurses uncomfortable, you can choose to stop participating in the study. If you like, I can help you meet with another professional person on your care team who will help you feel better.

As I said above, the conversations in our formal meetings will be audiotaped. Despite all of my efforts to maintain your privacy, in this kind of research, there is a risk that someone could discover that you participated in the study. Your name will never be recorded in the transcription of our conversations or used in any research report. Your name will never be directly associated with your words. Even so, there is a small chance that someone who is reading the text of our conversations in a research report may be able to identify you by your words.

15. Are there other choices?

You do not have to participate in this study to get care for your problems.

16. What are my responsibilities?

As a study participant you will be required to:

- Report any changes in your health or your admissions status to the Principal Investigator
- Renew informed consent at every interview
- Tell me if you feel upset and need help while you and I are talking, or while I am observing you

17. Can I be taken out of the study without my consent?

Yes. You may be taken out of the study at any time if

- In the opinion of the Principal Investigator you are experiencing effects of being in the study that are harmful to your health and well-being
- There is new information that shows that being in this study in not in your best interests
- The _____ Research Ethics Board or Principal Investigator decides to stop this study.

You will be told about reasons that you might need to come out of the study.

18. What about new information?

You will be told about any other new information that might affect your health, welfare, or willingness to stay in the study.

19. Will it cost me anything?

Compensation

You will not be paid to be in the study.

Research Related Injury

If you become ill or you are injured because you are in the study, necessary medical treatment will be available at no additional cost to you. Your signature on this form only indicates that you have understood to your satisfaction the information regarding your participation in this study and agree to participate in the study. In no way does this waive your legal rights, nor release the Principal Investigator or involved institutions from their legal and professional responsibilities.

As a Registered Nurse and a researcher, I have a responsibility to inform you of any risks as they arise, and to help you get appropriate care if you suffer any distress or worsening of your illness as a result of participating in this study. The research team and the hospital also have their usual legal and professional responsibilities. Signing this form does not alter any of that.

20. What about my right to privacy?

Protecting your privacy is an important part of this study. A copy of this consent will be put in your health record.

When you sign this consent form you give us permission to:

- Collect information from you
- Collect information from your health record
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Access to records

As the researcher, I will see health and study records that identify you by name. Other people may need to look at the health and study records that identify you by name. These might include the _____ Research Ethics Board and Research Quality Associate, the person who is supervising my research, and my research assistant.

Use of records

The research team will collect and use only the information they need to complete the study. This information will only be used for the purposes of this study.

This information will include your:

- Sex
- The unit in which you were a patient
- Medical condition
- Information from study interviews

Your name and contact information will be kept secure by the research team in _____. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study. Information collected for this study will be kept as long as required by law. This could be 7 years or more.

If you decide to withdraw from the study, the information collected up to that time will continue to be used by the research team. It may not be removed.

Information collected and used by the research team will be stored by the researcher at the _____. The researcher is the person responsible for keeping it secure.

You may also be contacted personally by Research Auditors for quality assurance purposes.

Your access to records

You may ask the researcher to see the information that has been collected about you.

21. Can I stop participating in this study?

If you chose to participate in this study and later change your mind, you can say no and stop the research at any time. All data collected up to the date you withdraw your consent will remain in the study records. If you are a patient, your decision to stop being in the study will not affect your health care.

22. Declaration of financial interests

No one conducting this study has any financial interest in this study. No one conducting this study will receive any money, other than their usual salary, for conducting this study.

23. What about questions or problems?

For further information about the study call Catherine Thibeault at _____.

24. What are my rights?

After you have signed this consent form you will be given a copy.

If you have any questions about your rights as a research subject, contact the **Patient Representative** at _____.

PART C

25. CONSENT FORM AND SIGNATURES

I have read all the information about this study, which is called: "The relationships of hospitalized persons with acute mental illness and their nurses: an interpretive inquiry"

I have been given the opportunity to discuss it. All my questions have been answered. I am satisfied with the answers.

I agree to allow the people described in the consent form above to have access to my medical records.

My signature on this consent form means that I agree to take part in this study.

_____	_____	___/_____ /___
SIGNATURE OF PARTICIPANT	NAME (PRINTED)	day month year*
_____	_____	____/__ /____
WITNESS TO PARTICIPANT'S SIGNATURE	NAME (PRINTED)	day month year*
_____	_____	____/_____ /____
SIGNATURE OF INVESTIGATOR	NAME (PRINTED)	day month year*
_____	_____	____/_____ /____
SIGNATURE OF PERSON CONDUCTING CONSENT DISCUSSION	NAME (PRINTED)	day month year*

I WILL BE GIVEN A SIGNED COPY OF THIS CONSENT FORM.

Thank you for your time and patience

Appendix C
Recruiting Poster-Patient

Are you a patient on this unit?
Are you interested in being in a research study?

What kind of study?

A researcher from Dalhousie University School of Nursing is interested in talking to you about your interactions with unit nurses.

Why is this study being done?

The purpose of this research is to get a better understanding of how nurses and patients talk and act together on an acute inpatient psychiatric unit.

What would I have to do?

As a participant, you would agree to:

- **Meet with a researcher at least three times**
- **Talk about your experiences**
- **Allow the researcher to observe you while you are interacting with nurses on the unit.**

If I am interested, what should I do?

Give your name to the unit clerk. A member of the research team will then contact you and give you more information. If you decide to participate, you will be told more about the study and asked to sign a consent form.

For more information about this study, please contact
Catherine Thibeault at _____ or via email
Catherine.thibeault@dal.ca

Appendix D
Recruiting Poster-Nurse

Registered Nurses and Licensed Practical Nurses: Are you interested in being in a research study?

A researcher from Dalhousie University School of Nursing is interested in talking to you about your interactions with patients. The purpose of this research is to get a better understanding of nurse-patient relationships on an acute inpatient psychiatric unit.

As a participant, you would agree to:

- **Meet with the nurse-researcher at least three times**
- **Talk about your experiences**
- **Allow the researcher to observe you while you are interacting with patients on the unit.**

If you are interesting in learning more about this study, please contact Catherine Thibeault at _____ or via email Catherine.thibeault@dal.ca. A member of the research team will then contact you and give you more information. If you are interested in participating, the study will be explained in detail. If you decide to participate, you will be asked to sign a consent form.