A PHENOMENOLOGICAL APPROACH TO UNDERTANDING NURSES' EXPERIENCES WORKING WITH PATIENTS IN INPATIENT PSYCHIATRIC CARE SETTINGS

by

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The purpose of this phenomenological study was to explore and describe nurses' perceptions of their experiences in their relationships with patients in inpatient psychiatric care settings, with the aim of uncovering knowledge and understanding of this phenomenon.

Data were collected through 16 in depth interviews with eight female registered nurses currently employed in inpatient psychiatric care settings.

Data analysis of the verbatim transcripts began concurrently with data collection and continued during the formal analytic phase with meaning units emerging from the data. In the final analysis six major themes and one subtheme were explicated to form the essential features of the nurses' experiences of working with patients in inpatient care settings. The six major themes and one subtheme are: one, the experience of fear of being physically harmed; two, the experience of conflict; three, the experience of ambivalence in relationships with physicians; four, the experience of sadness, disappointment and frustration; five, the experience of satisfaction; six, the experience of growth. A subtheme of a lack of administrative support emerged in conjunction with the theme of fear of being
physically harmed. The six themes and one subtheme represent the range of the nurses' experience in their relationships with patients in inpatient psychiatric care settings.

Implications for nursing practice, administration, education and research are suggested. General implications for nursing research are in the realm of studies which will further nurses' understanding of particular aspects of their experiences with patients in inpatient care settings such as fear of being physically harmed.
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CHAPTER ONE: INTRODUCTION

Conceptualization of the Problem

The philosophical themes and interpretations of the nurse's experience are part of the key to understanding the nurse's world, its true meaning and reality for the nurse. In order to understand nursing as it is experienced we must describe and explicate those meanings (Watson, 1985).

This study is an exploration of nurses' perceptions of their experiences working with patients in inpatient psychiatric care settings. Because psychiatric nursing is practised within the context of a nurse-patient relationship, the study specifically explores nurses' perceptions of their experiences in their relationships with patients admitted to an inpatient psychiatric care setting because of a severe mental health problem.

The impetus for this study grew out of my own clinical experience, both as a nurse and nursing instructor, in inpatient psychiatric care settings. From my work with patients in inpatient psychiatric care settings, I have gained considerable understanding of what it means to become a co-participant in the subjective world of a person who suffers from a severe mental health problem.
I have journeyed through a realm of strong emotional tones both, my patients' and my own, which have shaped and moved me. I have worked with patients whose worlds I felt afraid to enter and others whose worlds I entered without fear or difficulty. I have successfully engaged troubled people through empathic means; entering their world, seeing through their eyes. I have shared their fears and their joys. I have been trusted by patients to assist them in their understanding of their perceptions of the world. I have also felt the helplessness of being unable to effect change in patients either as a result of the alien nature of the patient's world or my own inability to deal with what the patient's behaviour evoked within me. In all these encounters with patients I have experienced the relationship as a learning experience where either myself or the patient or both of us have gained new knowledge and skills, each becoming more competent; the patient in coping with illness and me in helping patients.

In spite of what I and other nurses know and understand of our experiences in these relationships with patients, psychiatric nursing remains a complex phenomenon that is poorly understood by nurses themselves and other members of the health care team.
One of the main reasons for this lack of understanding is due to the lack of knowledge about that intersubjective experience of both the nurse and the patient in the nurse-patient relationship. Specifically, there is little known about nurses' experiences in their relationships with patients in psychiatric care settings that helps us understand the meanings and interpretations of their experiences. There has been a lack of systematic investigation of the lived experience of the nurse in this relationship.

**Purpose of the Study**

Given the lack of systematic investigation detailing nurses' perceptions of their experiences in their relationships with patients in inpatient psychiatric care settings, the purpose of this study was to explore and describe nurses' perceptions of those experiences, with the aim of uncovering knowledge and understanding of this phenomenon. Specifically, the study aimed to uncover and describe common themes expressed by nurses through their perceptions of and their responses to events that happen between them and the patients they nurse in inpatient psychiatric care settings.

As a nurse committed to the advancement of psychiatric nursing practice and theory, I believe that
a study of nurses' perceptions of their experiences in working with patients who suffer from severe mental health problems will generate valuable insights about their relationships with patients and the meaning these relationships have for them. This knowledge will also contribute to a better understanding of the practice of psychiatric nursing in inpatient psychiatric care settings. Such knowledge could also contribute to the continued formulation of theories of psychiatric nursing practice that are based on and are faithful to realities of practice.

Research Question

The research question for the study was: "What are nurses' perceptions of their experiences working with patients in inpatient psychiatric care settings?" Because psychiatric nursing is practiced within the context of a nurse-patient relationship, the study specifically asked: "What are nurses' perceptions of their experiences in their relationships with patients that are admitted to an inpatient psychiatric care setting because of a severe mental health problem?"

Background to the Problem

Psychiatric nursing

Psychiatric nursing is both a part of all nursing and a specialized area of nursing. This study focuses
on psychiatric nursing as a specialty. As a nursing specialty, it is described as an area of nursing practice employing theories of human behaviour as its science and the purposeful use of self as its art. It is directed toward both preventative and corrective impacts upon mental disorders and their sequelae and is concerned with the promotion of optimal mental health for society, the community, and those who live within it (ANA, 1976). As specialists, psychiatric nurses focus their practice on persons experiencing mental health problems that are typically associated with either severe emotional distress or impairment in one or more important areas of functioning or with a significant increased risk of suffering death, pain, disability, or an important loss of freedom (DSM III-R, 1987). Within the context of psychiatric nursing, emphasis is placed on the relationship between the nurse and the patient which is aimed at promoting patient growth, change, coping and adaption (Orlando, 1961; Peplau, 1952, 1964, 1989; Travelbee, 1971; Ujhely, 1968, 1985).

Characteristically, "psychiatric nursing is similar to all nursing in that it uses an interpersonal process to achieve the purpose of nursing" (Doona, 1979, p. 93). The nurse-patient relationship,
consciously and deliberately established and maintained by the nurse, is the medium through which the nursing process is implemented and the means by which a patient is helped to grow and cope through an experience of illness.

In psychiatric nursing however, the patient and the nurse make special use of this interpersonal process. This process is referred to as the therapeutic nurse-patient relationship and is used for the purpose of intensive short term intervention such as assisting patients to solve immediate problems, and when appropriate, for supportive psychotherapy (Lego, 1980). The relationship also serves as a corrective emotional experience for patients, an experience that facilitates the healing of wounds inflicted by previously damaging relationships with significant others and a model for future relationships. The relationship provides a way for patients to learn through experience to solve problems and to develop interpersonal competencies that have been lost or never learned (Peplau, 1952).

In guiding patients through this interpersonal process, psychiatric nurses make use of advanced knowledge of the psychosocial and biophysical sciences, theories of personality, human behaviour,
psychopathology and pharmacology. Psychiatric nursing also demands independent thinking, creativity, keen observation skills, interactive skills, decision-making skills and skill in the therapeutic use of self.

The concept of therapeutic use of self implies that nurses, not only procedures or techniques, facilitate healing and constructive personal growth in patients. It implies that nurses use themselves as the instruments of change; that they bring themselves as real people to their relationships with patients influencing them in positive directions (Travelbee, 1971). This involves the pulling together of several important personal elements in combination with the knowledge and the skills listed above to create conditions of trust and safety whereby patients can respond in a trusting manner and help themselves. It involves self awareness and the ability to interpret and monitor one's own behaviour; knowledge about one's beliefs, values, attitudes and dominant emotional themes that may prevent the growth of both or either the patient and the nurse in the relationship. It involves the expression of the human qualities of compassion, caring, empathy understanding and acceptance of the patient as worthy of respect and dignity (Stuart & Sundeen, 1987).
Within the context of the nurse-patient relationship, psychiatric nurses perform a variety of roles in caring for patients. The therapeutic use of self is operative in all of these roles. Each of these roles arises out of the multiplicity of patient's needs (Benfer, 1980; Peplau, 1952, 1964, 1989). These roles include: Nurturer, counsellor, teacher, technician, and advocate.

As nurturer, the nurse functions as physical care giver and protector from injury. The nurse assists patients to meet basic physiological needs such as safety and nutrition. The nurse is warm and caring and is a source of unconditional acceptance as patients move toward more autonomous and adaptive behaviour.

As counsellor, the nurse assists patients to examine current responses to painful and frightening stressors, patterns of problem solving and interpersonal difficulties and to develop appropriate coping strategies.

As teacher, the nurse helps patients learn behaviours that promote mental and physical health and improved interpersonal skills leading to success in living with other people. This may include basic aspects of self care, how to relate to others, how to determine appropriate social behaviour, how to solve
problems and how to use time productively. As teacher the nurse is also a role model for patients.

As technician, the nurse administers medications, monitors their desired effects and assesses for side effects. This requires knowledge about several dimensions of psychotropic drug use, such as drug interactions, therapeutic versus toxic dosage levels, desired effects and side effects and clinical judgement about patient behaviour and the need for and timing of medications. As technician, the nurse may also be involved in carrying out medical and surgical procedures.

As advocate, the nurse educates patients and families about their rights and protects patients from health care system abuses or neglect (Haber et al., 1987).

In psychiatric nursing, as in nursing in general, "nurses are accountable for gathering complete and accurate data about patient's needs, making sound judgements about the data, planning and implementing appropriate nursing care, and evaluating the effects of care in an ongoing, dynamic manner" (Hagerty, 1984, p. 4). This is accomplished by using the nursing process, a deliberate, problem solving activity consisting of five major components. The five components are
assessment, diagnosis, planning, intervention and evaluation within which exists a series of ongoing, systematic actions, interactions, and transactions between the nurse and the patient. The use of the nursing process is central to the nurse's practice and to the role of the nurse.

Psychiatric nursing as a process orientated practice with a scientific knowledge base is guided by the American Nurses' Association Standards of Psychiatric Mental Health Nursing Practice (1982). The standards prescribe the skills and behaviours initiated and carried out independently by the nurse. These standards are applied to the practice of psychiatric nursing in Canada and the U.S. (see Appendix A). The Canadian Federation of Mental Health Nurses is presently developing Canadian standards for mental health and psychiatric nursing practice.

Psychiatric nursing is practised in a variety of settings. The setting further defines the nature of the nurse's practice by determining the kinds of experiences psychiatric nurses have in working with patients with mental health problems. The nurse who works an 8 to 12 hour shift with patients in an inpatient setting has different kinds of experiences than, for example, the nurse who sees patients for one
hour once a week in a community setting. For the purposes of this study, the inpatient psychiatric care setting is described.

The Inpatient Psychiatric Care Setting

The inpatient setting is one of the contexts in which psychiatric nursing is practised. Within the inpatient setting nurses form part of an interdisciplinary team usually consisting of medical doctors of whom the majority are psychiatrists, other physicians, pharmacists, social workers, clinical psychologists, occupational and recreational therapists. The team's overall purpose is to provide treatment for patients who are unable to remain at home or in the community because of the severity of their mental health problems. These mental health problems generally include behaviours that threaten the patient's own safety and the safety of others, or that interfere with the person's ability to independently meet his/her basic human needs such as nutrition, activity, and rest. The nursing diagnoses most commonly associated with such problems are potential for violence, self-directed or directed at others; self-care deficit due to severe withdrawal into the self, regression to an earlier level of development or alterations in thought and perceptual processes
(Townsend, 1988). The team also assists patients in crisis. Specifically, psychiatric treatment in an inpatient setting is for the following purposes:
1. To protect the patient and others from the patient's suicidal or homicidal behaviour.  
2. To safeguard the patient's reputation in the community (when behaviour is bizarre).  
3. To remove the patient from an intolerable environment or situation.  
4. To provide close observation and monitoring of patient's mental status in order to formulate a differential diagnosis.  
5. To explore and improve critical relationships and conflict situations.  
6. To provide psychotherapies and sociotherapies that promote optimal functioning in daily living.  
7. To provide rapid administration and professional monitoring of psychotropic medication schedules too complex for home use (Parios, 1984, p. 90).  

The major approach used by the mental health team to achieve these objectives is the use of milieu therapy. Milieu therapy is defined as "the purposeful use of people, resources, and events in the patient's environment to promote optimal functioning in activities of daily living, development/improvement of
interpersonal skills, and capacity to manage outside the institutional setting" (Wilson & Kneisl, 1989, p. 1170). In milieu therapy the environment is deliberately structured to be therapeutic; to provide human relationships that satisfy emotional needs, reduce psychological conflicts and deprivation and strengthen impaired ego functions (Haber et al., 1987). This concept is based on the assumption that the social milieu itself can be an instrument of change; that people change, learn and mature as a result of their interpersonal and social relationships and experiences. Jones (1953), the originator of the concept of the therapeutic community in which the total environment is used to promote behavioural change suggests that in some, but not all, psychiatric conditions, there is much to be learned from observing patients in a familiar social environment so that their usual ways of relating to other people and their reactions to stress can be observed. The situation is potentially therapeutic when patients are made aware of the effect of their behaviour on other people, and helped to understand some of the motivation underlying their actions.

Although the roles of each member of the interdisciplinary team are similar and often overlap,
each discipline performs different functions related to their area of expertise. Within the inpatient setting nurses have the uniqueness of being in the environment 24 hours a day and so, in addition to functioning as the primary care givers, nurses are also responsible for the management of the patient's environment and for the coordination of the mental health team's activities (Benfer, 1980).

As the primary care givers, nurses are responsible for entering into therapeutic relationships with patients for the purposes of providing short term interventions, providing physical care to patients, administering and monitoring of psychopharmacological treatments, doing health teaching and participating in therapy groups and activities. Because of the severity of patient's problems encountered in inpatient psychiatric care settings, nurses are also responsible for intervening in situations that require immediate, intensive interventions to relieve the patient's severe emotional distress and to prevent behaviours that are a potential danger to self and others.

As managers of the patient's environment, nurses are responsible for the maintenance of a therapeutic environment and awareness of the ongoing and ever-changing processes occurring in it. They are
responsible for providing a physical environment that is safe and secure for patients. They must create an atmosphere or "tone" in the environment which is sensed by patients as healing and nurturing. They must be mindful of sensory and social stimuli that may contribute to increased disturbed behaviour in patients. They must prepare structured schedules; time for therapy, for meals, for activities of daily living, for therapy groups and activities on and off the unit. Nurses must use clinical judgement in enforcing the unit's norms and rules and regulations (Johnson, 1986).

As coordinator of the mental health team's activities, nurses organize all aspects of patient care, continually assessing patients' level of functioning, communicating their findings to other team members and collaborating in the planning and implementation of interventions.

Psychiatric nursing and the inpatient context of care have been described. It should be noted, however, that psychiatric nursing and the many contexts of psychiatric nursing care do not lend themselves easily to concrete, one dimensional descriptions. They are both processes and parts of larger systems; psychiatric nursing is part of nursing and inpatient psychiatric
care settings are part of the total mental health system and the hospital organization.

**Theoretical Framework**

A humanistic interpersonal nursing model provides the theoretical framework for this study. This nursing model synthesizes the theoretical frameworks of Paterson and Zderad's humanistic model (1988), Peplau's developmental interpersonal model (1952) and Travelbee's interpersonal process model (1971). In this psychiatric nursing model, emphasis is placed on the relationship between the nurse and patient which is described as "an existential experience lived between the nurse and patient whereby each nursing situation reciprocally evokes and affects the expression and manifestations of these human beings' capacity for and condition of existence" (Paterson & Zderad, 1988, p. 3). Nursing is viewed as a living, intersubjective, transactional act or phenomenon which comes into existence when one person needs a specialized form of help; it involves a mode of being and a mode of doing something (Paterson & Zderad, 1988). Nursing is more than the application of knowledge and skills, although necessary to an act of nursing, it is a sense of being with or a co-participant in the subjective-internal world of the experiencing person (Watson, 1985). It is
a relationship of I and Thou "no matter whether spoken or silent—where each of the participants really has in mind the other or others in their present and particular being and turns to them with the intention of establishing a living mutual relation" (Buber, 1965, p. 19).

Within this conceptual framework each person is viewed as a complex living organism with the capacity to learn and grow in spite of limitations imposed by biological and environmental factors. Recognition is given to the uniqueness of each person's subjective experience, of discovering and respecting those experiences and the meanings attached to them. Emphasis is placed on the preservation of their integrity and freedom of the person to participate in decisions that directly affect them.

The nurse-patient relationship serves as a corrective emotional experience for patients; an experience which provides for the healing of wounds inflicted by previously damaging relationships with significant others and as a model for future relationships. It is in the relationship where patients learn to develop ways to convert tension and anxiety associated with intrapsychic and relationship conflicts into more purposeful activity.
Communication is viewed as a means in helping patients establish relatedness, sustain their movement toward health, and achieve interpersonal competency. Nurses understand the elements of the communication process and use specific skills and techniques to achieve the goals of the nurse-patient relationship. Purposeful communication within the relationship is achieved when the nurse uses the communication skills of empathy, reflecting and paraphrasing, self-disclosure, confronting and interpreting, and immediacy. Self-awareness, respect, compassion, empathic understanding blended with a strong belief in the self-actualizing potential of the patient are all essential personal qualities of the nurse in the nurse-patient relationship.

Although each nurse-patient encounter is unique and original, all nurse-patient interactions proceed through four distinct but interrelated phases; orientation phase, identification phase, working phase, and termination phase. In theory, each phase builds upon the preceding phase and defines roles and tasks required of the nurse; however in reality, issues and tasks belonging in one phase may surface in another.

The orientation phase begins when patient and nurse meet and become known to each other and begin
establishing a working partnership. Roles and responsibilities of both participants are discussed. Patient problems are identified and the nurse listens for themes that may help both patient and nurse define these problems more clearly. The nurse collects data about the patient and begins to make tentative hypotheses while the patient gathers data and makes inferences about the nurse.

The gradual transition into the identification phase is accompanied by deeper exploration of the patient's feelings, needs and goals. The nurse's responsiveness and empathy is crucial for the development of trust and emotional security in the relationship.

Once a patient has identified with a nurse, they enter the working phase in which patients begin an intensive process of understanding themselves and the ways they need to change. Increased insight is gained; the meaning of illness and the dynamics of one's behaviour are better understood. New ways of behaving are identified and are tested within the relationship.

Ideally termination of the relationship occurs when both patient and nurse believe it is appropriate. Termination occurs when the patient has attained sufficient intellectual and interpersonal competency to
maintain an optimal level of well being. Issues such as loss, abandonment and anger are frequent patient reactions to termination and must be addressed. Termination provides a purposeful closure to meaningful relationships by providing a modelling experience for the termination of future relationships.

The humanistic-interpersonal model of psychiatric nursing emphasizes the relationship between the nurse and patient as the interpersonal structure within which the nurse provides nursing care to the patient.

Methodological Approach

The phenomenological approach of qualitative research was used to investigate this study's research question. Since phenomenological research exists for the purpose of exploring individuals' perceptions of their experiences, it is an appropriate methodology for exploring the experience of nurses working with patients in psychiatric care settings (Giorgi, 1975; Polkinghorne, 1989).

Phenomenology, the study of human experience as it is lived (Merleau-Ponty, 1964), is a method in philosophy that has grown in reaction to "the denigration of philosophical knowledge and the objectification of humans" (Omery, 1983, p. 51). Phenomenological researchers do not refuse to examine
the sum of the parts of a phenomenon but recognise that a whole may be different from the sum of its parts. Omery (1983) states "phenomenology accepts the experience as it exists in the consciousness of the subject (p. 60) ...[and] it does not reduce the human being under study to an object with many small quantitative units" (p. 49).

"Human phenomena [such as nursing] are not object like; they cannot be inspected and studied in the manner of objects ....they are not neutral items that call for a neutral and detached independent description. They have to do with modes of existing and the meaning of being" (Watson, 1985, p. 81). Psychiatric nursing, and nursing in general, which describe their practice in terms of the interactive nature of human organisms and which pronounces nursing's humanistic and multidimensional approaches to patient care, need to be studied using a research method that embraces a holistic perspective. Phenomenology is a research method that provides nursing with new ways of knowing, particularly ways of grasping wholes and complex meanings of both nurses' and patients' experiences as they exist. Phenomenology reveals that which is not seen or observed by others but which is experienced and is "inextricably bound
with objective reality" (Munhall & Oiler, 1986, p. xiv). Phenomenology seeks to understand the subjective meaning of human experience.

**Operational Definitions**

The following is a list of operational definitions for the terms used in the research question:

**Patient:** An individual who is experiencing a mental health problem and who is hospitalized in a psychiatric care setting, specifically an inpatient psychiatric unit.

**Nurse:** A registered nurse who is prepared at the diploma, baccalaureate, or masters level and who is currently working in an inpatient psychiatric care setting.

**Psychiatric Nursing:** A specialized area of nursing practice employing theories of human behaviour as its science and purposeful use of self as its art. It is directed toward both preventative and corrective impacts upon mental disorders and their sequelae and is concerned with the promotion of optimal mental health for society, the community, and those individuals who live within it (ANA, 1976).

**Psychiatric Care Setting:** Psychiatric care settings include those specialized programs within hospitals that are structured to provide for individuals who are
experiencing mental health problems. These units and/or programs include inpatient psychiatric units, day or evening hospital programs, and outpatient therapy programs.

**Assumptions**

The phenomenological method requires that researchers reveal their assumptions about the phenomena under investigation and then suspend these in order to fully understand the experience of the participant and not impose a prior explanation on these experiences. The technique used to control preconceived expectations and explanations is called bracketing. In bracketing researchers hold their beliefs and notions about the phenomena "in abeyance while watching themes, essences, and meanings surface from the data during the process of analyzing, intuiting, and describing" (Smith, 1989, p. 15). The personal assumptions brought to this study by the researcher are described in Appendix B.

Five additional assumptions made by this researcher were: one, that psychiatric nursing practice is based on a therapeutic relationship between the nurse and the patient; two, the nurse initiates the nurse-patient relationship for the purpose of implementing the nursing process and to bring about
patient growth, change, coping, and adaptation; three, the nurse-patient relationship is affected by the nurse's experiences with specific patient behaviour and situations, nursing colleagues and superiors, physicians, hospital policies and procedures and by changes in the health care system; four, nurses who have the highest degree of contact with patients in psychiatric care settings have unique and different experiences working with patients than do other professionals, such as occupational therapists and social workers, who also work with patients in psychiatric care settings; five, nurses who work with patients in psychiatric care settings have similar and different experiences of nursing as their counterparts in other areas of nursing.

Limitations

Limits to the general application of this study were set by the chosen method of inquiry namely, the phenomenological method. The goal of the phenomenological method is to "uncover the meaning of humanly experienced phenomenon" through the analysis of participants' concrete descriptions. Because the researcher was interested in allowing a phenomenon to "show itself" without the use of "predictive prescriptions of the quantitative methods", the
researcher selected the study's participants according to their knowledge base and receptivity and not to achieve statistical generalization (Parse et al., 1985, p. 15). The researcher therefore, used non-probability sampling techniques and kept the sample size small because of the amount of time it takes to transcribe and analyze the verbatim notes for each participant. A primary limitation of non-probability sampling techniques and a small sample size is that the researcher cannot generalize the findings of a study to the population being studied. Therefore, the findings of this study cannot be generalized or applied to other populations of nurses working in other areas of psychiatric nursing practice or to the practice of nursing in general. Generalization, a term rooted in quantitative methods of inquiry, does not relate to phenomenological research and therefore to this study (Smith, 1989).
CHAPTER TWO: REVIEW OF RELATED LITERATURE

The purpose of this chapter is to provide a review of literature related to the conceptualization of the problem statement in Chapter One. Relevant research and theory will be explored to further substantiate the conceptualization of the problem. This chapter will therefore centre around theoretical and research works related to the therapeutic nurse-patient relationship. The discussion of relevant research on the therapeutic nurse-patient relationship is divided into four sections: one, the communicative action of the nurse in the constitution of the nurse-patient relationship; two, patient and nurse characteristics in the constitution of the nurse-patient relationship; three, the social organization in the constitution of the nurse-patient relationship; four, events in the wider social context and changes in nursing ideologies.

The Therapeutic Nurse-Patient Relationship: Theoretical Works

The nurse-patient relationship has a very special place in psychiatric nursing discourse. The therapeutic nurse-patient relationship, firmly established as the cornerstone of psychiatric nursing, is a phenomenon well defined and described in both the general and psychiatric nursing literature.
Peplau, in her classic work, *Interpersonal Relations in Nursing* (1952), heralded the introduction of the first systematic theoretical framework for psychiatric nursing and focused on the therapeutic role of the nurse in a one-to-one relationship with patients. Peplau's theory which draws from Sullivan's Interpersonal theory and, in part from learning theory, provides a framework within which nurses help patients to explore their current interpersonal experiences in order to improve them through the development of interpersonal competencies (Lego, 1980). Peplau (1952) defined nursing as, "a significant, therapeutic, interpersonal process that aims to promote a patient's health in the direction of creative, constructive, productive, personal and community living" (p. 16).

Mellow (1968) introduced a second theoretical framework for psychiatric nursing practice which also centred on the development of a nurse-patient relationship but drew from psychoanalytic theory rather than from Sullivan's interpersonal theory. Mellow believed that the nurse-patient relationship served as a corrective experience for the patient. The premise was that the patient would learn to have more satisfying interpersonal relationships in general.

Orlando (1961), drawing from Sullivan's
interpersonal theory and symbolic interactionism, presented a third conceptual framework for all nurse-patient relationships, not just psychiatric situations. Orlando's framework focused on the nurse responding to patients' unmet needs through a dynamic nurse-patient relationship; dynamic, meaning the nurse is actively involved with patients continually assessing and responding to their unmet needs. Orlando emphasized deliberate actions by nurses within the interpersonal process: first, the nurse observes the patients' distress and helps the patient to express the meaning of his/her behaviour, and secondly, the nurse assists the patient in identifying ways to relieve his/her distress. Orlando's theory is significant because it provided a framework for the development of the components of the nursing process which is nursing's model for problem solving in the clinical practice.

Although Peplau's, Mellow's and Orlando's theories have formed the basis for most psychiatric nursing practice theory, there has been in the last 20 years, a great deal of psychiatric nursing practice theory based on concepts from existential and humanistic psychology (Paterson & Zderad, 1978; Peplau, 1952, 1964, 1987, 1989; Travelbee, 1971; Ujhely, 1968,
1985). The synthesis of existential and humanistic concepts into a nursing practice theory has resulted in an emphasis in the literature on the self-awareness of the nurse; therapeutic use of self in the nurse-patient relationship; facilitative conditions for constructive personality change, and the development of therapeutic communication skills.

Most psychiatric nursing theorists today conceptualize psychiatric nursing practice from existential and humanistic thinkers such as May, Buber, Maslow and Rogers. Theory development is devoted to theories of helping with emphasis on the nurse-patient relationship defining the relationship as an "I-Thou" relationship: doing and being with patients. Rogers' facilitative conditions, aimed at helping patients to become more fully functioning, are consistently included in discussions of the nurse-patient relationship. There is also an emphasis toward the training of nurses in helping skills to develop therapeutic relationships.

In spite of a long and a continued emphasis on the nurse-patient relationship both in general nursing and in psychiatric nursing theory, the literature reveals a less than comprehensive research tradition on the nurse-patient relationship.
The literature also reveals that investigations of the nurse-patient relationship generally fall into themes and are constituted on "assumptions and ideas derived from a range of theoretical and ideological frameworks which have acted to frame research questions, and to determine the perspective from which research has been directed" (May, 1990, p. 307).

In psychiatric nursing, research on the nurse-patient relationship can be divided into four types: one, the communicative action of the nurse in the constitution of the relationship; two, patient and nurse characteristics in the constitution of the nurse-patient relationship; three, the social organization in the constitution of the nurse-patient relationship. More recently, nurse theorists have proposed that the nurse-patient relationship may also be constituted by events in the wider social context and changes in nursing ideologies. Although no research could be found to support this view, a brief discussion of it is included because of its relevance to this study.

The Communicative Action of the Nurse in the Constitution of the Nurse-patient Relationship.

May (1990) described the communicative action of the nurse as "those aspects of interpersonal encounters between nurses and patients which are in some way
quantifiable" and "from which inferences may be drawn about the nature of the social relationship between them" (p. 308). This type of research focuses on the direct observation and measurement of nurse-patient interactions and it assumes that there is a connection between the frequency, duration, and quality of nurse-patient interactions and the formation of a therapeutic relationship.

Measurement of duration and frequency of verbal interaction. Studies which measure the duration and frequency of verbal interaction have consistently shown that nurse-patient interaction is typically of short duration, infrequent and the content of the interaction delimited and controlled by nurses (Adams & MacIlwraith, 1963; Keck & Walther, 1977; McLeod Clark, 1982; Stockwell, 1972). Interestingly, very little of this type of research has been conducted with nurses in psychiatric care settings. It has taken place mostly in medical and surgical care settings where patients are hospitalized for a physical illness.

There is some evidence, however, to suggest that nurse-patient interaction in psychiatric care settings is also of short duration, infrequent and focused on nursing tasks and administrative activities. Altschul (1972) reported observational data concerning nurse-
patient interaction rates and times on four psychiatric wards. Although interesting, the lack of homogeneity among the patient sample and the wards used to carry out these observations raises questions about the accuracy of these findings. The study also excluded other verbal interchanges between the nurses and patients that may contribute to the nurse-patient relationship or be perceived by both nurses and patients as helpful encounters. For example, interchanges that occurred during rounds, meal times, at the time of drug administration, during recreational activities and following off-ward activities such as occupational therapy. Altschul did not describe what the nurses were doing when they were not in contact with patients.

Bunch (1982) in a qualitative comparative field study that examined the effect of abnormal schizophrenic communication on the nurse-patient interactions on a psychiatric ward reported, that, in spite of their professional mandate to engage in therapeutic relationships with patients, the nurses spent more time in talking business with each other, medicating and secluding patients than interacting with them, even when wards were quiet. The institutional requirements seemed to take precedence over
professional and clinical requirements. Bunch (1982) suggested that nurses have "great difficulty operationalizing their professional mandates, knowledge, and understanding of psychopathology and balancing these satisfactorily with the institutional demands" (p. 107).

The dearth of research on the communicative action of the psychiatric nurse with patients is surprising given the high priority that quality nurse-patient interaction and the nurse-patient relationship receive in psychiatric nursing literature (Field, Pierce-Jones, 1967; Mellow, 1968; Orlando, 1961; Peplau, 1952, 1964, 1987, 1989; Travelbee, 1971). Three reasons may account for this, one, there may exist an assumption amongst nurse researchers that because psychiatric nursing is focused on the use of self in a relationship with patients, there is no need for this type of research. The assumption is that, because psychiatric nurses are not bound by numerous tasks and procedures, the frequency and duration of their interactions with patients must be superior to those of their general nursing counterparts.

A second reason, which may account for the paucity of research on the communicative action of the nurse in psychiatric settings, may have to do with the fact that
the focus on interpersonal relationships in psychiatric nursing emerged in concert with milieu therapy. The study of nurse-patient interaction rates and frequency of time as measures of the quality of the nurse-patient relationship is hampered by the numerous other therapeutic activities structured into the milieu. It may be that many of the nurses' therapeutic interactions, assessments, and interventions are carried out in the context of the groups and activities and not solely during one-to-one time with the patient. Lego (1980), in a review of literature on the nurse-patient relationship, stated that "it was difficult to separate studies in milieu therapy from studies in one-to-one relationships because the two have so often been studied together" (p. 79).

A third explanation for the lack of research on the communicative action of the nurse may have to do with the fact that psychiatric nursing concepts were developed using concepts borrowed from psychoanalytic theory and interpersonal theory. It is only natural therefore that research into the nurse-patient relationship would focus on the larger relationship dynamics occurring between the nurse and the patient than on the communicative actions of the nurse. Measurement of general aspects of nurse-patient
relationships. While psychiatric nursing has produced instruments that purport to measure aspects of nurse-patient interactions it has not produced significant research measuring the duration and frequency of nurse-patient interactions. Three scales have emerged from the field of psychiatric nursing. Methven and Schlofeldt (1962) developed the "Social Interaction Inventory" to study the nature of verbal responses nurses give in emotional-laden situations. Mathews (1962) constructed the "Response to Patient" instrument to measure person-centred qualities of nurses' responses to patients. Aiken and Aiken (1973) designed a scale based on Carl Rogers' (1968) and Carkhuff and Berenson's (1967) work to measure the facilitative level of therapeutic relationship.

The applicability of these scales is questionable in terms of validity and reliability as no additional indication of their use in clinical settings could be found in the literature. It also appears that these scales were developed for educational purposes; to be used as testing methods in the teaching or training of helping skills to nursing students and practising nurses.

More recently, Forchuk and Brown (1989) developed an instrument to measure the phases of the nurse-
patient relationship as described by Peplau (1952). The scale includes nurse and patient behaviours in each phase. Preliminary results have established initial reliability and validity of the instrument. Forchuk and Brown also reported on the usefulness of the scale in practice. Reports from nurses revealed that the instrument provides an accurate assessment of the nurse-patient relationship. Nurses reported that when they can accurately assess the phase of the relationship, appropriate interventions are more likely to be selected.

Measurement of the effect of specific communicative behaviours. A small number of psychiatric nursing studies have also focused on the effects of a particular pattern of communication on the nurse-patient relationship. These studies examined the effects of touch, silence, and the use of empathy.

De Augustinis et al's (1963) study of the use of touch in the nurse-patient relationship found that touch was often interpreted in many different ways by psychiatric patients, mainly increasing their anxiety. For some patients, it was experienced as a bringing back to reality; back from inner thoughts and fantasies. Aguilera (1965) reported that touching by the nurse increased verbal communications, rapport,
approach behaviour and positive attitudes of patients toward nurses (Lego, 1980).

A recent study by Smith and Cantrell (1988) using measures of anxiety (physiological and self-report) suggests that contrary to previous research findings that general medical and surgical patients experience both verbal and physical intrusiveness, such as touch, as comforting, patients with schizophrenic disorders experienced increased anxiety by both verbal and physical and intrusiveness (Oland, 1978). Smith and Cantrell acknowledged that the applicability of these findings to psychiatric patients may be questionable as these patients may need increased personal space because of their disorders. Self-report measures of patient anxiety may also lead to inaccurate conclusions.

Mansfield (1973) conducted an investigation to identify verbal and non-verbal behaviours that facilitated empathic communication on initial interactions between an experienced psychiatric nurse and a psychiatric patient. Seven behaviours that conveyed high levels of empathy to the patients were identified. These behaviour categories were: introduction to the patient, head and body positions, verbal behaviour, response to non-verbal cues, facial
expressions, voice tones, and mirror images. The generalizability of the study is minimal because it was limited to one nurse interacting with six patients (Doyle, 1989).

Although these studies are useful in guiding psychiatric nursing practice, the literature reveals that these type of studies were rarely replicated and when they were, the findings were inconsistent. Lego (1980), in a review of the literature, noted that psychiatric nursing researchers tended to work in isolation from one another and rarely built on one another's work which "gives the literature a piece meal look" (p. 81).

**Summary:** The research on the communicative actions of the nurse in the nurse-patient relationship contributes little to the research question in this study. Because the studies concentrated on the mechanics of individual encounters, the meanings and understandings attributed to these encounters by the actors were neglected.

**Nurse-patient Characteristics in the Constitution of the Nurse-patient Relationship**

Since the nurse-patient relationship involves two-way communication between nurse and patient, it is important to examine the influence of patient behaviour on the nurse and vice versa. Research involving the
study of nurse and patient characteristics and the interaction of these characteristics in the constitution of the nurse-patient relationship has been popular in psychiatric nursing. However, this type of research frequently focuses on identifying and describing clinical conditions, diagnostic categories of patients and patient behaviours, that are believed to increase or decrease social distance or simply create problems in the nurse-patient relationship. In other words, the patient is viewed as the problem. The inferences drawn about the nurse-patient relationship in this type of research have also frequently been formulated from psychoanalytic and Sullivan's interpersonal theory.

Mutual withdrawal. Gwen Tudor's (1952) benchmark study, *A Sociopsychiatric Nursing Approach to Intervention in a Problem of Mutual Withdrawal on a Mental Hospital Ward* signalled a shift in the conceptualization of psychiatric nursing theory and research from an intrapersonal focus (popular prior to the 1950's) to an interpersonal focus and, to some extent to a focus on the social milieu of a ward. The early 1950's was also when milieu therapy was first being implemented in psychiatric care settings. Through the presentation of two case studies, Tudor
demonstrated a relationship between nursing staff's withdrawal from patients and patients' withdrawal from reality. She discovered that when patients were labelled as hopeless, assaultive, unresponsive, and unable to tolerate closeness, they were ignored by nursing staff who then engaged in further labelling of patients as unable to handle interactions and avoided contacts with them even more and in doing so, the patients withdrew even more and became unapproachable. She labelled this process "mutual withdrawal" and reasoned that this pattern of staff avoidance and patient withdrawal contributed to illness maintaining behaviour. Tudor tested her formulation by devising and implementing interpersonal nursing interventions on this pattern of nurse-patient interaction. She found that patients who experienced the nursing interventions became less withdrawn.

Tescher (1964) and Cloud (1972), using a case example approach, described the phenomenon of resistance in the nurse-patient relationship. Tescher suggested that when an interpersonal relationship is perceived as threatening by either the patient or the nurse, distance maneuvers will be used to push the other person away. Forms of resistance were also described and effective nursing interventions were
identified and demonstrated through the case examples.

Hall (1972) reporting results from a field study in a psychiatric short stay setting also identified the phenomenon of mutual withdrawal. While observing groups she noticed that nurses ignored patients who did not discuss their feelings, problems or life experiences and that this carried over to outside the groups both in the number of staff contacts and frequency of mention in reports. Patients who did little to draw attention to themselves were unconsciously ignored by staff. Hall (1977) suggested that variables other than bizarre behaviour stimulate mutual withdrawal in today's therapeutic situations and proposed interpersonal attraction as an area for research. Research related to interpersonal attraction in the nurse-patient relationship is discussed later in this section of the literature review.

The chronic patient. Slavinsky and Krauss (1980) report that the phenomenon of mutual withdrawal is evident in today's psychiatric care settings in which the patient population is labelled as chronically mentally ill.

Deinstitutionalization which was believed would bring about tremendous hope for the quality of life for the chronically mentally ill seems to have done nothing
more than change the setting of care for them. Eliminating institutional care has not eliminated chronic illness. Rarely are those aspects of institutional life such as tolerance of dependence, that were a benefit to chronic patients transferred to the community and to contemporary inpatient psychiatric settings in general hospitals where these patients are treated during acute phases of their illness. Therefore, what has resulted is a large group of patients being frequently admitted to inpatient psychiatric care settings of general hospitals and labelled as 'difficult' because of their chronicity.

Sheets, Provost, and Reihman (1982) and Glick, Klar, and Braff (1984) reported that nurses labelled chronic patient populations as 'difficult', to care for because they alternate between help seeking behaviour and help rejecting behaviour and therefore precipitate countertransference responses of frustration and anger in the nurse.

The difficult patient. Gallop and Wynn (1987), in a study of the phenomenology of the 'difficult' patient, reported that nurses identified the chronically ill as 'difficult' to establish relationships with because they experienced a lack of control and felt totally incompetent in caring for them. The two dominant sets
of patient characteristics nurses perceived as 'difficult' were high affect/high intensity/chronic/attractive and high affect/high intensity/chronic and unattractive. These characteristics were linked with the diagnostic category of personality disorder, specifically borderline personality disorder. Nurses reported feeling intensely overwhelmed, guilty, helpless, engulfed and tearful when nursing these patients.

Gallop and Wynn state that "the current pattern of crisis admissions for chronic patients means that nurses are unlikely to see change or growth. Instead, nurses care for chronically ill patients, who during their admissions, express intense feelings of rage, hopelessness, and who do not respond to treatment interventions" (p. 214). Drawing from psychoanalytic theory, Gallop & Wynn proposed that the patients' angry feelings become projected onto staff who then experience them as their own helplessness (p. 214). Gallop further suggested that in nursing "patients are a critical source of confirmation of the caring, curing and compassionate qualities of health care professionals" and that the "difficult patient may fail in this task of confirmation or in fact may be, labelled 'difficult' because they fail to confirm these
qualities" (p. 214).

A number of other studies have demonstrated links between psychiatric patient characteristics and psychiatric nurses' responses. Characteristics that are typically considered 'difficult' by nurses and as creating problems of avoidance, anger and frustration in the nurse-patient relationship are: manipulative, demanding, non-compliant, over-dependant, dangerous to self and others and withdrawn psychosis (Colson et al, 1985; Highly & Norris, 1957; Newsom et al. 1963; Neill, 1979; Rosenthal et al, 1980; Stockwell, 1972; Ujhely, 1963). The abundant literature on transference and countertransference phenomenon in the nurse-patient relationship (Gallop, 1985; Hay, Drake, & Lindy, 1985; Johnson, 1967; Schroder, 1985; Witherspoon, 1985) stands as evidence that the interaction of nurse and patient characteristics play an important part in the nurse-patient relationship.

Interpersonal attraction. Interpersonal attraction has also been studied as a variable that influences the nurse-patient relationship in psychiatric care settings. Non-nursing studies repeatedly reveal that attraction, based on similarity, social desirability, reciprocity of liking and proximity, is a factor in the establishment and maintenance of therapeutic
relationships (Hall, 1977). Nursing studies indicate that initial liking of the patient is related to favourable outcomes (Shader, Kellman, & Durrell, 1967) and that the patient characteristics liked by nurses in patients were conformity, compliance, appreciativeness, and respect (Blaylock, 1972; Levine, 1970; Rickleman, 1972). Gallop (1985) reporting results of a study of interpersonal attraction and nursing needs indicated that nurses show increased liking for patients who they perceived as sharing similar beliefs about their nursing needs. In a later study on the phenomenon of the 'difficult' patient, Gallop and Wynn (1987) proposed that interpersonal attraction is a factor in labelling patients as 'difficult'.

**Suicidal patients.** Another category of patients considered difficult are suicidal patients. Studies of nurses' responses working with suicidal patients reveal that their experiences are highly conflictual and emotional because they are often in conflict between their code of ethics and the patients' choices. Although they believe that lives can be preserved through careful listening, talking, compassion, and working with patients to identify alternate options, they also express apprehension, anger and helplessness in their relationships with suicidal patients because
there is no statistically proven effective approach to dealing with suicidal patients. (Hamel-Bissell, 1985; Landeen, 1987; Reguero, 1979; Sencicle, 1978; Sumner, 1976).

Although research which seeks to explain problems of avoidance, anger and helplessness in the nurse-patient relationship has been useful in adding to nursing practice theory, it has, of lately, come under some criticism in the literature. May (1990), in a selected review of the literature on the nurse-patient relationship, suggests that this type of research may add to the body of knowledge about the difficult or bad patient but it generally neglects the large numbers of patients with whom nurses easily and successfully establish and maintain relationships with during their hospitalization. Because this type of research frequently lies heavily on the side of the patient's characteristics as problematic it promotes a view that nurses' responses and consequent problems in the relationship are related directly and solely to the anxiety patients create in the nurse. It also implies that nurses' responses are consistent in all situations with certain types of patients and that the nurse-patient relationship is a unidirectional process: the reciprocal nature of the relationship is overlooked.
May (1990) referred to this type of research as "patient stereotyping and defensive nursing" (p. 308). Kelly and May (1982) suggested that much of the literature on good and bad patients is apparently about patients but most of it focuses on nurses' opinions about patients because of the methodologies used in collecting data, namely questionnaires and interviews. Kelly and May also viewed this type of research as problematic because rarely are concepts such as manipulative, uncooperative etc., adequately defined. It is assumed that the reader and researcher share a similar understanding of the concepts.

A final criticism of this type of research is that the nurse-patient relationship is not viewed as part of a wider social context which is also significant in constituting the nurse-patient relationship.

The Social Organization in the Constitution of the Nurse-patient Relationship

The literature makes it abundantly clear that the dyadic encounter between the nurse and patient gives rise to emotional responses in both the nurse and the patient and therefore constitutes the nurse-patient relationship. Only recently, however, has the literature addressed the social organization as a creator of conditions in which different forms of
nurse-patient relationships are promoted or inhibited.

Dawkins, Depp and Selzer (1985) using a 78-item scale measured psychiatric nurses' perceptions of occupational stress. They reported psychiatric nursing job stress as multifaceted and the issues involved were administrative/organizational, staff conflict, limited resources, scheduling issues, negative patient characteristics and staff performance. Fifty percent of the high stressor items were produced by administrative/organizational issues, with the single most stressful item being "not being notified of changes before they occur" (p. 12). The remaining high stressor items centred on themes related to working in an unresponsive, unappreciated, uncommunicative work environment that made changes for the sake of change and that made too many widely divergent demands on nurses. Negative patient characteristics were viewed as moderately to highly stressful with patient characteristics related to violence as most stressful. The degree of stress associated with these characteristics was also related to the amount and nature of resources available to the nurses in dealing with these characteristics. For example, working with hostile patients on an inadequately staffed ward was rated as a high stress item.
Trygstad (1986), using semi-structured interviews, conducted an exploratory study on stress and coping in psychiatric nursing. She identified that the most important determinants of work stress were difficulties in the nurse-nurse or staff nurse-head nurse relationship and their ability to work together. This determinant accounted for 50% of all stress reported by nurses. Thematically, the stressors converged on relationship problems related to inadequate or ineffective communication, performance problems, and staff coping problems. Head nurses were viewed as pivotal in resolving these problems. They were identified as either contributing to staff-staff friction or helpful in resolving problems. Head nurses' and supervisors' attitudes and practices which contributed to stress included scheduling, unilateral decision making, insufficient positive reinforcement or support, insufficient information to staff, lack of clinical or administrative expertise and lack of responsiveness to staff.

While a source of stress, positive relationships with other co-workers and head nurses were also reported as a major source of satisfaction, with being listened to, as the most helpful response. Problems with patients accounted for only 13% of stressors and
these centred around patient chronicity, recidivism and the potential for violence. Doing one's best for patients, working cooperatively with other staff in the care of patients and revising one's expectations of desired patient outcome were described as effective coping strategies. Trygstad's (1986) study is significant for two reasons: first, it provides "one link specific to psychiatric staff nurses in the study of stress and coping as a complex process" (p. 27) and secondly, because of its chosen methodology, provides insight and therefore greater understanding of psychiatric nursing practice as it is experienced by nurses themselves.

Cronin-Stubbs and Brophy (1985) in a study which investigated the relationship of social support, occupational stress and work setting (4 specialty areas) to the burnout of staff nurses found that psychiatric nurses experienced significantly less affirmation, on and off their job, than intensive care nurses and significantly less assistance than operating room nurses. They suggest that what may account for these differences is that most of the care given by psychiatric nurses occurs as interactions with the nurse-patient relationship; hence their nursing interventions are less observable than are those of
intensive care nurses. Outcomes are also less concrete.

**Events in the Wider Social Context and Changes in Nursing Ideologies in the Constitution of the Nurse-patient Relationship**

A final example of the impact of wider social context on interpersonal relationships is William's (1974) sensitive account of changing ideologies of nursing on nurse-patient relationships. The concept of vocation, she argues, legitimizes nineteenth-century views of the role of working-class females as obedient servants. But, as a side affect, it sanctified the unpleasant and menial tasks which the nurse had to perform for the patient, transforming the status of both. Current 'professional' concepts of nursing reflect pressures towards greater equality between the social classes and the sexes. But an unintended consequence of such a re-definition is that everyday care for the patient may be seen as outside the 'professional' nurse's role. As a result, the helpless patient may no longer be offered definitions of his helplessness, which allow him to feel a person of worth, and instead may be treated custodially as a regressed
child. (Heyman & Shaw, 1984, p. 40)

In spite of the continued emphasis on the therapeutic role of the nurse in psychiatric nursing literature, nursing leaders (Carter, 1986; Orlando, 1987; Peplau, 1989) are expressing concern that the nurse's therapeutic role may slowly disappear in psychiatric care settings. Carter (1986) and Westwell and McCay (1988) suggest that the remedicalization of psychiatry and deinstitutionalization of psychiatric patients are factors contributing to the demise of the therapeutic nurse-patient relationship as the major focus of psychiatric nursing. The shift toward defining mental illness as a dysfunction that has biochemical, genetic, or somatic etiology seems to be leading nurses away from therapeutic work with patients. Westwell and McCay (1988) stated "it takes less time to administer a pill and wait for the anticipated results that it [does] to start the process of establishing a relationship with a patient and begin to do some therapeutic work" (p. 148).

Westwell and McCay challenged psychiatric nurses to take charge of this situation and use it as an opportunity to carve out a professional role for themselves. They stressed the need to identify, describe and promote the clinical skills and knowledge
that are unique to psychiatric nursing. They advised psychiatric nurses to recognize and revive the one-to-one nurse-patient relationship as the central focus of psychiatric nursing practice and that to further abandon this focus will lead to "impersonal and dehumanized nursing care" (p. 157).

Westwell and McCay (1988), citing Lego, suggested that society's movement towards technology is contributing to the erosion of the human aspects of nursing care provided in both psychiatric and medical care settings. Lego believes that nurses have leapt on to the technological band wagon and are abandoning the more humanistic interpersonal aspects of nursing practice. She believes this has led to a devaluation of the nurse-patient relationship in all areas of nursing practice. Westwell and McCay (1988) state "that without a strong belief in the value of the therapeutic relationship, nurses caring for psychiatric patients have begun to feel devalued and demoralized" (p. 151).

Benner (1984a) argues that the power of nursing practice lies in caring and that the early roots psychiatric nursing which lie in the relationship aspects of care, have been instrumental in fostering expert psychiatric nursing care. She advises
psychiatric nurses to uncover, name, and describe the components of expert nursing and caring and to do so using interpretative research methods. Benner states that with an interpretative approach, the meaning of the nursing experience is maintained rather than stripped away to objectified, context-free traits or behaviours, thus providing nurses with a fuller and clearer understanding of nursing. This valuable knowledge can serve as a scientific basis for practice rather than imposing theory on practice.

**Summary**

It is clear from the literature that the nurse-patient relationship is a complex phenomenon. The complexity of this relationship is not always given adequate recognition in both theory and research. Rarely are the intentions and understandings of the actors taken into consideration nor is their experience, as they live it, maintained. (Benner, 1984a) The way patients and nurses talk about their experiences in their relationships with each other is significant, "the language they use and the connections they make reveal the world that they see and in which they act" (Krauss, 1987, p. 14).

Nurses who are co-participants in these relationships experience their own reality of these
relationships. This reality arises from a continuity of consciousness (awareness) "along with their perceptions of self and others; feelings, thoughts, bodily sensations, spiritual beliefs, desires, goals, expectations [and] environmental considerations..." (Watson, 1985, p. 56).

In order to gain a better understanding of the nurses' experiences in their relationships with patients, we need to ask questions that will uncover their experiences in their totality.

The purpose of this study is to explore nurses' perceptions of their experiences in their relationships with patients admitted to inpatient psychiatric care settings because of a severe mental health problem with the aim of uncovering knowledge and understanding of these relationships.

Chapter Three describes the research methodology. It includes a description of the research approach, procedures for collection and treatment of data, and data analysis.
CHAPTER THREE: METHODOLOGY

Introduction

The phenomenological approach of qualitative research theory was chosen as the methodological approach to this study. Given the emphasis of phenomenology on the meanings and interpretations of human experience, it was believed that a phenomenological method would best describe and explicate the meaning of nurses' experiences working with patients in inpatient psychiatric care settings. A pilot interview with one participant provided additional support for using the phenomenological method to study nurses' experiences. The interview revealed a rich source of data from which themes of experience could be explicated. The interview also helped the researcher to begin to explicate and bracket out her own presuppositions and explanations of these experiences, an important process when studying a familiar phenomenon.

This chapter will describe the application of phenomenology as a method in the selection of participants, and in the process of data collection and data analysis.

Setting for the Study

The setting for the study was the Lower Mainland
of the Province of British Columbia, Canada.

Selection of Participants

Population

The population for this study was Registered Nurses employed in four inpatient psychiatric care settings of General Hospitals located in the Lower Mainland of the Province of B.C.

Selection Procedures

The phenomenological research method directed the researcher to use non-probability sampling for the study. Because phenomenological researchers seek rich and varied descriptions from informants, participants were selected according to their knowledge base and not to achieve statistical generalization (Morse, 1986; Polkinghorne, 1989). Participants were chosen according to the criteria of appropriateness and adequacy: appropriateness refers "to the degree in which the method of sampling fits the purpose of the study as determined by the question [and] adequacy refers to the quality, completeness, and amount of information contributed by informants..." (Morse, 1986, p. 185). For this study, the criterion of appropriateness of participant was met by nurses who were able to function as informants by describing their experiences of working with patients in inpatient
psychiatric care settings. Adequacy of sample was determined by the quality, completeness, and amount of information contributed by the informants. Adequacy was achieved by interviewing informants until the researcher had gained a full and coherent understanding of the situation and experienced "redundancy in informants' descriptions" (Parse, Coyne, & Smith, 1985, p. 17). For this study, adequacy was achieved by interviewing all eight participants twice.

Criteria for Selection of Participants

The sample for the study consisted of eight nurses who met the following set of criteria:

1. Female Registered Nurses.
2. Currently employed as Registered Nurses on a full time basis in an inpatient psychiatric care setting of a general hospital.
3. A minimum of five years nursing experience in an inpatient psychiatric care setting of a general hospital as a Registered Nurse.

This study excluded registered nurses such as head nurses, nurse managers, coordinators and clinical nurse specialists as each of these categories of nursing personnel assume different roles and functions than the staff nurse. These individuals are also rarely the primary care givers in inpatient psychiatric care
units. The study sample was restricted to a small homogeneous group in order to decrease the potential degree of variation in the participants' descriptions of their experiences and because of the small sample size used for this study.

Inpatient units were specified from which the sample was drawn because the researcher wanted to focus specifically on nurses' experiences working with patients whose mental health problems were varied in nature and generally considered severe enough to warrant an inpatient admission to hospital.

The researcher's role as a nursing instructor in some of the hospitals on the Lower Mainland of B.C. added another criteria for participation in the study. In order to minimize pre-conceived expectations between the investigator and participants, the investigator interviewed only participants with whom she had no ongoing relationship. Given that the investigator's role is only to teach nursing students in these settings and is employed by an agency outside the hospitals, the investigator did not encounter problems with bias or expectation during the interviews.

Procedure for Participant Recruitment

Initial recruitment of participants was accomplished by placing advertisements in inpatient
psychiatric care settings of General Hospitals in the Lower Mainland of B.C. Letters were sent to the appropriate nursing administrators of hospitals in the Lower Mainland of B.C. known to have inpatient psychiatric care units (see Appendix C). The administrators were asked to place an enclosed advertisement on the psychiatric unit(s) of the hospital (see Appendix D). Those nurses interested in participating were asked to contact the researcher by telephone. A letter of explanation was sent to the prospective participants by the investigator further outlining the nature of the research (see appendix D). The letter was followed up by a phone call approximately ten days later to ask participants to confirm their participation and to set up a date for the first interview. At the beginning of the first interview further explanation of the study was given about the study when requested. A written consent was obtained and a copy was given to each participant (see Appendix F).

Additional recruitment involved the use of a snowball sampling technique (Morse, 1986). Once initial selected informants were contacted and the study discussed with them, they were asked to introduce the researcher to other knowledgeable informants.
Morse (1986) states that in the snowball sampling technique "receptivity problems are partially overcome, as some trust is established through introductions by a mutual acquaintance, and the researcher is using the first informant's judgement that the next informant has some knowledge of the topic" (p. 184). Two participants were recruited using the snowball sampling technique.

**Characteristics of the Participants**

The characteristics of all eight participants are presented in Table 1.

**Table 1**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>No. of Years Psych Nursing</th>
<th>Levels of Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Sarah</td>
<td>61</td>
<td>24</td>
<td>Diploma R.N.</td>
</tr>
<tr>
<td>* Leah</td>
<td>36</td>
<td>10</td>
<td>Diploma R.N.&amp; R.P.N.; B.A.</td>
</tr>
<tr>
<td>* Rachel</td>
<td>39</td>
<td>18</td>
<td>Diploma R.N.</td>
</tr>
<tr>
<td>* Diana</td>
<td>27</td>
<td>5</td>
<td>Diploma R.N. plus university courses</td>
</tr>
<tr>
<td>* Rose</td>
<td>37</td>
<td>6</td>
<td>Diploma R.N.</td>
</tr>
<tr>
<td>* Rebecca</td>
<td>43</td>
<td>17</td>
<td>Diploma R.N plus university courses</td>
</tr>
<tr>
<td>* Lily</td>
<td>35</td>
<td>5</td>
<td>Diploma R.N.</td>
</tr>
<tr>
<td>* Brigit</td>
<td>41</td>
<td>10</td>
<td>Diploma R.N.</td>
</tr>
</tbody>
</table>

* pseudonym
**Ethical Considerations**

Before initiating this study the investigator obtained approval from the University of British Columbia's behavioral sciences screening committee for research involving human subjects.

The rights of the participants in the study were safeguarded by providing them with information regarding the research question, the purpose of the study, and confidentiality. Participants were also informed that they may be quoted verbatim in the results of the study. This information was discussed verbally with participants and each was provided with a letter of information (see Appendix E) and a consent (see Appendix F). Those agreeing to participate were asked to sign the consent form. Both the letter of information and the written consent gave clear information about the participants' rights to refuse to participate, answer any questions, request erasure of any tape or portion of a tape, and the right to withdraw from the study at any time.

**Data Collection**

The phenomenological method is based on the assumption that the reality of a phenomenon can be revealed through the participants' concrete descriptions of their experiences (Smith, 1989). Smith
(1989) states "by allowing unbridled descriptions of the lived experiences, the researcher has data reflecting the personal realities of the lived experiences for all subjects" (p. 14). The data for this study were collected in a series of intensive unstructured interviews conducted over a period of three months. The initial interviews explored the participants' experiences in a broad general sense. Each participant was asked to describe in their words their perceptions of their experiences of working with patients in inpatient psychiatric care settings. Participants were encouraged to elaborate on and include detailed descriptions of personal encounters with specific patients. Participants were encouraged to describe their relationships with patients and what meaning these had for them.

Second interviews were used for clarification and validation of the data. This process was accomplished by presenting the preliminary thematic analysis to each of the participants. Each participant was asked to clarify and validate whether the themes inferred from their accounts were an accurate representation of their experiences.

Because the phenomenological researcher sought to gain a deeper and clearer understanding of what it is
like for someone to experience something, the researcher asked open-ended questions that focused the participant on their experience. A sample of trigger questions used are listed in appendix G.

In addition to the use of questions, the researcher occasionally needed to use probes to keep a participant's line of thought focused on their experience. An example of a probe used in this study is: "You talked about a ... and you said "it really impacted me", ... could you tell me more about what that meant for you ".

All eight participants had initial interviews that lasted from 60 to 90 minutes. Data collection ceased following the second interview for all eight of the participants. The second interview also lasted for 60 to 90 minutes. Data collection ceased when the researcher had gained full and coherent descriptions of the participants' experiences or when participants had exhausted the topic.

The setting for the interviews was where it was most comfortable, convenient and appropriate for the participant and the researcher. For all eight of the participants, the setting for the interviews was the participant's home. For each of the interviews the researcher ensured that optimal conditions were created
for the interviews; conditions that facilitated serious, purposeful interaction. The interview room was quiet and free of distractions and measures were implemented to prevent interruptions and interferences.

Data Analysis

The aim of phenomenological research is to disclose lived experiences; to draw thinking closer to the reality of experience itself through descriptions of concrete experiences (Oiler Boyd, 1989, p. 17). Data analysis therefore, was geared toward constructing an abstract description of each participant's experiences, how she interpreted them and how she gave meaning to her situations within an intersubjective reality (Benner, 1985; Oiler, 1982, 1989; Omery, 1983; Rodney, 1988).

Following each interview the audio tapes were transcribed verbatim and a formal process of identifying the categories or themes that appeared in the descriptions of the participants' experience began. The unravelling of these categories or themes required a process of sequential steps (Colaizzi, 1978; Giorgi, 1975; Polkinghorne, 1989; Van Kaam, 1966). Because this study sought to understand the structure of a context-related phenomenon, the nurses' experience with patients, Giorgi's (1975a) steps were an appropriate
framework for data analysis. The steps of Giorgio's framework are as follows:

1. The researcher reads the entire description straight through to get some sense of the whole....

2. The researcher reads the same description more slowly and delineates each time that a transition in meaning is perceived... [and] obtains a series of meaning units or constituents ....

3. The researcher then eliminates redundancies, but otherwise keeps all units. He then clarifies or elaborates the meaning of the constituents by relating them to each other and to the sense of the whole ....

4. The researcher reflects on the given constituents, still expressed in the concrete language of the subject, and transforms the meaning of each unit from the everyday naive language of the subject into the language of psychological science ....

5. The researcher then synthesizes and integrates the insights achieved into a description ... (pp. 74-75).

The end result of the application of this procedure was a number of descriptive statements that captured the participants' naive descriptions in a clear and psychologically relevant way (Giorgi, 1975). Through the identification and integration of categories or themes, the essential features or
structure of the nurses' experience of working with patients in inpatient psychiatric care settings were explicated. In other words, implicit awareness of this complex phenomenon became explicit formulated knowledge (Van Kaam, 1969).

The analysis of data was facilitated through the use of the Ethnograph computer program for qualitative research. The entire data file was entered onto the program, each interview record coded and categorized, and then, portions of the text corresponding to specified codes retrieved and printed for analysis.

Reliability, Validity, and Bias

Trustworthy research data must be reliable, valid and bias free. The stability and consistency of a measure contributes to reliability of research data. To ensure external reliability in this study, all data were collected in precisely the same way through the use of unstructured interviews. Each participant was asked the same open-ended question and a nondirective interview style was used. Internal reliability was ensured by treating all data collected in exactly the same way. All interviews were audio-taped and transcribed verbatim.

A key concern in using unstructured interviews is validity, the degree to which the questions elicit the
information that was intended. In other words, were the responses to my questions truthful ones or were they altered by the respondent's desire to please me; tell me what I wanted to hear to ensure the success of my research or were they altered for fear of reprisal from their employer. There are a number of ways in which I attempted to control for these problems. All participants were informed that full confidentiality would be maintained throughout the study and in any published and unpublished material resulting from the study. The study was not affiliated with any health care agency nor was any health care agency or persons (including the participants) in an agency identified. Participants were also made aware in my recruitment advertisement, information letter, and the written consent that all interviews would be audiotaped, transcribed verbatim and that they may be quoted verbatim in the results of the study. Participants were also informed that they could terminate an interview or their participation in the study should they wish to do so. Optimal conditions were also created for the interview so that participants remain focused on the interview and felt safe enough to disclose personal aspects of themselves and their experiences. The interview setting was private,
comfortable, free of distractions and noise and measures were taken to prevent interruptions and interferences. Active listening skills and probing techniques were used to assist participants in talking about their experiences. Second interviews were used with each participant for the purposes of clarification, expansion of descriptions, and validation of data. These interviews were also used to challenge participant's data to ensure that they had not biased their responses to meet the approval of the research or to ensure the success of the study.

There were different aspects to the problem of bias in this study. As stated in the introduction my own experience of nursing patients in inpatient psychiatric care settings is what fired the inception of my study.

Because my personal investment in this study was high and I was studying a phenomenon familiar to me, I kept a journal of the research process, specifically the data collection process, to augment my awareness of any bias taking place. I also used a bracketing technique. Prior to interviewing the participants I generated a list of possible themes that I thought would emerge from the nurses' accounts. This list included themes I hoped would be revealed and those I
expected would be revealed. This list forms part of my personal assumptions described in Appendix B. This process of identifying my preconceived notions provided some protection against the unwitting imposition of my expectations on the study.

**Summary**

This study through a phenomenological approach aims to uncover the real experience of the nurse working in inpatient psychiatric care settings. By studying the nurses' perceptions of their experience, a clearer, deeper and more accurate description of what it means for nurses to work with patients in psychiatric care settings will be obtained. From these descriptions, nursing concepts that are faithful to the real world of the nurse's experience will provide an accurate basis for theory development and further research.
CHAPTER FOUR: PRESENTATION OF THE ACCOUNTS

The results of the study are presented in this chapter. The accounts given by the participants describe their perceptions of their experiences in their relationships with patients in inpatient psychiatric care settings. Although common themes emerged across all of the accounts, recognition is given to the uniqueness of each participant's subjective experience and the meanings they attach to them.

The construction of these accounts is the result of two parallel processes: the interviewing process and the data analysis process. The interviewing process reflected an evolving dialogue between the researcher and the participants. Each participant was initially approached with broad open-ended questions to focus them on describing their experiences with patients. Participants were asked to tell the researcher about their experiences by recounting a specific encounter or a relationship they had had with a patient. Following each initial interview, the formal process of analysis began with the reading and rereading of the entire descriptions. This was done to get a sense of the nurses' experiences as a whole. The next step of the analysis involved the identification
of meaning units (Giorgi, 1975). These meaning units were attained by rereading the transcript and delineating each time a transition in meaning was perceived. Each unit or constituent was then reflected upon until the meaning within each unit was fully apprehended. The units were then transformed into the researchers' words. These aggregates of formulated meaning units were then organized into tentative categories or themes of experience. Finally, the researcher searched for and identified common themes that had emerged across all of the participants' accounts. These themes were then organized into a tentative framework and used by the researcher in the second interviews to further clarify and validate participants' descriptions of their experiences. Each participant was presented with the preliminary thematic analysis and asked to clarify and validate whether the themes explicated from their accounts were an accurate representation of their experiences. This process resulted in the refinement of some themes and in the theme of team support being dropped because the nurses did not provide sufficient experiential data for the theme. In the final stage of analysis, the researcher attempted to weave the thematic pieces into an integrated whole that is true to the participants'
experiences and represents the essential features of nurses' experiences working with patients in inpatient psychiatric care settings. The themes of experience will now be presented.

**Descriptions of the Themes of Experience:**

The findings of this study indicate that the nurses' experiences in their relationships with patients in inpatient psychiatric care settings are a complex and multifaceted phenomenon which resists being fixed or reified. Each one of the themes moves, flows, and meshes to represent the nurses' total experience even when they appear contradictory. No one, pair or group of themes of the nurses' experience can be isolated from the others and set apart as most significant or important. Opposites are equally meaningful. Conflict is as much part of the nurses' experiences as is satisfaction.

Although the presentation of the themes will be in a linear order it must be remembered that "Each constituent (theme) participates in the others in a non-linear fashion, bringing the experience into fullness..." (Claspell, 1983, p. 88). The presentation of the themes is therefore not in order of priority or progression but connotes a flow, a continuous process.

Six major themes and one subtheme have been
explicated from the nurses' accounts of their lived experience.

1. The experience of fear of being physically harmed.
   Subtheme: The experience of a lack of administrative support.

2. The experience of conflict.

3. The experience of ambivalence in relationships with physicians.

4. The experience of sadness, disappointment and frustration.

5. The experience of satisfaction.

6. The experience of growth.

The next section of this chapter is an explanation of each of these themes of experience followed by a presentation of the accounts from which the themes were explicated. Each participant has been given a pseudonym to enhance the readability of the accounts without compromising her anonymity.

The Experience of Fear of Being Physically Harmed

The risk of physical assault in caring for patients with mental health problems is always in the background. Dangerous, unpredictable patient behaviour engenders anxiety and fear sometimes interfering with relationship building. Actual situations of violence produce additional feelings of inadequacy, self-blame
and anger. Inadequacy at possibly not having recognized the signs and in dealing effectively with the violent situation and self-blame, in the notion that one had somehow provoked the situation or will be found out as having provoked the situation. Anger resulting from being placed or placing oneself in potentially or actual violent situations and anger resulting from inadequate emotional and resource support during and after incidents of violence.

**Subtheme: The Experience of a Lack of Administrative Support.** There is a perceived lack of administrative support by nurses in caring for patients with mental health problems in inpatient psychiatric care settings. Emotional and resource support in times of crisis is particularly difficult to actualize.

**The Experience of Conflict**

The nurses' descriptions reveal establishing meaningful contact with patients they perceived as manipulative, dependent, non-compliant, demanding and dangerous is extremely challenging for nurses. Their encounters with these patients and their colleagues become fraught with feelings of anger, frustration, fear and disgust. Protective defense strategies such as distancing, stereotyping, and rigid treatment regimes are employed to deal with the intensely felt
conflicts and feeling of helplessness.

The Experience of Ambivalence in Relationships with Physicians

The physician's presence in the nurse-patient relationship is a source of pleasure and satisfaction and a source of conflict. Superficially and compared to other clinical settings greater equality between nurse and physician is perceived and enjoyed in psychiatric care settings. The opposite forms an equal part of their perception. Physicians' perceived opposition to nurses' needs, goals, philosophies and perceptions of patient situations is also experienced and produces conflict. Tension and resentments are felt and build up with patient care ultimately affected.

The Experience of Sadness, Disappointment, and Frustration

The experience of being in relationships with patients often creates feelings of loss for the nurse when the patient's life plans or potential is destroyed by a mental illness. There is sadness and disappointment. Frustration is experienced when patients make choices perceived as keeping them sick or when one cannot effect change in a patient who has the capabilities to change and alter the course of his/her
life. The lowering of one's expectations and doing the best one can for the patient in these circumstances is a coping strategy. It serves to rationalize the feelings of helplessness and hopelessness and provides for some measure of success for both patient and nurse.

**The Experience of Satisfaction**

Experiences of satisfaction are revealed in the nurses' descriptions of their relationships with patients in inpatient psychiatric care settings. These are revealed as having achieved trust, intimacy, closeness, connectedness, and rapport. They are described as a reciprocal way of relating where mutual caring and sharing occur. They are experiences of being in the relationship with patients: authentic and empathic.

**The Experience of Growth**

Being in relationships with patients and nursing colleagues in inpatient psychiatric care settings is described as contributing to both personal and professional growth. Awareness of self is gained and personal changes are experienced. One's nursing practice is refined and personal styles of helping are developed and extended.
THE PARTICIPANTS' ACCOUNTS

The Experience of Fear of Being Physically Harmed

Fear of becoming physically harmed by patients was experienced as a common stressor. The risk of assault associated with caring for patients with mental health problems on inpatient units was stated repeatedly. Although participants accepted the potential for assault as part of their job and felt varying degrees of competency in dealing with violent situations, their fear of being physically harmed was always in the background. It seems no matter how long nurses have worked in a psychiatric care setting, they still experience fear when they are faced with aggressive patients. One participant had worked in psychiatry for over 24 years. The following excerpts illustrate this theme.

Sarah: ...I am always frightened when we have an aggressive patient... It can be terribly fearful. For instance, in the particular place I'm working in now, if it's really a safety thing and if you have nobody around to help you call the RCMP to help you. And it's an okay feeling that you've got someone to help you but it's not an okay feeling to have such fear. And I don't care for the kind of tenseness that it evokes. Umm I'm not
sure that there is an easy answer to it, certainly the risk of being hurt is just an awful feeling and that never diminishes.

Lily: ...It is scary at times, we've had our violent situations where I've seen a security guard with his hair ripped out, I've had metal trays thrown at me, umm I have, shake every time I think of that particular situation where those trays were flying at me, we had no control over this man. I got this hot sweat and it's a very scary feeling to have these things that I only thought were in pubs or something like that, you know, and they were happening on my unit. Umm but again, that's the excitement and the challenge of dealing with people like that.

Rose: I remember we had one lady who was very very sick, very psychotic she was quite violent and she would just freak out, take all her clothes off and run down the ward. She was very frightening she would come at people with high kicks and she was abrupt and hallucinating very badly...
The following participant's excerpt further illustrates this theme. The participant's affect and choice of words in describing the patient are evidence of the extreme feelings of fear she experienced nursing a patient who was also known to have a history of violence. The element of intentionality to the patient's violent behaviour also seemed to intensify the nurses fear and also engender feelings of anger.

Brigit: ...about a month ago. We had this, he's schizophrenic also known history of violence and jail and quite sadistic, a real winner. This guy was a real horror show but unfortunately he was also very psychotic at the time and paranoid and really some really strange twisted bizarre stuff, you know delusions to do with hurting people and oh it was just gross. Anyway he started to lose it one afternoon, this female patient went to talk to him and he just yelled out "fuck off" and I thought oh God, I know what's going to happen so I went out and I told the female patient just to leave and I said what's the problem and he said "she was coming at me ..." and now he was really paranoid about all of this so I told him I wanted him to take some medications so I poured him a walloping dose of haldol and ativan and he took it
and said "you can give me all the medication you want but it's probably not going to do any good, this time I just yelled, next time I'm coming out biting, punching, ...." And I said, "well", and I really hoped this medication would take effect soon. And within 15 minutes he was at the desk again and he was saying "... I want my clothes and if I can't have that", the guy was unfortunately certified as well, "and if I can't have that then I'm going to kick ...." And so he marched away and so I thought this is it, and I just called the Code and I thought I'm not even going to fool around with this one. I just, usually I just phone the supervisor and say could you send for 5 guys but I thought this is a Code all over the hospital so the guys started coming and when he saw them he ran into the dining room and picked up a chair and he said "anyone comes near me you're gonna get it." So I said to the unit clerk, phone the police, this is a Code like for the police and just as she was reaching for the phone one of the guys just, I mean they don't pay me enough to do any of this, he just went up and grabbed the chair and put it down. Which, and the patient seemed to realize yeah there's other people taking control
of the situation and so I had the medication all
drawn up to give him IM as well as, the restraints
ready. And he didn't fight at all, he says "you
guys can do this it's been done to me before, when
I get out of these things I'm going to break your
fucking faces and you're dead, you're all dead."
Which I thought, they say that, but when everyone
left, and he, and you know those restraints are
useless Linda, people get out of them. So he
started getting out of them, so I called everyone
back and so I said "this guy is going to need a
constant", just to make sure that if he's going to
get out he's not going to come up at us from
behind and brain us with a chair or something. So
we got a constant, I had to call the people back
to put him back in restraints and then finally
when people left he was looking right at me and
saying that especially me, because I gave the
medication and orchestrated the whole thing, that
I was, he said "when", it wasn't if, "I get out of
these you are dead" and he called me names, you
know you can imagine the usual 4 letter. And then
talking about, he says "I'm not even going to come
at you from in front, I'm going to come at you
from behind and you won't know what hit you. And
if I don't do it here, I'll do it some night on the street." And then I said, "yeah right." But still that kind of thing, you know you're listening to, that kind of verbal abuse and it kind of gets to you, you know. But anyway situations like that are very anxiety producing and I am, in fact, when I was giving the IM medication my hands, they always, I hate that, but it happens, especially when people are around holding down the patient and your standing there giving this medication with trembling hands.

Brigit goes on to say how she feels when she has time to reflect on these situations. She feels angry at her complete vulnerability.

Brigit: ...And those kinds of things can be basically or potentially soul destroying because you go home and you think of the anger of having someone clutch you around your clothing and how dare they do that and how did you get yourself into that situation where they did that.... you're suddenly vulnerable, that the way he had me he could have put his fist up in my face and I don't know what I could have done about it.... sometimes, it's, it makes you angry. Well it makes me angry that I've put myself in a position
where I'm vulnerable to someone's physical attacks and it's somehow, well you're the nurse, you're the front line.

The next participant's account described the fear she experienced when she became incorporated into a patient's delusional system that contained themes of violence and satanism.

Rachel: ...One case that I can think of was a man who incorporated me into his delusional system, which was full of demons and symbols and satanic kinds of messages and I became a satanic spy or something and that was when I realized that there was no way I could have a therapeutic relationship with him. A change had to be made.... The man decided that I was satanic, had apparently also spoken to his doctor about it. It was actually during a meeting that he told, expressed his fear and anger, very angry... he announces to the whole community that I wasn't really a nurse, that I was part of a satanic cult that was giving him his poison four times a day or whatever. And certainly I was extremely afraid when I had that information ... there was no way I could continue nursing this patient. It was certainly not helpful for him or helpful for me because I was
too anxious, that he had a history of violence as well.

Even though nurses experience fear nursing patients who become aggressive because of a psychotic illness, the nurses' accounts reveal a more compassionate attitude toward psychotic patients who became aggressive. They feel more protective toward the patient and are better able to rationalize the patient's behaviour. They also express less anger when describing situations with these patients. This is reflected in Leah's description of an actual situation with a patient whom she believed was deliberately violent towards another patient.

Leah: ...I remember working and witnessing one of the patients who was... there being assessed because he was apparently insane... the patient picked up a [hard object] and threw it full face at another patient across the room hitting him right in the head.... I remember feeling not only anger but total rage...I just felt just totally disgusted by the whole incident. I found that I couldn't even rationalize his behaviour of somebody who was insane or very mentally ill because of the feelings of anger that I had. Another participant, Diana, reveals similar
emotional reactions. She states:

Diana: For people that are suffering from some kind of psychotic illness and are out of control I guess... I find it harder to understand intellectually what they are going through, there's no questions about that. I don't so much understand what their experience could be like except that it must be very terrifying. And so, when I'm faced with somebody that is very ill, like that, I guess I feel protective of them, I feel sympathy for them....

In addition to evoking feelings of fear and anger, violent situations seem to evoke feelings of inadequacy and raise doubt in nurses in terms of their competency. Nurses question their actions and review violent incidents over and over again to determine if they missed any cues or if they acted in the best way possible.

Brigit: ....having a patient out of control and angry is very frightening and your physical safety threatened but I'm also thinking my physical safety but also my accountability what can I do here, because if someone gets hurt or it ends up being an investigation of some kind and I'm looked at as the one who screwed up. You know all these
things are racing through your mind. How is this
going to look on paper when I chart it, did I do
the right things did I cover all the
possibilities.... you get home, and you get off
work and it takes a long time to unwind. Things
just keep going round and round your head. Even
after 10 years and these things happen fairly
frequently but there is always that major anxiety
of did I do everything right, you know. Could I
have done it better? ...Did I catch it soon,
because I'm constantly assessing the patient to
see, now is this one escalating or whatever,
because the sooner you catch it the less chance
there is of a major full blown acting out violent
episode.

Lily:  ...I remember one time this girl had gone a
bit psychotic on her meds at 8:30 in the
morning... both this male nurse and myself were
planted on top of this girl and she was just going
wild. ...this doctor comes walking in the ward...
"well I'm glad you're here" and I'm just shaking.
...I said, "I would like to come and sit down with
you [and patient] and that moment tears just
came... it was quite overwhelming - I just went
into the bathroom and cried my eyes out and I think it was because I was so unsure that what I was doing was right. I'd had the CPZ thrown all over me, she just about threw a table through the tv, another patient just about got involved with the fight, we had about four patients on at that time that were quite volatile and that would if she had sworn at them or called them a you know what she would have maybe set them all off. And I was under so much tension. ...did I miss something? was I supposed to do this?

In summary, the accounts reveal that becoming the target of inpatient psychiatric care, violence is always in the background and engenders feelings of fear, anger, inadequacy and self doubt. A perceived lack of administrative support contributes to this fear and produces long term personal and professional ramifications.

**Subtheme: The Experience of a Lack of Administrative Support**

Nurses who work in difficult and demanding situations expect to be guided, affirmed and supported by their nursing leaders. They need to have a sense of reliable alliance and support in which they can expect continuing assistance and support from trustworthy and
authoritative persons in the hospital organization. The nurses' descriptions reveal a perceived lack of administrative understanding and support in caring for patients in psychiatric care settings. There is a perceived unwillingness of administrators to learn about the "work" of psychiatric nurses and a lack of genuine interest and concern for the emotional needs of the nurse who chooses to work in psychiatry. This lack of emotional support was felt more acutely in crisis situations particularly situations involving the management of an aggressive patient.

Diana: I think psychiatry really lacks support... I think we lack a lot of support that other nursing units get... how do you explain to people who are coming around for two minutes what you're doing. And a lot of times that makes me feel very conflicted because I sense that there's this bias towards psychiatry that we're not doing anything and I really hate that-I really hate it. The amount of work we do is incredible and you can't explain it to someone who is trained in medical surgical nursing and that's what they've been doing for 25 years that's where I feel there is a big problem. If there is going to be supervisor there should be some people with psychiatric
experience that know what you're talking about.... You really have to give each other support in psych because it really doesn't come from the rest of the hospital and it's very obvious. I mean most psychiatric units are in some back wing of the hospital or they're in a totally separate building and that says something.

In addition to a perceived lack of willingness from other hospital personnel to try and understand the "work" of psychiatric nurses, Diana's account also reveals a lack of attachment and sense of place in the hospital organization. The "two minute" visit from the nursing supervisor is significant in reinforcing psychiatric nurses' feelings of separateness and difference from other nurses in the hospital organization.

In the next excerpt the participant describes an incident, with a nursing supervisor, involving the potential for violence, where she experienced a disregard for her own and her patient's welfare and safety. Not only did the supervisor communicate her displeasure at having to come to the psychiatric unit to assist her, Rachel also felt that policy and procedure took precedence over the people involved in the situation.
Rachel: I have an example of that. A few weeks ago when I was working nights a patient who has a history of violence and had been rather high would get up during the night, and ... he would get up a couple of times during the night and he would need a lot of redirection to get back to his room... We would call the security to come over and give us a hand. And at about 5:00 in the morning we were working in the office and we heard [a noise]... he was quite threatening in his voice tone.... We had concerns that he would then maybe run off down the street ... I ran to the phone and dialled [number], it rang three times with no response so I hung up and dialled [code number], what I needed was a quick response from the security... to come and help us redirect him. The [code] number is one that is immediately responded to at the switchboard for emergency fire, emergency medical conditions if someone has a cardiac arrest.... And I said "please page the security to come stat to -- ". ... I assumed that she [switchboard] would go through their paging system she however, did not... the supervisor came running.... And so after we got him [patient] back into his room... the supervisor said to me "why did you dial [code
number]" and I said well, "because I dialled [a number] and it rang about three times and I didn't have the time and it was an urgent situation. And she said to me, "well that's the code phone, that's only for code [X], which is a cardiac arrest"... I heard the next night, the day supervisor also had questioned why we used that phone and that irritated me. That became more the issue than the urgency of the situation. The safety, our safety, the safety of the patient... Those kind of things irritate me. What becomes the issue. And I find the supervisors maybe more inclined to not understand completely the situation in psychiatry.

Rachel told the researcher of another situation with a nursing supervisor where she experienced a lack of understanding. This situation seemed to make Rachel particularly angry because the supervisor's behaviour displayed a fundamental lack of compassion for the patient in his predicament as well as a disregard for the fact that Rachel's work with this patient does not begin and end with this particular situation. There was no recognition that Rachel might have a therapeutic relationship with the patient that was worth preserving.
Rachel: ... Something happened one night ... he [a patient Rachel had been looking after] became more decompensated, in terms of delusions and hearing voices and was getting very agitated... he lunged at me... he was... having trouble with his control... So I had to call in some assistance to medicate him. I had nurses and the supervisor and security. We had to ask him to get into his pyjamas and I would be giving him intramuscular medication... anyway when I went in with the gang and told him I would be giving him some medication because he appeared and presented agitated... he wanted to talk about it for a short time, I felt a reasonable length of time. And I allowed that to happen. And I heard the supervisor behind me whisper, "let's get on with it". It distressed me terribly, because I felt it was okay for her to come this one time and assist and maybe it was using up her some valuable time of hers. However, what I think she failed to see is that my relationship with him went beyond this one night and that, that's just not the way I operate. I have to consider the on going rapport. ...I was irritated...I felt it was a bit, well certainly uncalled for and very uncompassionate.

Another participant felt that there seemed to be a prevailing attitude among nursing supervisors, that
"they [meaning psychiatric nurses] could cope with aggressive situations on their own because they were psych nurses," and that because of this attitude nurses lacked support with these situations. This perceived lack of concern engenders feelings of anger.

Rose: ...they think oh you can cope, you can manage this because you're psych nurses and you have more skills to deal with a violent or aggressive patient but if they hit you haven't got any more armour than anybody else has. So you know they expect you to be able to deal with it but I think as a psych nurse I get just as frightened and worried as anyone else would if somebody is threatening me. I feel frightened and I feel nervous and I want to be supported by my supervisors. I want them to take it seriously and I want them to provide me with a safe work environment and I don't get paid to get hit and pushed around and verbally abused and I don't consider $20 an hour is enough to get all that rough treatment. And they don't take it seriously and the only reason they don't is because they're not dealing with it directly. If they were dealing with it directly all day they would take it seriously....
Being told one "can cope" does not encourage nurses to ask for help and support during and after violent situations. It could also contribute to nurses not reporting assault situations as doing so would indicate that they were not coping. The participants perceived a lack of support in the form of education and adequate human and other resources. In particular, participants felt a lack of education and training in the management of aggressive patients. They expressed the need for more information about aggression and ongoing skill training in the use of techniques for managing aggressive situations. Participants stated, that even though they felt competent in managing aggressive situations, they were concerned about beginning nurses who lacked education and skills in managing aggression and that this was crucial to their own safety. When team members are incompetent in dealing with aggressive situations everyone was at risk of harm, patients and nurses. Nurses also wanted a safe work environment, a locked room and more male nursing staff. They also wanted the help of a crisis response team to assist them in aggressive situations. There was also a felt need for emotional support from their nursing leaders and doctors following aggressive situations.
Rose: I'd like them to provide us with a safe room, a room we could lock because I don't like to see these people all chemically restrained and getting horrible side affects and getting toxic and getting worse than they were in the first place. ...And I'd like more inservices and I'd like more men working there... more education in violence, how to defuse it and how to not just diffuse but how to recognize that you've got a potentially violent situation, how to deal with it when you can't diffuse it, you know and feel safe and feel in control and we don't get enough of that.... Yeah more support and more education. Education on the unit as a whole... Just so that you knew you're working with people who also know what they were doing because if you know what you're doing and no one else does or not everybody else does then what happens is you have to educate them in a crisis and then you get in a real muddle because they're frightened, they don't know what they're doing and they could mess it up.

The debriefing of traumatic situations, particularly violent situations through formal and informal programs by nursing leaders was associated with support and when it was not initiated by nursing
leaders nurses felt unsupported. They wanted emotional support and recognition that they had been through a difficult situation, no matter how skillfully they had dealt with the event. When such support is absent the nurses experienced doubts about their competency and their value as a professional.

Diana: ...I think the value in debriefing situations like this is that for one thing you get the support that people need. The support then gives people the feeling that they've done an okay job. I think if you don't get support, you feel almost like, did I do something wrong? and you start to feel resentments and also you've been put through a stressful situation and anybody who goes through a stressful situation should be given the opportunity to talk about that experience and get some feedback I mean that's just basic... it's a trauma and if you're not giving that in your place of employment or you're not participating in that process then I think you are traumatizing because anything that evokes such strong feelings in another human being needs to have time to be worked through. Any institution that doesn't give that time I don't think they're going to keep their nurses because I mean who on earth wants to
go through those experiences and not have any place to deal with the feelings... [otherwise] I think you're going to be a mess in no time because those feelings have to go somewhere. And I think what they can end up doing is really poisoning people, they can become very cynical, very angry.

The nurses' accounts revealed that when assault situations are not debriefed nurses, patients and the whole milieu are affected for a long time. The long term effects of an assault situation to individuals and to the ward milieu were articulated by two participants who were adamant about the need to debrief violent situations that occur on the wards. Blaming the victim, divisions among staff, and absenteeism were common responses to assault. One participant even cited an incident where a nurse actually resigned.

Rose: You need to debrief people, they... go through a crisis if something terrible happens, like it has done a couple of times where I've worked, someone was attacked and threatened, you need somebody has to be able to debrief everyone... because what often happens after that kind of thing, if you're not careful, is people get criticized for what they did and what they didn't do and they feel even worse then, they feel
frightened and angry to begin with, they've been attacked and all you need is some smart person saying "well if you'd only done this it wouldn't have happened"... if you don't deal with that you're going to get staff who refuse one to ones, who go off sick when they've got a violent patient on a one to one they won't come to work... So more support, not just from the supervisors, but more support within the unit you know the head nurse or the assistant head nurse or even the director... It's not the kind of stuff you can ignore, it happens on psych ward again and again and unless you've got a good vehicle to deal with then people aren't going to want to stay there.

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Sarah: ...one year ago a nurse was badly hurt and left quickly. The ward remained divided a long time, it was never resolved, people were blaming each other it really set off a set of circumstances that, I don't know if it will ever heal. It still comes up today, a man was transferred to us a week ago, he didn't want to come to us he wanted to go to a locked ward, he was 6ft. 2in. weighed 198 or 200 lbs., definitely meaning to hurt someone and he didn't want to be
there, he was strong, kicked over chairs, threatened you with his fist, and the size of him was intimidating enough and um. I explained to him that he was frightening us, he said "I know" he wasn't psychotic and he said "you can't commit me, because I'm a behaviour problem I'm not psychotic". When I got back to the nursing station the other nurses said "it was just like that, just like that other incident when the nurse resigned" and I thought that's how close it is to the surface it just brings it up all those feelings, of you are frightened, you don't know what to do, you don't where your support is going to come from"... This incident was not diffused and that's not being done any more, it used to be done right away. We talked about our feelings and we've stopped doing this. I guess I'm angry at the leadership.

Debriefing was considered important to maintaining positive relationships with patients.

Diana: Well the long term effect is usually positive because people will probably have anger towards that patient, fear or fear that has turned into anger all different combinations. So if you're given the opportunity to talk about those
feelings then you're not going to pass them out to your patient, act them out on your patient so the relationship is definitely going to be better.

In summary, the findings of this study suggest that nurses perceive a lack of administrative support in caring for patients in inpatient psychiatric care settings. They do not think that they receive adequate emotional, educational and resource support particularly during and following situations involving violence. They believe that training in dealing with aggressive situations and the debriefing of aggressive situations should be initiated at the institutional level by their leaders.

The Experience of Conflict

Intense conflictual feelings are revealed in nurses' accounts of their encounters with patients they perceive as manipulative, non-compliant, dependent, disrespectful, and dangerous. These patients are reported as having been diagnosed as personality disorders, such as borderline personality disorder or anti-social personality disorder. These patients were experienced by the nurse with intense emotional responses. Extreme feelings of anger, frustration, fear and disgust were evident in the nurses' affect and choice of language when describing such patients. "You
just want to shake her because it is just like you are wasting my time, you're wasting my money and you're wasting the governments time, you should be back in [another city]." Participants repeatedly used similar terms to emphasize their responses. They said these patients "set you up", "suck you in", "push your buttons" and "split" nursing staff. A sense of helplessness and powerlessness was also evident in the nurses' descriptions. These feelings were associated with a loss of power and control and an inability to make a difference in these situations. The nurses felt they had to keep a lid on their feelings and keep some distance between them and the patient so that their own feelings did not interfere with the care of the patient. Another phenomenon observed by the investigator is the frequent use of diagnoses when discussing these patients. The stereotyping of patients appears to be a way of coping; a way of distancing one's self from the patient and the intense emotional responses they create in the nurse.

Leah: ...I've had extreme feelings of anger in working with some patients who were perhaps hostile to other patients or who I knew were deliberately manipulating or doing things. And I would become very angry and learning how to
maintain that relationship without just shutting off is a real challenge for me even now... working with patients who evoke that kind of response I have found that to be a real challenge....

One nurse described manipulative behaviour in terms of disrespectful behaviour toward her which made it difficult for her to become totally accepting of the patient.

Rachel: Well there is always going to be patients that are going to manipulate or attempt to manipulate. That's unpleasant because I guess it automatically conveys a disrespect and so maybe as much as I want to respect patients I want them to respect me back. And generally speaking I think that happens. You get someone who is pretty slick and is going to start playing games then ah.... they're not saying "I respect you" and I don't like that. I don't like that anywhere....

Rachel adds that she finds nursing these patients more difficult than nursing patients who are out of control and psychotic. She expects them to know better because they are not crazy. They are patients who "press my buttons." When asked to relate an example of a patient who had "pressed her buttons" Rachel reveals her protective mechanisms in dealing with such
patients.

Rachel: Who has pressed my buttons. Mmm I have to think for a little bit. Part of the difficulty of remembering who pushes my buttons is that I don't want to remember. I think that's maybe important. Because I'm sure there has been a number but I can't think of a specific incident. (long pause) I can't, isn't that something. It's my old protective device. It allows me to keep going back there day after day.... I was trying to think if there maybe there was someone even back east ten years ago but I can't, I can't remember.

In the next excerpt Rachel discloses the need to distance herself and be cautious with patients she perceives as manipulative. They engender anger in her and fear that she will be placed in situations she cannot handle.

Rachel: I can think of picking people up in the emergency room and going from the emergency room to the ward and already getting a sense that ah there may be some personality disorder stuff about this person. The energy that I put into developing some kind of rapport with them would certainly be different than the chronic patient
who has decompensated and who is psychotic and yeah there would be more distance I guess. There would be yeah I would feel a little more cautious I guess.

Rachel goes on to explain what she would be guarding against by distancing herself from such patients.

Rachel: Well I guess maybe putting myself into a situation that maybe I don't feel that capable of handling, for example the manipulation. Or getting angry that they would come to the hospital under the demise of wanting help and then taking advantage of the people that are there to provide it. That is, that makes me mad.

When the researcher revealed to Rachel that other nurses stated they were guarding against getting hurt, and did that have any significance for her she initially denied any significance.

Rachel: Umm no it doesn't actually. Getting hurt on a personal level, no I can't actually say that it's a concern that I have. I don't know actually ... Well I guess yeah, oh yeah. I would feel hurt as well. Hurt and angry. I guess maybe I was denying that one. Because yeah I have felt hurt in some relationships with patients. Umm
hurt that some would seemingly choose to be manipulative or abusive, verbally. Or misunderstand I guess misunderstand me, yeah.

Patients perceived as manipulative were frequently described as engaging in behaviours that were hurtful and sometimes humiliating to nurses. Behaviours such as rejecting the nurses efforts to help and drawing this to the attention of other staff. The next participant describes how she protects herself from being hurt when nursing patients she perceives as manipulative, and as instigating problems in their relationships.

Lily:... I listen a lot with these people, I don't try to give solutions. ...then you just realize that no, these people are skilled, they have learned how to survive with their manipulations, they're very good at it. So just because you're the nurse don't think you're not going to get sucked into it too. ...But I guess initially you could get hurt, sucked in.

When asked to explain what she meant by getting "sucked in" Lily describes this as having "lost the game", being "beat out", and losing pride. She states she must remain "neutral" with these patients, revealing little of herself, and never letting them
become a friend. She believes that her "caring" behaviours and self-disclosures would be used against her by the patient to gain control or to pit her against other staff.

Lily: ...you never tell people about your own personal self ...with a manipulative personality disorder type patient, you are more neutral - neutral. Because they use some of those personal, you're giving, you're caring, to manipulate you. They use that against you, "oh well so and so she used to rub my back every night when I complained about a back ache you don't do that." ...So that nurse thought that warm touch and all that feeling she was giving that patient was great but what ended up happening she, the patient, used that against you and split staff all up manipulating people. So I think that's the difference. No, not to all people do you show that level of warmth to.

There is a sense that nurses work hard to discover manipulative patterns early in a patient's hospitalization so that they can gather up their defenses in order to deal with these patients with the least amount of personal discomfort possible.

Rose: ...I think you have to be able to spot
somebody like that fairly early on as to whether they are going to be very very demanding and very manipulative and I think you have to be able to realize when they are going to do that. And it's very hard to begin with....

In a second interview Rose was asked to elaborate on what it means to her to nurse a patient whom she perceives as manipulative.

Rose: Umm it's very difficult to work with a manipulative patient. I find it very frustrating. If somebody's got a personality disorder if their borderline or histrionic... they will split, that's what they do... As soon as you find yourself at another staff member's throat about that patient then you've split. And I find them very frustrating people to work with - manipulators - because I'm not very sympathetic to them, I'm fairly matter of fact and very black and white and I don't give an inch. I contract with them, I set limits... I give them very strong structure. I'm not sure whether I overdue it a bit. I may be doing it to protect myself rather than for their benefit, but I don't really have much trouble with them, with the manipulators.... I find them frustrating and difficult to work with
because they tend to destroy the whole ward atmosphere I mean they get everybody going. People are up in arms and crying and complaining and everything and it just takes two personality disorders in a ward of 24 patients and you've got chaos. And I think that's probably why they irritate me.

Rose then describes what it would be like for her if she did not set up these protective measures.

Rose: Oh it would be terrible it would make you feel engulfed and actually, the way I describe them to co-workers... is I describe them as black holes because they're absolutely bottomless and they're like a big negative force and like it doesn't matter how much you put in there it will get lost and it won't make any difference. Because what will happen is you'll get sucked in too and you'll disappear down the black hole and that's I guess how I feel about some of those people.

Participants in the current study repeatedly expressed concern about manipulative and demanding patients "splitting" them or they described actual situations where the phenomenon of "splitting" was experienced by them. The next participant's
description of her experience nursing a patient who staff perceived as dependent and manipulative illustrates the divisiveness that resulted from staff perceptions of this patient.

Lily: Okay, I'll talk to you about one little lady that came in and she had had a mild stroke. And she was severely depressed .... And here's this little lady, she looked like everyone's little granny and spoke that way too, very soft spoken and very kind ... I was her primary and it was a major challenge because this lady only spoke in terms of somatic complaints.... I would spend a lot of time talking with her which caused a lot of problems on the ward because some people thought I was being sucked in to this lady.... So umm at times I was really upset because different staff would come to me and give me ideas... so it was a constant re-evaluating, is this the right care plan that I was doing... so I picked up on a lot of frustration from the staff over that particular situation. They wanted me to be quite blunt with her and tell her to get her act together and some people just couldn't see that this lady saw herself as paralysed from the neck down regardless. She needed, in a way, that sickness
because it got her a lot of attention from her family which she would have never got unless she was physically ill because they didn't understand depression, sadness, deep sadness....

personality disorder, can cause a lot of mixed feelings with the staff.

One participant describes the problems in diagnosing a patient as personality disordered. These problems often begin prior to the patient's admission when staff disagree about whether the patient should be admitted to an inpatient unit and about treatment methods. Conflict also arises with regards to the accuracy of the diagnosis. The following participant believes that the diagnosis itself is problematic, that once a patient is labelled as a personality disorder the staff automatically assume that the patient will behave in certain ways or that certain behaviours are quickly attributed to a personality disorder and further assessments of the patient appears to cease.

Rebecca: I hate the diagnosis personality disorder ...it's kind of a write off diagnosis that I find very frustrating. People can act in ways that make them possibly make them appear to be personality disorders but for a whole different set of reasons. And I really sometimes feel that
so little goes into discovering who these people are about or why. Why they are like this. And you give somebody some of these diagnosis and that's it, if they want help in the future somebody just looks at that and they're scurried off to somebody else and it goes on and on. So that's a frustrating one, that diagnosis.... the therapy takes a long long time. ...on an inpatient unit we don't have that luxury of doing long term therapy. The doctors will work very hard at not admitting somebody with that diagnosis... Once it's there on somebody's records it's like a brand and the assumption is that they are going to come into hospital, they're going to cause problems, they're going to self-mutilate...

In summary, the experience of conflict in nurse-patient encounters was described by nurses in the current study. Patient variables were cited as the major reason for the conflict. Behaviours that were viewed as particularly troublesome to the nurses were: manipulative, non-compliant, dependent, demanding, disrespectful and dangerous to others. These "difficult" behaviours were perceived as interfering with relationship building and often intractable, no matter what the nurse said or did.
The Experience of Ambivalence in Relationships with Physicians

The nurses' accounts reveal that the physician's power to define situations involving nurses and patients, both together and separately, directly and indirectly, is enormous. Superficially the nurses in the current study described satisfactory relationships with physicians in the psychiatric care setting particularly when they are compared to relationships with physicians in other clinical settings. However, when the participants described actual situations with doctors a different picture emerged. Nurses did not feel listened to, consulted or given credit for their knowledge and skills. They felt doctors called all the shots and that many times they had little choice but to comply which left them feeling angry. This is illustrated in the following account.

Rachel: ...I do find that generally speaking probably 80% of the physicians will want to hear what you have to say and respect what you have to say.

The same participant later described a situation where she was totally left out of a treatment decision by a doctor. As a result the patient ended up
receiving medication he did not need. It left her feeling angry, undermined and invalidated especially since she had nursed on that unit for ten years and takes her work very seriously.

Rachel: ... When you do rounds and you've got, a particular patient sleeping soundly, snoring, grinding their teeth and they complain all day that they don't sleep and the doctor comes in and keeps changing their H.S. sedation because they're not sleeping but in fact they are sleeping. Perhaps they don't feel rested when they wake up or they, you know, want more medication. It doesn't seem to matter, my partner and I make a point of saying, "I understand you feel like you're not sleeping that well at night so if you see the flashlight you give us a sign, we may not be able to do anything except acknowledge that you're awake but then we can document it and your doctor will know." So we even document that... they sleep all night, snore and grind their teeth and the next day the medication is doubled or tripled. So that's a little bit irritating... I feel angry about that and invalidated. You know, I take my work very seriously and I don't feel that I that I document something that is not so
and I would like to think that after being in the same place for almost ten years that, I guess that's part of it too, they know I'm not going to write something down that isn't so. And so if it's reflected in what they order then I realize that it doesn't matter what I say, it's irritating and it makes me mad.

The nurses' accounts revealed that it is difficult for nurses to apply their knowledge with physicians. Either they are not consulted by physicians or their recommendations are not accepted. This is clearly indicated in the following account. The nurse's knowledge of medications and her assessment of the effects of the medication on the patient are completely negated by the physician.

Rose: ... We've got this guy right now he's on desipramine and he's having it all at night and it speeds you up I mean it's an energizing antidepressant, he can't sleep. And I tried to point that out to the doctor and say "well don't you think if he had it in the morning it would help." "Oh no, it won't make any difference." Well that kind of thing frustrates me because I know damn well that it would make a difference. ...And somehow we're playing second fiddle to the medical
profession and we shouldn't we should be a profession in our own right but it doesn't seem like we are yet. So I guess I get steamed up about that.

Rose also points out that she not only ends up having to live with the doctor's decision by having to manage the patient's unnecessary distress but she also has the added task of explaining the doctor's actions to the patient.

Rose: ... It's so stupid it really is. And like I mean you don't work in psychiatry for years and years not to know what kind of anti-depressant that person should probably be on, what kind of side effects they're going to get while they're on it and what dosage they need. And the doctors kind of pretend that we don't know that stuff and we do. But they're not there all day and they don't see, they see the patient for ten minutes a day and we're there for eight hours so we're a better judge of what that patient is doing. And it's such a shame because you just see them making such incredibly, I mean they're not bad mistakes they're just not doing the patient any good...like this patient that's on desipramine and couldn't sleep he said "I can't sleep I feel terrible." I
said "well sometimes these medications give you side affects for a couple of weeks and you just feel lousy and what happens is your energy level comes up before your mood does so you actually feel worse." And I said "some of them are energizing so you don't sleep very well and he said "well wouldn't it be better if I took it in the morning" even he figured that out. And I said "well you have to talk to your doctor about it..."

Another participant talked about the control over treatment plans that doctors have and how frustrating that was for her particularly when she could see that the patient was ready to work on important issues but the doctor would direct them not to. She describes her frustration as it relates to working with patients with eating disorders.

Rebecca: Yes, working with eating disorder patients umm without being able to work on what issues put them -- gave them that diagnosis in the first place. Umm I find that just very frustrating. I feel like we're fixing up a symptom, we're taking care of someone's temperature and sending them out with the rest of whatever their infection is. Umm again it seems
like sexual abuse comes up often with eating disorders and in the past we've had very clear directions from medical staff not to deal with those issues. And that feels like we're not even doing half job, we're simply dealing with symptoms. It's especially frustrating when you can see that the patient themselves are ready. So yeah I mean that's frustrating...

The nurses in the study were adamant that they needed to feel safe while at work; that under no circumstances should they become victims of violence. Because the doctor often has the final say when it comes to treatment decisions such as medicating, restraining or secluding patients some participants felt that their safety with patients was sometimes in jeopardy.

Rachel: ... sometimes you feel like, I feel like it doesn't matter what my opinion or concerns may be, I don't always get the support from the doctors... in the management [of a patient], for example, the nurses feel that the seclusion room, for example, that we're using for now, should continue. And the doctor may say that he doesn't agree with that, let's try him out and see how he does. That sort of thing. ...in the last week or
so we've had a case like this. And it did turn out that although the doctor didn't agree, the head nurse intervened and supported the staff and there was a staff decision that was upheld. It's not always like that though. It seems that what the doctors says goes. And yet he's not the one that's there through the night, you know, in the middle of the night when there's only two of you there and things can be pretty scary... you feel anxious and vulnerable....

Another participant expressed anger at doctors who disappear or do not participate in assisting nursing staff when patients become violent. She reveals feeling dehumanized by what she perceives as their lack of caring towards nurses.

Brigit: ...you're the nurse, you're the front line. I'll tell you I've worked at another place that if patients got violent the residents, and I'm talking about the doctors, the residents did not even deal with it they back right off and it was our job to deal with the violent patient and once they were subdued then they would step in. Like women and these guys would suddenly walk quickly away from a verbal or a physical threat... at times think well what am I - the handmaiden,
the body guard, the watch dog, the punching bag - you know, what is this? Sometimes I do get quite angry about this profession that I've chosen and I'm sure that I don't know, sometimes I wonder what the interns and the doctors say "don't worry the nurses will take care of it, they're trained to." Trained like dogs I mean what is this. Like it really is.

Another participant talked about her and other nurses' reactions following a series of violent situations with patients on their ward where they felt unsupported by the doctors. The confrontation that eventually occurred between the nurses and doctors reveals the lack of empathy that the nurses perceived they received from the doctors. They seemed to think that offering a bit of reassurance would be sufficient. This situation reveals how assertive the nurses had to become with the doctors to ensure their own and others' safety.

Lily: ... it got to the point the staff were refusing to care for these people, do one to one care and for violent situations. So I mentioned it to my clinician, I said "something's got to be done, they have valid reason for refusing even though they're not supposed to refuse nursing care
because violence is part of a psychiatry unit but I can see why they're refusing, we can't just tell them to go out there and care for that patient regardless of how you feel. We should get down to the feeling level and I'll tell you what it is, they don't feel supported by the doctors." We had a couple of situations where the doctors were , the main doctors were away, and they would leave their residents on call. And the residents didn't know the patients and they weren't familiar with the drugs, it was a real zoo. And so I said "I think it's time that this comes to a surface ... I think it's time that you plan an open agenda staff meeting where all this stuff can be vented openly and all this bitterness specifically." So anyway it turned out that umm we did and ah I was so pleased because that particular staff member who was strangled, for the first time, blasted that doctor... that he did not feel the doctor had medicated that patient enough. And really put the doctor on the spot. The doctors said "you know we understand it's very difficult to deal with violent patients" and then I said "we are not supposed to refuse to care for violent people, we are not allowed to refuse our assignments because
we are supposed to know what to do with these people. But that means you can't either. So that means on the weekends you have someone on call, no more of this mixing up the call buttons so no one is on call on the other end. No more putting a family practice resident to be first on call on a long weekend. If we have a violent patient on board I want to have someone who knows what they are doing. And you can't refuse that, it's a two sided thing. We can only give the meds that are ordered, we can only give the care in that respect that you say is okay. We can't do it on our own". So they kind of went blank at that one... But there still is a tension around a violent patient.

The participants accounts reveal that they perceive their relationships with patients as different than those of doctors with patients. They do not see themselves as extensions of doctors but as a separate helping discipline with its own ways of caring for patients. The next participant described feeling challenged by a psychiatrist who during a staff education session (inservice) on transference and countertransference told them that therapists should not use any self-disclosure with patients. She describes her reaction to this "strong statement" and
why she had difficulty accepting this for her, as a nurse, who has spent many years developing a style of helping that works for her. The nurse felt that the doctors' statement reflected a lack of awareness of the differences between nurses' relationships and doctors' relationships with patients; that the doctor simply assumed that nurses did therapy or worked with patients in exactly the same way as doctors.

Rebecca: ...we had an inservice at work a few weeks ago on transference and countertransference issues and one of the things that came up during that was the psychiatrist who was presenting made ... a very strong statement in terms of therapists using no self-disclosure at all. And that didn't sit right with me at the time and I've been doing a lot of thinking about why that didn't sit right with me. And I think it has to do with this - I end up using a lot of my own life experiences in how I do therapy. Even relating what those experiences are.... And I guess I found that, for me it's an effective way to deal with a lot of people using that. Umm I don't fabricate stories but I will smooth out life details so that they make a better story for making the point... I talk about my garden and my cats, the trouble I have
picking things out when I go shopping because sometimes with a patient you can work things out together and to me it's such a valuable thing, and to suddenly be you know told this is not allowable. I go back to thinking yeah, as a psychiatrist who sees a patient for a limited amount of time to maintain that distance, everything within that time that the psychiatrist sees the patient is therapy underlined with a capital T, it's therapy. With us we're with the patient so much it would be good if all of our contacts were therapeutic but they're not therapy all the time... I've thought about this a lot since she gave the inservice and I don't know how to eliminate the self-disclosure without redoing everything and I don't think I'd be willing to do that.

The following excerpt further reveals the nurses' perceptions of their relationship with patients as compared to their perceptions of physicians' relationships with patients.

Diana: ... I believe, compared to the medical model in which we're working with - that nursing has sort of a different approach even though it's somewhat based on the medical model it's
different... It's based on more of a relationship, a more personal relationship, more holistic relationship than umm that I see with patients versus doctors or other workers in the hospital... the relationship with nursing staff is different... It's less formal and it's more enjoyable I think. You get to experience people as themselves and a lot of things come out in that process... having this opportunity to see people through a wide range of experiences... you get to make a finer assessment... no one else in the team has that opportunity and so again the value of nursing is very important there. It's enjoyable... it I believe is more reality based.

In summary, the nurses' descriptions of their experiences in their relationships with patients inevitably involved some discussion about their relationships with doctors. Although they generally felt supported by doctors in inpatient psychiatric care settings with regards to patient care they also frequently describe situations where they did not feel consulted, supported, listened to and given credit for their skills. There were frequent complaints that doctors always have the final say, no matter what. The perceived differences in nurses relationships with
patients and doctor's relationships with patients is also revealed by the nurses in the study.

The Experience of Sadness, Disappointment, and Frustration

The realities of working in inpatient psychiatric care settings means that nurses care for patients who suffer from mental health problems that carry a high potential for progressive and pervasive impairment in multiple areas of functioning. The accounts reveal that the inability of the nurse to effect change, alter the course of a mental illness or make a difference in the lives of some patients results in feelings of sadness, disappointment, and frustration.

Rose: It's very very tragic especially with schizophrenia because most of the people get it when they're so young, they get it when they're 18 or 19 their whole lives are destroyed. Their functioning goes downhill rapidly, they can't form relationships, they can't hold jobs, they can't get a good income, they just end up on the street. It's so sad, and people with manic depression they're alright for a while and then they spend all their money or kill themselves because they get so depressed. Some of the other, you know the unipolar depressions and anxiety disorders they're
much more treatable and they can go away for good but the umm psychosis is so damaging to people's lives.

Sarah: ... I'm looking after a lady who was just discharged... who has decompensated so badly, she is totally chronic care, she has no insight, very bright all through university, career in [a profession] and around age 28 became unmanageable and went to T and spent $15,000 in one day.... And I see her now and she's never complied with medication, she comes in now and she's age [a number] and I, what's going to happen to her and that is really sad. And I'm close to her but there's no, I very close to her and she depends on me when she comes to the ward because there is lots of new nurses now that she has no relationship with and it's hard for her ... we see her now she's poorly groomed , and her goals are expansive ... a lot of anger, she's troublesome in the community I seen the deterioration and I wonder where is this lady going to end up...yes I feel a tremendous sadness... especially when you see them from maybe the first or second admission and then ten admissions later or ten years later
or whatever. And see the decompensation and the lack of coping skills. Oh yes that's very sad, very sad.

For another participant, Rachel, the patient she described was the first patient that came to her mind when asked to describe her experience in her relationships with patients. The patient was a young man whose potential to become a successful athlete was halted by a mental illness.

Rachel: So a patient that sticks out in my mind? There are actually a number of them. I guess the first one that came to mind is a male in his middle 20s, who had been incredibly successful in his teen years and had his first break when he was 18 or 19 and ah (pause) it impacted me, I think, how sad it was that he had such potential and that he is really barely functioning in a one bedroom suite having gone through the usual boarding home system. So that is progress, I guess in a sense. It sometimes make me feel very sad that, there can be so much potential and then something like mental illness will just change their whole life plan... It's very sad. It's really sad. It feels like it's not fair. And I think that's what keeps me really motivated to really bend over backwards...
for people because it's really not fair that they end up psychotic. It's a devastating life long affliction that gets very little respect and understanding in society. So I guess yeah that's part of it too, you want to make up for all the people that are who are, I was going to say stupid, but ah who are not compassionate and don't really know, don't understand or stigmatize people with mental illness.

One participant talked about her feelings of sadness and disappointment when families are unable to accept a mental health problem or the particular treatment plans for a patient.

Lily: ... My last situation wasn't so happy. He was an old gent and they wanted to do ECT....and the family wouldn't allow ECT and so he would cry all the time and if he wasn't crying he would cry out loud... you do everything for him, you make sure he's clean you talk to him, you take him for rides, I'd take him, I even brought flowers into him .... Anything to make his environment a bit better, I'd orient him to the time, date and place, I'd tell him about the weather, everything before he was crying or moaning out loud.

The participants' accounts reveal that they
frequently felt frustrated in their relationships with patients. Frustration was primarily associated with patients who rejected their help or who made choices that nurses perceived kept them sick.

Rachel: ... There is of course times when you don't always meet with success and that's ... can be for a variety of reasons. You just can't get rapport and uh, I actually have a man right now that I can think about who is really difficult to get rapport with. He remains superficial and non-disclosing and doesn't give out a lot...he will certainly be amenable to getting together daily to sit and have a chat but I don't always get anything back, seldom actually... except that "I'm fine, oh yeah, oh yeah, I see what you mean" but he just doesn't give anything. Which may be just the way he always is, it may be too that he just, I don't know, he's guarded... it's a little bit frustrating and I need to remind myself that it isn't always possible with everybody. Because I can feel some sense of failure. I do for me. And that the reality is he doesn't, he's not forthcoming with anybody, including his doctor. So it isn't like a personal affront. But it can be very disappointing because I like to think by
the end of the day that something has happened for everyone that I have worked with, even minor, certainly everyday there isn't some major shift but that there be something. But with this particular man there are many days when there isn't anything. It sort of stays the same.

Brigit: This would have been quite a few years ago I'd been a nurse for maybe 3 to 4 years and this patient, he was in his 80's but he looked and presented much younger and he had all his faculties, and he was agitated depression and he was one of those, literally, wringing his hands and he was delusional ....but underneath all that he seemed like a really nice man. He was the first patient, I felt, I really felt a real liking for and I really would look forward to working with him although he was extremely difficult in that he just would have these, they seemed at the time, fixed delusions that he would not get enough food, that he would continually moan over and over "Oh my god, Oh my god" and it was just really, and he wouldn't go out. He was totally indecisive... we ended up with ECT as the choice and ...it did have good results, he stopped all this and he was
able to relax more. But then what he would do is... minimize any problems or not, or deny that he had any problems... he would not want to discuss any problems that he had in his life. You know he wanted to keep things very superficial. And I really wanted him to, I just wanted so much to help him, because as I said, I really liked him. But he just wouldn't go along with that.

Leah: ...I get frustrated, particularly if it's somebody who has been on a round robin admission and they're making poor choices again and again or very dysfunctional choices...

The nurses' accounts reveal that specific strategies are used to deal with these experiences. It appears that nurses attempt to create some common ground, a mutually understood negotiated reality with patients. First, there is a recognition and acceptance of the patient and the limitations resulting from their mental health problems and or an acceptance of patients decisions even when they do not agree with them.

Secondly, there is a lowering of one's expectations so that both patient and nurse can achieve some measure of success. The following excerpt illustrates the use of this strategy.
Rose: Yeah, it's a revolving door. You do see the same patients over and over again and it's quite nice actually because you get somebody you know "oh Mrs. so and so is coming back - oh fine great no problem, don't need to show her around she's been here before" you know but on the other hand you feel a bit sad that they had to come back. But then you think well you kept them out for a while, you got them back on their feet for a while so they stayed out and they're coming back you know for a recharge (laughing) but it's sad cause you don't really want them to have to come back at all but then you know they always will... I think you just have to be in the field for awhile... your perspective changes, for awhile it's the first bit, oh dear that poor person had to come back again, and then it changes to, well they've been out for eight months, they've been functioning, they've been living with their families, they've been doing this and that, they had a job or whatever they were doing, going to school, they've been you know and they're just having a relapse and they'll be here for two months like they were last time and we'll get them back on their feet and they'll go out again for
another eight months so your perspective changes.... It certainly isn't ideal by any means but at least if your expectations are lowered or changed then you don't drive yourself crazy trying to get everybody better because it doesn't work... if your expectations are lowered and your anxieties are less, you'll relate to them much better because you won't be putting so much pressure on them to change when they can't. You know they can't and if they have all this pressure put on them by health professionals to do this and do that they just feel more hopeless than they did in the first place....

In summary, the accounts reveal that being in relationships with patients evokes feelings of sadness, disappointment and frustration in the nurse. Nurses feel particularly sad by patient's experiences with intractable mental health problems. Disappointment and frustration is more often associated with caring for patients who the nurses perceive as making choices that keep them sick.

The Experience of Satisfaction

The self-disclosures of the nurses reveal experiences of deep satisfaction in their relationships with patients in inpatient psychiatric care settings.
They reveal these as experiences of trust, intimacy, reciprocity, and as having achieved rapport. They describe these as moments or relationships where they felt connected with patients and experienced their own presence as valuable and worthwhile to the patient. They are also moments of realization and validation of the nurses' held professional values of respect, honesty, consistency, empathy and caring. In other words, the actualization of one's values and beliefs about nursing. The following excerpts of actual nurse-patient situations reveals moments when nurses experienced satisfaction.

Diana: ... One of the things about nursing is there are so many little incidents that happen, you know, day to day kinds of things that nobody really pays much attention to or talks a lot about in rounds or anything like that but there's these little encounters that you have with patients that really make nursing enjoyable and worthwhile. I'm thinking about a few years back when I was still in W. a particularly agitated fellow had come in from emergency. There were ten orderlies on him, within seconds, he was fearful... I really felt for the guy. I mean he was totally out of control ... I see as my role is connecting with that
person in no matter what state they're in. I drew an injection and went into the seclusion room and meanwhile he was being held down by ten orderlies and he made eye contact with me and for that moment I could really appreciate how scared this guy was and stopped the procedure and actually took the time out to just comfort him and talk to him about his experience, empathize how scary it must be at this time and that I'm going to help him get some control back because he's feeling so out of control that makes it even more scary. So just taking that time out I could just see him relax and he took the injection and settled but it's those kind of experiences that, you know, or also watching one of my clients abreact, like a child abreacting abuse and being there with that child who is in an adult body but reliving this terrible experience and helping them get through it. They make eye contact with you and, you know, it could be a 32 year old woman but it's a 4 year old child in that state looking at you to be there and to comfort them and being able to do so that is really something else. I mean those are the little experiences that no one really hears about because some of that stuff is really horrible and
it's enough to make you really sick but helping people get through those experiences is something that I find quite rewarding.

In the next excerpt Leah reveals a moment of reciprocity - deep felt appreciation from the patient for caring. The account reveals that "being with" a patient involves touching that goes beyond what is necessary to attend to physical and psychological needs. It is more than doing for the patient, it is a "presencing" that conveys caring and that transcends barriers such as that inability to engage in verbal communication.

Leah: ... what I have found to be very gratifying with patients that I have worked with is when they have, achieved the level of trust and then been able to let me into some of their inner most areas which perhaps they haven't been able to share with somebody or it's an area that has been very painful. And these are the rewarding times. I've worked with one patient in particular who stands out who didn't speak for six months and was hospitalized and I was working with this patient quite closely, I was her primary nurse. And even though she never spoke a word to me for the first six months of the relationship I would go in and
continue working with her as if she was speaking. And there were non-verbal cues and I knew she was quite aware of what was happening with me.... But on that day I remember saying to her "I'm going on holidays and I'm going to be away for three weeks and we won't be working together (she hadn't uttered a word before that) and I'm not going to be back until then but I will be back after three weeks". She sat and she didn't say anything and I started to walk out of the room and she said, "thank you very much". And I turned around and I was absolutely floored and I said, "pardon me". And she said, "thank you very much for having been with me for these last six months". And for me that was incredible because it showed that she trusted enough to have been able to share that even though she had perhaps wanted to speak before, and this later developed into a deeper relationship with us, she was able to take that first stance. So that was really gratifying. And when I came back she continued to speak, it was very selective who she spoke with but she continued to do that. So I think a lot of that was because of the type of relationship we had and the way it was established and the fact that I
wasn't willing to just give up on her or just say oh well she's not talking and whatever her problem is.

Satisfaction was derived from being able to develop relationships with patients who are extremely difficult to connect with because of a mental health problems such as extreme withdrawal from reality and suspiciousness which interfere with the patient's ability to trust others.

Rachel: ... That's probably who I like to work with the best. Is the schizophrenic who needs a lot of support and follow-up in the community... I find it very gratifying and satisfying. I feel that I'm playing a vital part in their future, really. And that if I can become their resource and support and get some rapport. When you get some rapport with someone like that, you feel like you can move mountains. There isn't anything, I don't think, that's more gratifying. (pause) In a crisis to have 6 people in a room, because a patient is going to act out or is very paranoid you have to call the troops to come and give some assistance, and they turn and look straight at you, and will look to you to help them because they're really so scared. That, it's all worth
it... to think that I could connect with someone as disturbed as an acutely paranoid schizophrenic because they are so umm involved in their own world, that ah, to think that you could connect at some level, it's a challenge and then when you can, when you achieve that it's very rewarding, it's very rewarding for me... I would be the primary nurse, but I might be the only person that they can do that with. So even that is kind of I feel a bit privileged almost maybe...there is something that feels good about the fact that this person will disclose with me and trust me...I guess it's trust, and it is very, it's incredibly satisfying.

The following excerpts reveal how nurses learn from first hand experience the therapeutic possibilities that giving of the self and "being in" a relationship with a patient brings. The encounters with their patients reveal the consequences of trust. This is evidence to the nurses that they have cared in a way that allows patients to disclose their emotional pain.

Diana: ... the relationship that I hold with one patient in particular - is it's umm a validation of all my beliefs around this area because I've
gotten to know every aspect of her life and have challenged her to change things that are a problem, and to develop things that are not a problem like strengthen those parts of herself that are not in turmoil. And we haven't had to use any drugs, we've had to - I mean she's defied all the odds about personality disorders in inpatient settings. So something is working there, I'm not trying to be self-righteous in my statement there but it's like something is obviously working for this person and it is I think, a direct, result of the relationship that she's been able to develop with not just myself but other staff as well. That to me is rewarding cause I'm giving something of myself, I'm not giving a drug, I'm not giving whatever it is I'm giving myself to this person. I'm giving her my time, my energy, whatever and it's working.

Leah: ...And I have found that probably to be one of the most fulfilling times is when I see somebody who has a lot of bottled up emotions and finally has enough trust to let it go. And I remember once sitting with a patient who cried for 2 hours straight and I sat and did nothing but sit
with this patient and after she cried for 2 hours
umm she stopped and she looked at me and she said
"you know this is really one of the first times in
my life since being a child that I remember being
allowed to do this". The patient had had a
horrendous history of physical and sexual abuse
and had been extremely emotionally abused as well
and had always been told not to share, not to
talk... I really felt a sense of achievement for
her because she had crossed one milestone and I
knew that this was a really good sign for her. My
being comfortable with that situation umm
indicated to me that I was developing as a
clinician and in the relationship... and was at a
level that I felt comfortable it and she did too.
And I felt that I was doing a good job and I was
proud of where she was at.

Participants described satisfying encounters with
patients in various ways which suggest a connectedness,
an intimacy, and fondness for patients. One talked
about "a feeling between them". One used the term
"we." Others talked about "being with" patients. One
participant, Brigit, described it as "a certain look"
that passed between the patient and the nurse. When
asked to describe what she meant by this "certain look"
she explained it as the look that tells you, you have made "contact" with another human being. She also states that when she makes this contact with a patient she sees them more as a person rather than a diagnosis. She also feels more competent.

Brigit: ... when, you know, that ah, he or she has been acknowledged as a human being and it's almost like (sigh) umm what can I say, it's like a nod... you get a patient I think that maybe this way -- often you get a patient who is really not very appropriate socially and has never been and is you know just not ever going to, the prognosis is really terrible but you get that patient and at the end of the conversation will grab your hand and either shake it or try to kiss it but it's they're saying "I just." This has happened so many times in my career it's really hard to describe it because it sounds like hand shaking or kissing is really inappropriate but with certain patients it's like it's done impulsively at the end of a conversation it's like as they're holding your hand either wanting to shake it or kiss it they look at you and acknowledge that you, they take my hand and it's like a clutch and it's direct eye contact, no matter how crazy they've
been or how difficult or unusual the conversation... has been for them, I am talking about something real in their lives, something concrete that they are able to respond to appropriately. It's like they acknowledge that you've touched the part of me that I know exists but no one else can see, not that I'm any major Houdini in ferreting out but it's just, take a few minutes to talk about, yeah sure it's hard to get up this morning and yeah I had a hard time getting up myself this morning but we want you in group your input is welcome and it's your chance to see that like. Just treat them with some dignity or having the conversation with them when they start out really crazy but you say something really concrete... it's just this eye contact and it's a lightning of the facial expression it's like that person at that moment could be your next door neighbour you're talking to over the fence. It's acknowledging two human beings and your facial expressions equal to equal. They look at you they smile and you look back and you smile and that's not to say that ten minutes later they're not gonna be gesturing at their shadow in the window but it's that you've made that contact and they
know you have and that it gives them, it's a plus for them, that yes I can be appropriate. What it means to me is I still have the ability not to see people as a diagnosis, stereotype people, umm be cynical and fed up with the job which often I am umm but if I can remember to do this kind of contact, it just reminds me that it it's part of the human condition and as I said these illnesses are... really chronic and debilitating as well. It also gives me the satisfaction of knowing that I think I'm skilled at my job, that I have the ability to work around that sea of craziness and bring out and I think after ten years if I can't do that... ... touch that human part of that person or that appropriate part and be therapeutic without being sort of text book condescending it shows that there is a reason why you chose your career and you do have something to offer it even if it's only temporary that gives that person maybe for a couple of days a good feeling about themselves. It's not going to cure them or make them want to go on to you know being compliant with their medication or whatever but it's a little drop in the bucket, a brick in the wall that says okay there are sometimes that it's so I
guess it kind of reaffirms that.

Fond sentiments were frequently expressed by the nurses toward patients. This fondness was evident in the way participants talked about particular patients they had nursed or were presently nursing. These experiences are "remembered" with the same fondness by nurses even many years later and contribute to their satisfaction with patients.

Rose: ... I worked in England in a very large psychiatric hospital with some very very chronic, very very sick people ... And umm some of those people were real characters and I mean it was a long time ago but I remember some of them clearly, really clearly and some of them were... stand out... There was this wonderful woman called I. . She was just a wonderful woman, she was a manic-depressive and she had had 25 admissions in 25 years and she used to come in really really high and really really low and we nearly lost her once because she was so emaciated and she wouldn't eat and we had to give her ECT... Everybody loved her she would tell the most hilarious jokes when she was high and it was very hard not to laugh in fact we always did anyway, and umm the other person I remember and this is a really funny story. This
patient who when he was high he was very, well he was very naughty, he would go after all the young girls and I think he frightened the life out of a couple, anyway, one day he came up to me and he was really high as usual and he said to me "I've got a fish bone stuck in the roof of my mouth", and he'd try all sorts of ploys to try and get close to young ladies. And I said "I don't believe you". And he said "I have, I've got a fish bone stuck in my mouth. And I said "alright you keep you're hands to yourself and I'll have a look in". And I had a look in and sure enough there it was so I went and got a pair tweezers and I just pulled it out and he was so grateful that, what he did was, he went, he said "I've got to get you something, a little present." I said "You don't have to". "No I do" he said. So he went rummaging around all the old clothes we used to save for patients for the jumble sales and things, rummage sales. And he came back with this bra and he said "here you are dear" and he was so grateful, he really, you know and the gesture was really nice and he really meant it, with, it's just so funny. I remember him and lots of other patients. We had a lovely patient called D who
was a schizophrenic, for oh I don't know, poor lady, she was about 65 and she'd been a schizophrenic since she was about 18 and she'd probably been in hospital that long. And she was sitting next to one of the other patients and she said to him "A" she said "I know you've got my stomach give it back" and I hadn't been in psychiatry very long and I just couldn't believe my ears. That was typical, that was a sample...

Fondness was also experienced as focusing on what really matters and what the patient really needs.

Lily: ...I had another old guy. That's my specialty, it seems like it's the old people. And he came in and he was like 90 pounds, tiny little man about 5 foot nothing ... Well I'll tell you that man, I got really, they all said "you should take him home".... We'd go for walks, he wouldn't go with anyone else, he really got connected to me and I haven't seen him back either. And he went from, he wouldn't even feed himself, when we got him we had to feed him and then by the time he left he was talking, wouldn't get out of his room too much... But he hasn't been back so I guess he's doing okay... So that was a happy ending.

Meeting patients basic needs such as nutrition, rest,
activity and safety was viewed as source of mutual satisfaction and significant in establishing rapport. It was viewed as the right thing to do with patients who were very sick and unable to meet those basic needs themselves.

Rose: I think that hands on, literally hands on approach with some patients who are psychotic... often they don't eat properly either they don't drink properly they have to be encouraged of all those things... it's a way of connecting them to the outside world because they're not connected in very many ways when they're psychotic and that can make them feel cared for and real. I have example of that, recently a lady, very psychotic, quite aggressive... her hair was filthy, awful and nobody had bothered to wash it, either that or they couldn't get near her so I offered to wash her hair. She didn't really want me to so I asked her once again "can I wash your hair, I'll wash your hair for you". She eventually agreed so we filled the bathtub up and she got in it and I put lots of bubbles in it and I washed her hair about 3 or 4 times I had to it was so greasy. And then she accepted it really well she was great, she was sitting in the bathtub and I was pouring water all
over her and she really liked that and it calmed her down quite a bit actually. And then the next week I was there she remembered it... she said "could you wash my hair again, can you help me wash my hair" and I said sure sure I will. And so we did it again and I think every week for about 4 weeks I washed her hair for her because she had terrible tardive dyskinesia... she couldn't actually wash her hair herself. And when she was well every time she saw me she'd say, "do you know that really meant so much to me to have somebody do that you know I couldn't do it myself and it really made me feel good"... I enjoy caring... it really gives me a lot of satisfaction...

Another participant, Rachel, believes that meeting patients' basic needs contributes to both the patients and her own sense of worth.

Rachel: ... I think that if a patient believes that you think that they are important enough that you see to their needs then you convey that you have some respect for who they are. And it doesn't matter how crazy they are, they still have needs and ah they have a right to ah having their needs met... these are people who for whatever reason are not able to do that for themselves I
ended up being a nurse because I like to help people... it makes me feel umm good about myself it helps my own sense of who I am or my sense of productiveness and worth as well that I'm doing something that helps someone else.

Brigit whose experience is that satisfying relationships with patients are rare in psychiatric care settings reveals the positive value of relationships for her. There is a sense of renewed belief that one can still do a good job and enjoyment being with the patient. Satisfying relationships with patients sustains her through difficult times and helps her accept some of the harsh realities of work in a psychiatric care setting.

Brigit: ... it happens one out of ten and it's I think just a little drop in the bucket that it helps, it helps me when I start feeling cynical you know about how everyone is so sick and so unmotivated and I'm getting cynical, I've been in the business for ten years and you keep seeing the same people back. But every positive thing helps if I can make them feel good and they can make me feel good by wanting to help them then we're both helping each other... it gives me confirmation that I'm not a nurse Ratchet or seeing people as
ciphers or diagnosis that I'm really not. Sometimes I get really concerned that I'm on the way to burn-out and then occasionally a patient will come along that just confirms that I'm not burnt out and I really do care about people... A couple of weeks ago on our unit we admitted a old man who is chronically schizophrenic... He's been that way for at least forty years but he somehow managed to live in the community but every once in a while he has a break down. And there's no hope for him and he's got this chronic delusion that he has an invisible girlfriend. And there is no validation of this and it's a whole intricate delusion and fixed... This has been going on for years and years and no one can break him of this. Usually he can work around it but sometimes he just delaminates or disencapsulates and there we are. He's you know really full blown quite agitatedly crazy. And yet there is just something so endearing and engaging about this man, I mean he's as crazy as a hoot owl... I would engage him in conversation that was not to do with his crazy part and ask him "where were you born" and "how were you brought up"... reality based stuff... And he waxed eloquent... I totally stayed away from
all his craziness and you know there was kind of
bond there between us that he knew that I
recognized him as a human being that had a past
and had family and friends and had done other
things besides be crazy out on the street.
In a second interview Brigit talked again about
her experience nursing this same patient. She reveals
that her relationship with the patient as what "really
matters" to her as a nurse. It is not the thanks, the
praise or the great strides made by patients.
Brigit: Working in psychiatry if you're looking
for success, great strides, thanks and praise
forget it. You're in the wrong profession
absolutely. It's just to me and I can't believe
I'm saying this because I am quite cynical and
hardened but when that does happen with a patient,
that acknowledgement of human to human and that I
care enough and I'm saying to the patient that I
care enough about you that I'm willing to look
beyond your craziness to see the human bit and
that you have the gumption to rise above your
craziness to acknowledge that, even though it's
only temporary... it's something that is instilled
in my mind as well as the patient's... to be able
to relate on an adult to adult basis even if it's
only for a few minutes it gives me a positive feeling, it's like money in the bank in a way. Because when things get really awful and we seem to get nothing but major sociopaths that are and you think "why am I in this business" and you look back and okay there are these times and it means something. And you know with that patient it has also meant something.

The existential values of respect, honesty, caring, being non-judgemental, consistency, commitment and empathy were repeatedly stated as the means or conditions the nurses used for creating trust and rapport. The actualization of these values was satisfying to nurses.

Rachel: ... That's the biggest thing we have to do in psychiatry is, well what I do, the secret, what I do is, I can't really... put myself in their shoes but I try to imagine what it would be like if it was one of my children or brother or father. That's how I think a lot and it really helps when I feel frustrated and impatient and all those things that you are naturally going to feel from time to time... I just imagine what it would be like if it was my son or brother. And depending on the patient, we had a, not an elderly man, a
man in his 60s who was confused and disoriented and probably alzheimer and became very abusive and assaultive with us. And it's very hard to deal with that kind of abuse. It turned out actually the man was not alzheimer, it was drug related. But to deal with that I thought - oh gee he's about the same age as my father. You know so that helps you to keep some compassion and empathy, I guess.

Brigit: ... if you treat them with respect that is a plus for them and a plus for you as well. Because I know a lot of co-workers over all the years I've worked in psych, you know they are so contemptuous of the patients. You know if you give that person the basic respect and politeness, and an acknowledgment that they are a human being that we're all in this together, kind of, that you usually do get some kind of respect back from the patient or they seem to be appreciative of being treated like a human being... It's a look on their face or how they will just look at you. You know there is a certain look that they get where there is direct eye contact or they will sometimes end a request with an "I appreciate that". It's just a
feeling that it's passed between you and the patient. I've really seen that happen quite a bit. Or even an acknowledgment that you know of how they're feeling, like a depressed patient where you'll say "well, you look a bit better today" and often you'll hear a patient say "well looks can be deceiving" and I'll say, and, you know, I've said this to a few depressed patients, and it's amazing how the response you get. I'll say "I guess it's kind of scary because people say you're looking better and they expect you to start doing a lot of things that maybe your not quite ready but you know" yeah yeah that happens. And it's just the fact that you acknowledge that and care enough to know that. That they appreciate that. I found that with patients if you acknowledge their feelings they appreciate that or the reaction you get is surprise...

Because someone cares to notice or to even mention it.

The next participant talked about how she uses recreational activities to help her connect with patients. By doing so she conveys to the patient she has some understanding of their experience in a way that is less threatening for them.
Lily: ...I take people out for walks as much as I can... people will open up more in the outdoors. We go play frisbee in the park and things like that... For some really withdrawn people that don't speak a lot that's quite a feat for them even to have a superficial conversation. So a walk is very therapeutic...

In summary, the experience of satisfaction in relationships with patients is revealed in the nurses' accounts. Satisfaction is described as having achieved trust and rapport and is marked by intimacy between nurse and patient, reciprocity and a sense of having actualized one's values and beliefs. It is described as instances when the nurses knew by the patient's response that their presence was significant to the patient and that the patient trusted them.

The Experience of Personal and Professional Growth

The nurses' descriptions of their experiences with patients revealed that their relationships with patients and colleagues in the psychiatric care setting contributed to their personal and professional growth. They also experienced their growth in their encounters with patients. For some participants, it was a specific patient experience while for others, it was the culmination of many experiences with patients. Some
participants referred to these experiences as learning lessons while others referred to them as gaining insights about the self. Changes in nursing practice were attributed to more experience and to increased knowledge. The following participant's description of a recent patient situation illustrates both the personal and professional changes frequently revealed by the participants. She describes being more thoughtful, reflective, and analytical about the patient's behaviour rather than responding to the behaviour alone. She also describes being more confident with her own assessments and interventions. On a personal level, she describes being better able to separate herself from the patient's behaviour and examine it more objectively and not as a response to something she had said or done.

Leah: One very interesting example that would indicate a lot of the changes that have occurred in my years of practice was something that happened on the weekend in working with a patient... that was quite disturbed and it was very interesting because of the emotional response that I had to the experience, that was very different now than it would have been eight years ago. The patient came in and for two or three
days was extremely angry on admission and my technique was giving her space and just observing her behaviour and when I approached her and she didn't want to talk, I didn't feel offended, I didn't take it personally. Rather I used the whole experience as being an assessment puzzle rather than taking it as a rude behaviour. Why was she really doing this? What was happening? The staff all said "oh boy here's another PD and she's angry and manipulating". And I said "no I don't think so, my interpretation is that she's using it as a defense mechanism not only towards her own feelings but towards us and let's just give her the space and see what happens". And that change in thinking is very different from what it would have been years ago for me. I think years ago I would have reacted more to the behaviour rather than being able to analyze why this was happening and feeling okay with it ... days into the weekend the patient began to be quite self abusive... I felt totally in control of the situation... I knew what was going on, the other nurse wanted to call a code, another one said "I'll call the doctor for medication" and my initial response was a very quick assessment of
what was happening with this patient and because I had the facts of where she was coming from in her therapy I was able to intervene and I was able to be very calming for her, very therapeutic instead of yelling at her to stop the behaviour or restraining or doing anything like that... it was a very supportive role and... I think that shift for me in role is very interesting because years ago I think I would have reacted more to the behaviour and not .... I would have probably done the same thing that happened with some of the co-nurses... who were novices and new grads.... I would not have had that confidence and perhaps the ability to be objective and make my own treatment assessments and plans as to how I wanted to progress with this patient... no.

Participants talked about change in their practice in terms of lessons they had learned. These lessons were most frequently gained during events or situations that stand out as significant markers in the nurses professional development. They were often situations where they were not satisfied with their performance, had used poor judgement or had acted in ways that were unhelpful to patients.

Sarah: ...I remember once learning, we had a lady
very much like the one I'm describing, very, very psychotic and she was in seclusion, we went in to medicate her and she looked up at me and said to me "oh Sarah [accessories] are so beautiful" and before I realized it I'm discussing those damn [accessories] with her, you know it was totally, that wasn't why we were there and I came out afterwards and somebody said "why would you have done that Sarah, why would you start talking about [accessories] when she had totally destroyed a room and was still really so very destructive?"
And I said "I don't know I didn't help much because she kept getting higher and higher talking about these earrings. I guess I just felt threatened that she was going to do something if I didn't respond."

Another participant disclosed that a critical event in her professional development was being asked to leave a job because of her lack of maturity which contributed to problems in her performance.

Rebecca: ...I haven't always liked psychiatry, I was afraid of it to begin with. I was young, I was out of a small town in Ontario and grew up with values that were very narrow, very closed lines about what was right and what was wrong,
most things were wrong... I started working in psychiatry and discovered that these values I had brought into the situation just weren't serving me at all, they didn't make sense... I was asked to leave that job for the reasons I just mentioned. The head nurse told me I was naive, I was too sexual, too young. And although I was quite ticked off and angry, hurt at the time, looking back she was right. I had a lot of growing up to do. The internal judgements I was making about patients were not valid umm they were based on this narrow upbringing, there wasn't, I needed time to grow up myself... I had to go back and readdress a lot of old values... And in a lot of cases they didn't make sense. And going through all of that was really helpful. When I started back working in psychiatry things had changed inside me considerably, and have only gotten better since. A lot of issues I would have focused all my attention on 20 years ago I don't think about any more. They're not issues, they were never issues for the patients, they should never have been issues for me.

For some participants change in their practice occurred as a result of insights gained when working with
certain patients. For example, Sarah reveals her struggle nursing adolescent patients and the insights she has gained about herself in the process. She also reveals how difficult this admission was for her and how she has chosen to deal with this problem.

Sarah: ...I do have trouble working with adolescents and in the area I'm working in that seems to be alright. There are the times I have to be a primary to an adolescent but not very often. Over the years the people I work with are quite willing to negotiate. I think I go from one extreme to the other I am a lovely kind, sweet lady then I'm a disciplinarian and the kids really don't like it at all.... Interestingly enough the same thing happened when I was in nursing school I hated working in paediatrics, I've never felt good about peds, the children used to get so sick, oh god, I just had difficulty with it and I've had five kids of my own and none of my children have been sick except one and she wasn't very sick and it was a very short time. I've never dealt with whatever it is that scares me about it. It's always a crisis, I have real difficulty sitting down and allowing a lot of adolescent behaviour, that's natural behaviour. I want them to conform,
I have trouble with it, and I go from one extreme to another.... I really can't stand that constant conflict, or uncertainty, whether they are going to beat you up or give you a big hug. I have been assaulted three times by adolescents and I really have difficulty. It took me a long time in my nursing career to say that's not my forte ....

The next participant also describes aspects of herself she has become aware of in her relationships with patients.

Rebecca: ...Something I have to watch out for is an over involvement cause I know that I can, I can develop almost a mother relationship if I'm not careful, if I'm not watching. And the patient ends up expecting, because I've led them to believe, I was going to be there for them. So again, that's something over the last five or six years that I've been more and more aware of...

I've had a couple of relationships with patients where I knew that part way through the demand on me was so extreme and I'd set it up that way myself... I rescue too much ... I'm not a confrontive kind of therapist. I don't do it well and I don't do it with any conviction and I usually do it with a lot of guilt unless it's very
specific, circumstances that make complete sense to me. So yeah, I go at things as generally very supportive so it's easy to get sucked in to being mum, really fast.

Some participants revealed changes in self and their practice by telling the interviewer about aspects of their practice they would not have talked about even just a few years ago. These disclosures centered mainly on the issue of violence against the nurse. The following participant tells the researcher that violence has always existed on psychiatric wards but it is only recently that nurses have begun to talk about it. She attributes this change to the changing role of the nurse. Another participant attributes this particular change to the "feminist movement" which has begun to influence the profession of nursing, a profession still dominated by women.

Sarah: It's always been there, it's always been there, Linda. I think it's just recently that we've been able to talk about it or bring it out in the open to anybody and everybody that wants to listen...the role of the nurse is changing a bit and it's changing that you want to be heard. And maybe you've come to the saturation point that you can't take any more. That it's umm that's not
really why I'm here to be hurt. I have some rights, I'm here to help and I'm not here to have my head beaten in or some other things. Where as before I think that was a subtle message that nurses got that that was part of their job. And we believed it (laughing) ... More and more I listen to what my body says there's all sorts of signs and symptoms, you come on and the ward's in chaos, beds aren't made, the nursing station is a mess, you look in the kitchen and the people are smoking where ever they want to... and if you ignore those it's even more unsafe. There's no doubt in my mind that you've got to listen to what your body is saying and the tenseness you know. I do more safety factors now than I've ever done in my life. With locking doors and putting on extra lights, this is at night. You know all sorts of things just to protect myself....

Participants revealed that they had to become more realistic in their expectations of self and the degree to which they would be able to change another person.

Leah: ...I think when I first started the types of relationships I had with patients were almost falling into the category of co-dependant. In the sense that I was very idealistic and I got very
caught up in many of my patients problems. I found it very hard to distinguish what my role was as a clinician and what I could do as a helper and what I could do as a facilitator. And ultimately what has evolved is my role as a facilitator now. But it has taken 10 years for that to happen...

my relationship with patients, in the beginning, got to a point where I would feel I was not doing my job because of my own unreal expectations that I would have... patient progress was based on my value system and not really understanding what the patient was saying or where they were coming from.

Rose: When I did outpatient psychiatry for a while I had these patients who I followed patients for a long time umm for years probably and I didn't see very many changes in them at all... eventually they changed but it was their agenda that I was working with it wasn't mine. And as much as I would try, to begin with, to force my goals and my expectations on these people--well I didn't force them but, I realized that I was coming out against brick walls all the time and it wasn't realistic to expect them to do what I wanted them to do. It was more realistic to
expect them to do what they wanted to do and help
them do it... also when I worked in England in a
very large psychiatric hospital with some very
very chronic, very very sick people....

Sarah: ... The end result is they have to do it
themselves but not like you're going to just go
out and save that person and they're never going
to come into hospital again because this is all
what you did or I did. You know I've never felt
that way, never felt that way. On the other hand
I know I've had some pretty big impact on some of
the people I have nursed... but you don't get that
with all your patient though... my expectations
are a certain quality of life rather than total
quality which is utopia and sort of the "saving".
You know if that's what you're going to do that's
unrealistic. What you'd like them to have and
what they can actually achieve are often far
apart.

Some participants talked about becoming "less
sensitive", hardened to the realities of psychiatric
nursing. This was revealed as being able to conduct a
bit of a balancing act for the nurses. On one hand
they coped better by becoming less sensitive but on the
other hand some worried that they would become overly hard and this would interfere with caring.

Brigit: ...Another thing about working in psychiatry that you also can't be too sensitive or expect pleases and thank yous because, or at Christmas you go to other wards and there's tons of chocolates and gifts from the patients and in psychiatry these people basically you could be haemorrhaging in front of them and "Oh could I have my cigarettes please?" You know, they are very caught up in themselves and that's psychiatry. And to expect a lot of gratitude or recognition you're not going to get it. That doesn't bother me too much. Occasionally if a patient says please or thank you I go oh boy that was nice... It didn't take me too long to see the real side of it.

The following excerpt describes the intrapersonal struggle nurses can experience in trying to remain sensitive to patient's experience while maintaining their sense of integration. Brigit discloses her concern about becoming less sensitive in her reactions to a patient who committed suicide while she was on duty. These reactions made her question whether she had become too hardened.
Brigit: ... I kept analyzing why am I not really upset. And I wasn't you know. I mean I felt really badly for the poor woman but this woman had made up her mind that this is what she was going to do.... But I kept thinking, why aren't I upset, why aren't I really upset like T and V. And I still I don't know why I wasn't emotionally overwrought. I mean all I was thinking, the first thing that came through my head was, Oh boy I hope I don't do anything illegal here, you know like make a mistake. Like was this going to lead to an inquest was... and I just thought the charting and everything has to be just right on and I have to make sure I contact all the right people. Oh my god and you know that was my first, and, I felt like "am I a cold and callous person?" because I wasn't really upset but I don't think I am. I know I'm not a cold and callous person. I think this woman was in horrible distress that these voices were just tormenting her.... So I'm just, so I thought to have lived such a tormented life was very sad but this is what she chose to do. And it's something she wanted to do and something she succeeded at doing. And I just sort of hoped that it wasn't painful, I think it was very
instant... I felt very sorry for her but I wasn't emotional I wasn't overwrought I wasn't crying and carrying on you know. And in fact, my first thought was the paperwork and I know that sounds callous but that's really, I just thought this is something I have to deal with and the woman is dead and she wanted to be dead....

In summary, the nurses' descriptions reveal that being in relationships with patients plays a significant part to both their personal and professional growth. Participants' described professional growth in terms of being more reflective, analytical and realistic in their practices. Personal growth included insights about the self, one's strengths and limitations.

**Summary**

The nurses' lived experiences in their relationships with patients in inpatient psychiatric care settings are complex and many-sided. The six major themes of experience derived from the nurses' accounts are: fear of being physically harmed; conflict; ambivalence in relationships with physicians; sadness, disappointment, and frustration; satisfaction and personal and professional growth. A subtheme of a lack of administrative support emerged in conjunction
with the theme of fear of being physically harmed. The six themes and subtheme of experience form part of the nurses' total experience with their relationships with patients. The deep satisfaction they experience is as much part of their experience as the intense, negative conflicts that are experienced caring for patients perceived as manipulative or demanding. In this study, it is evident that the nurse-patient dyad is not the sole creator of the nurses experiences in their relationships with patients. The presence of nursing administrators and physicians is also perceptible and cannot be separated out of the nurses' experiences with patients. The nurses also experienced personal and professional growth in their relationships with patients. This process of growth is continually being transformed and shapes all subsequent nurse-patient encounters.

Six major themes and one subtheme were revealed in the nurses' accounts of their experiences in their relationships with patients in inpatient care settings. The findings and implications of the study will be discussed in Chapter Five.
CHAPTER FIVE: DISCUSSION OF FINDINGS, IMPLICATIONS AND CONCLUSION OF THE STUDY

Discussion of Findings

This study has explored nurses' perceptions of their experiences in their relationships with patients in inpatient psychiatric care settings. The phenomenological approach to understanding the nurses' experience revealed six major themes and one subtheme that were common to all eight participants.

The findings indicate that nurses' experiences in their relationships with patients in inpatient psychiatric care settings are complex and multifaceted. This fact is supported in the literature review in this study. While nurses reveal that their experiences in these relationships are satisfying and growth-enhancing, the experiences of fear of being physically harmed and of conflict are also essential characteristics of their encounters and relationships with patients.

The nurses' accounts also reveal that physicians and nursing administrators, who are part of the social organization of inpatient psychiatric care settings, affect and determine their experiences with patients. The relationship between the nurse and the patient in inpatient psychiatric care settings is not simply a
two-party transaction. While certain aspects of the nurses' descriptions of their experiences are congruent with the theoretical works and research studies discussed in Chapter 2, the themes forming the overall description of nurses' experiences are unique to this study. No one research study discussed in Chapter 2 gathered data that revealed the range of nurses' experiences in their relationships with patients in inpatient psychiatric care settings.

In the current study, nurses reported that fear of being physically harmed by patients was always in the background. Dangerous, unpredictable behaviour is a reality of nursing in inpatient psychiatric care settings. Inadequate resources and information and a lack of administrative support, particularly during and following violent situations, further contributed to the nurses' fear, anger and self-doubt. These descriptions are congruent with some of the data gathered in studies on occupational stress in psychiatric nursing discussed in Chapter 2 of this study (Dawkins, Depp, & Selzer, 1985; Trygstad, 1986). The research literature on patient physical assault in nursing describes similar affective responses to potential and actual patient violence (Conn & Lion, 1983; Dawson, Kehiayan, Kyanko, Martinez, 1988; Holden,
In the current study, patient characteristics of manipulation, non-compliance, dependency, demanding behavior, disrespect, and a danger to others were cited as contributing to experiences of conflict in nurse-patient encounters and sometimes fear of being physically harmed. A number of researchers (Colson et al., 1985; Gallop, 1985; Gallop & Wynn, 1987; Glick, Klar, & Braff, 1984; Hall, 1972, 1977; Highley & Norris, 1957; Neill, 1979; Newsom et al, 1963; Rosenthal et al, 1980; Sheets, Provost, Reihman, 1982; Slavinsky & Krass, 1980; Stockwell, 1972; Tudor, 1952; Ujhely, 1963) have all reported similar patient characteristics as "difficult" for nurses and as creating problems in the nurse-patient relationship. The diagnostic label of personality disorder, specifically borderline personality disorder, which is most commonly associated with these characteristics was also frequently assigned by the nurse to patients who created conflicts in the nurse-patient relationship both in this study and in the studies cited above.

The nurses' accounts reveal that the presence of physicians' in inpatient psychiatric care settings
often negatively affects their experiences in their relationships with patients and ultimately the patient's care. Physicians were identified as stressors for nurses particularly when they ignored the nurses input, made unilateral decisions, and provided insufficient or inappropriate medical care. This phenomenon has been identified and discussed in both the literature on occupational stress and quality work environments in nursing (Attridge & Callahan, 1987; Dawkins, Depp & Selzer, 1985; Trygstad, 1986) and in theoretical works on the dynamics of the nurse-doctor relationship (Englehardt, 1985; Kalisch & Kalisch, 1977; Stein, 1967; Zaslove, Ungerleider & Fuller, 1968).

The experience of satisfaction has been explicated from the nurses' accounts of their lived experiences in their relationship with patients. Research focusing on the experience of satisfaction of nurses in their relationships with patients is virtually non-existent in both general and psychiatric nursing. In psychiatric nursing there have been virtually no studies to which the findings of this study could be compared. Research on nurses' work satisfaction does exist but centres mainly on working conditions, occupational stress of nurses, shortage of nurses, and
inadequate compensation. The findings of the current study are however, reflected in both the interpersonal and humanistic theories of nursing (Peplau, 1952, 1964, 1987, 1989; Orlando, 1971; Travelbee, 1971; and Paterson & Zderad, 1988). These theoretical works are described in Chapter 2 of this study and form the conceptual framework for the study.

The nurses' accounts reveal that nurses, as co-participants in their relationships with patients, experience the relationship as satisfying and as a learning experience as is described in both early and current nursing theory. For example, Travelbee (1971), drawing from existential philosophy, described nursing as an interpersonal process "an experience or happening, or series of happenings between a nurse, an individual or group of individuals in need of the assistance the nurse can offer" (p. 8). Characteristically the relationship is a mutually significant meaningful experience and through it the nursing needs of patient and/or family are met. She labelled these relationships human-to-human relationships believing that in order to establish relatedness and respond effectively to the humanness of the other both "nurse and patient" need to transcend their roles. Nursing activities are the means to
establishing relatedness and the nurses' values and beliefs determine the quality of nursing care provided and the extent to which nurses are able to assist patients to find meaning in their situation. Rapport is defined as all those experiences, thoughts, feelings and attitudes that both nurse and patient live through and are able to perceive, share and communicate. It is the ability to appreciate the "human-ness" of the other, the capacity to be, as opposed to doing. It is an openness to experience. Travelbee (1971) describes rapport as moments of relatedness "permeated by a type of ambient, enveloping, all pervasive quietness and understanding of each to the other" (p. 153).

The nurses' accounts revealed that the achievement of trust and rapport with patients is what really matters to them and is their major source of satisfaction. They revealed that even though it would be nice to see patients cured of their mental health problems, this was not always realistic and that if, at least, a relationship can be established or they are "with" a patient through an experience of illness or relapse they have been helpful. Satisfaction is described as instances when the nurse knew by the patient's response that she had made a difference and that the patient trusted her. What remains unclear
however, is whether these relationships are experienced as existential relationships of I and Thou as described by Travelbee (1971) and Paterson and Zderad (1988). The nurses described a kind of being, a being "with" patients and a being "there" for patients which involves the nurse's active presence in the relationship but descriptions of an I and Thou relationship where there is an exchange of two persons transcending themselves and participating in the other's being; "a mutual common union in being" (Paterson & Zderad, 1988, p.121) are rarely revealed. More often, the nurses' accounts revealed a lack of recognition, thanks, praise, or appreciation of their presence in their relationships with patients.

Another characteristic of the nurse-patient relationship, discussed in Chapter 2 of this study, is the ability of the nurse to use him/herself therapeutically in the helping process (Peplau, 1952; Travelbee, 1971). In this study the nurses perceived themselves as instruments of change. They stated that they used themselves as well as their nursing skills and knowledge in helping patients deal with their mental health problems. The nurses believed that patient improvement, however small it was, was directly related to their, or others' involvement with the
They repeatedly expressed the importance of being respectful, honest, empathic, caring and consistent in the performance of all nursing acts even though this was extremely challenging at times. They viewed these as the means they used to achieve trust and rapport. The nurses also considered the technical and nurturing aspects of their role, such as helping patients meet their basic needs for nutrition, rest, activity and safety as significant and necessary to the establishment of relatedness. It would seem therefore that the therapeutic use of self is not always actualized under the category of therapy or in the counselling of patients in inpatient psychiatric care settings. The therapeutic use of self is also used in the structuring of specific nursing interventions which call for the nurse to use both herself and her specialized nursing skills and knowledge.

Some nursing theorists (Benner, 1986; Carter, 1986; Lego, 1986; Westwell & McCay, 1988 & Williams, 1974) suggest that certain events in the wider social context and changes in nursing ideologies are eroding the therapeutic role of the nurse. They suggest that the historical nursing values rooted in human care are threatened by deinstitutionalization, the remedicalization of psychiatry and technology. The
findings of the current study do not reflect such a trend in psychiatric nursing practice. The nurses' accounts revealed that they valued their therapeutic role, specifically the therapeutic nurse-patient relationship. They acknowledged that therapeutic relationships are sometimes difficult to actualize in inpatient psychiatric care settings but that they approach each patient with the goal of establishing a therapeutic relationship. Events such as deinstitutionalization and the remedicalization of psychiatry were rarely mentioned by the participants as events or factors inhibiting or limiting the formation of therapeutic relationships. Patient characteristics were cited more frequently as inhibiting the formation of therapeutic relationships. Only one participant made a connection between patient characteristics and the deinstitutionalization of psychiatric patients. She stated that patients admitted to inpatient psychiatric care settings of general hospitals were "sicker" than before because there were insufficient community resources to catch them at earlier stages of their illnesses. For a clearer understanding of the perceived effects of these phenomena on the therapeutic role of the nurse in inpatient psychiatric care settings further study is required.
Personal Meanings of the Study

At the beginning of the study I revealed that my own personal experiences as a nurse and nurse educator in inpatient psychiatric care settings was what fired this study. In addition to generating valuable insights about nurses' experiences in their relationships with patients in inpatient psychiatric care settings I hoped that such a study would also validate my own experiences.

As I reflected on the explicated themes of experience I was both surprised at the differences and relieved by the similarities of the nurses' experiences to my own. I was particularly relieved to hear that nurses feared being physically harmed and that this fear is always in the background and that I was neither strange or alone in this experience. I was however, surprised at how open the nurses were regarding their feelings surrounding actual and potential acts of violence in inpatient units. I have always felt that admitting to feelings of vulnerability, such as fear, anger, inadequacy and self-doubt, about actual and potential acts of violence was a taboo subject in psychiatric nursing. That to do so would be equated to being incompetent or as someone that could not be relied on during such times of crisis. That somehow
this was part of the job and that if one could not handle it one should not work in psychiatric nursing. I was pleased to learn that the nurses in this study did not share my perception and that in fact were demanding more opportunities to talk about their feelings surrounding incidents of violence.

I also had a profound experience during the analysis process in the discovery that I was resisting the inclusion of one of the themes, specifically the theme of conflict. I realized that I wanted to discount this information because I thought it made nurses relationships with patients look bad. For me, it revealed what I perceived were deficiencies in their interpersonal skills. I also felt that the strategies they described using to deal with "difficult patients" were mainly self-protective rather than therapeutic. This awareness and my acceptance of conflict as a theme of experience helped me realize that I was unconsciously attempting to present the nurses in the best light possible and that somehow to do otherwise was also a reflection on me as a nurse. It is my belief that the eventual inclusion of the theme of conflict into my final description of the nurses' experiences contributes to a more accurate, richer and vibrant description of the nurses' experiences in their
relationships with patients in inpatient psychiatric care settings.

Implications of the Study

The purpose of this phenomenological study was to explore and describe nurses' perceptions of their experiences in their relationships with patients in inpatient psychiatric care settings, with the aim of uncovering knowledge and understanding of this phenomenon. The findings of the study suggest some implications for nursing practice, administration, education and research.

Nursing Practice

The themes of fear of being physically harmed and of conflict reveal that caring for patients with mental health problems presents nurses with many challenges. Relating to patients whose behaviour is experienced as frightening, conflictual, annoying, and anxiety-provoking often make it difficult for nurses to fulfil their professional role that is, to relate fully to patients and still maintain their own personal integration. The building of a personal support system and development of coping skills are essential. Although the use of peers can be invaluable in providing emotional support and feedback additional recommendations are suggested. These are:
1. The implementation of informal voluntary peer support groups or support networks to help nurses to cope with difficult patients.

2. The implementation of team building strategies, such as daily team conferences, buddy systems, and perceptorships for new staff to provide for the sharing of information and the giving and receiving of affirming feedback and support.

3. The use of supervision, the "process by which a nurse of lesser experience is assisted by a nurse clinician of greater experience to develop self-awareness and therapeutic skills" (Beck, Rawlins, & Williams, 1988, p. 1464), to help nurses grow in professional competence, confidence and satisfaction.

4. The implementation of master's level mental health/psychiatric clinical nurse specialists in psychiatric care settings. As experts in clinical practice and possessing of in depth knowledge of psychiatric nursing clinical specialists could provide supervision, education, and consultation to nurses who have been prepared at the generalist level, which generally means they have received minimal psychiatric nursing experience and theoretical content in their educational programs.

5. The undertaking of personal counselling by nurses
to assist them to develop healthy coping strategies and as a method for improving their interpersonal effectiveness by exploring blind spots, beliefs, values, world views and vulnerabilities that may contribute to the difficulties that they experience in their relationships with patients.

**Nursing Administration**

The nursing administrator's role in creating or enhancing a supportive climate in hospitals has been repeatedly reported in nursing literature (Brenner et al, 1982; Mallison, 1988; McClure et al, 1983). The current study's findings are important for nursing administration because they provide nursing administrators with the nurses' perspective of their experiences with patients in inpatient psychiatric care units. The nurses' accounts reveal that they perceive a lack of administrative support in caring for patients with mental health problems.

The importance of social support for nurses has been acknowledged for some time, "since nurses are often so in need of support themselves they are unable to give support to their patients" (Michaels, 1971, p. 1932). The literature on social support (Cobb, 1976; Kahn, 1979; Weiss, 1974) defines social support as the provision of social relationship that includes
components such as a sense of security and place; the expression of positive affect of one person toward another (caring, respect, love); the affirmation or endorsement of another's behaviours, perceptions or expressed views; and the giving of material and symbolic aid to another and guidance from a trustworthy and authoritative person in stressful situations. The nurses' accounts reveal the need for greater social support from head nurses and nursing supervisors in the form of information and material aids; emotional support and help particularly during and after crisis situations; and reassurance and confirmation of their worth as nurses. Attridge and Callahan (1987) state:

support provides reward, value, respect and caring to professionals who [work] in difficult and demanding...situations....

Nurses who feel supported can handle many distressing circumstances.... Nurses who do not perceive support in their work are often harassed, in conflict and experience lack of reward, value and respect, a situation which ultimately affects view of self as a worthwhile human being let alone as a deserving professional. (p. 36)

The regular provision of hospital inservice
programs focusing on psychiatric nursing content is recommended, particularly ongoing staff training and education in the management of aggressive patients. Trained emergency response teams for situations involving patient violence is recommended. Debriefing sessions led by skilled group facilitators or counsellors for staff involved in assault situations is also recommended.

Nursing Education

The nurses' accounts revealed that developing therapeutic relationships with patients perceived as manipulative, non-compliant, dependent, demanding, disrespectful and dangerous to others was difficult. Therefore the major implication of this finding is to increase the emphasis in nursing curricula on the interpersonal dynamics and management of these behaviours, the self awareness of the nurse, transference and countertransference reactions and relationship building skills. The use of teaching strategies that promote introspection, critical thinking and interactive skills development are also recommended. Bevis (1989) suggests the increased use of process education as a teaching strategy in nursing, education to assist student in the transfer of knowledge and skills to the clinical situation.
Gulino (1982) proposes the exploration and use of existential thought in nursing education to help nursing students "grapple with those aspects of experience that are uniquely human and subjective and that often become lost to her conscious awareness" (p. 357). Gulino suggests a move beyond the objective the problem-oriented method, so widely taught in nursing education programs to methods which encourage and prepare students to become more reflective and critical in their nursing practice. Gulino (1982) adds that "existentialism poses questions the nurse should consider when she is immersed in the clinical situation; it can generate questions that will move her to examine her choices, and prepare her, at least in some tentative sense, for the difficult reality" (p. 259). Nursing patient with complex mental health problems requires more than a set of prescribed intervention tactics. It requires a use of the self beginning with the capacity to step outside the self to grasp the experience of the other.

Nursing education programs at both the baccalaureate and masters degree level have been slow to develop and offer nursing degrees with a clinical focus. The findings of this study, particularly those findings which relate to the theme of conflict, suggest
that indepth study and clinically supervised practise in dealing with patients with complex mental health problems is required by nurses working in psychiatric care settings.

**Nursing Research**

This study has provided insights about nurses' experiences in their relationships with patients in inpatient psychiatric care settings. In view of these findings, areas for further study are suggested:

1. Study particular aspects of nurses' experience with patients in inpatient care settings in more depth, for example, fear of being physically harmed.

2. Study nurses' experiences in a particular phase of the nurse-patient relationship, as described by Peplau (1952), as it exists in inpatient psychiatric care settings.

3. Study nurses' perceptions of administrative support in nursing patients with mental health problems in inpatient units.

4. Do a phenomenological study exploring patients' perceptions of their experiences with psychiatric nurses on inpatient psychiatric care settings.

**Conclusion**

The purpose of this phenomenological study was to
explore and understand nurses' perceptions of their experiences in their relationships with patients in inpatient psychiatric care settings. Eight female registered nurses currently employed in psychiatric care settings were interviewed. Data collection and data analysis proceeded concurrently until all participants had been interviewed twice. Tentative themes identified from the first set of interviews were verified and elaborated on in the second set of interviews. The final analysis produced six major themes and one subtheme that were common to all eight participants and which represent the essential features of the nurses' experiences in their relationships with patients in inpatient psychiatric care settings.

A description of these experiences provides insight into nurses' relationships with patients and the meaning these have for them. This knowledge also sheds light on the practice of psychiatric nursing in inpatient psychiatric care settings. The study does not assume that this description of the nurses' experiences encompasses the experiences of all nurses' relationships with patients in inpatient psychiatric care settings. The study does not represent a singular, definitive understanding and interpretation of the nurses' experience. It provides a beginning
understanding of this complex phenomenon and a starting point for more in depth study.
References


Benfer, B. (1980). *Defining the role and function of the psychiatric nurse as a member of the team*. *Perspectives in Psychiatric Care, 18* (4), 166-177.


Journal of Nursing, 70, 2106-2111.


Appendix A

American Nursing Association Standards of Psychiatric and Mental Health Nursing Practice
American Nursing Association Standards of Psychiatric and Mental Health Nursing Practice

Professional Practice Standards

Standard 1  Theory
The nurse applies appropriate theory that is scientifically sound as a basis for decisions regarding nursing practice.

Standard 2  Data collection
The nurse continuously collects data that are comprehensive, accurate, and systematic.

Standard 3  Diagnosis
The nurse utilizes nursing diagnosis and/or standard classification of mental disorders to express conclusions supported by recorded assessment data and current scientific premises.

Standard 4  Planning
The nurse develops a nursing care plan with specific goals and interventions delineating nursing actions unique to each client's needs.

Standard 5  Intervention
The nurse intervenes as guided by the nursing care plan to implement nursing actions that promote, maintain, or restore physical and mental health, prevent illness, and effect rehabilitation.

Standard 5A  Psychotherapeutic Interventions
The nurse uses psychotherapeutic interventions to assist clients in regaining or improving their previous coping abilities and to prevent further disability.

Standard 5B  Health Teaching
The nurse assists clients, families, and groups to achieve satisfying and productive patterns of living through health teaching.

Standard 5C  Activities of Daily Living
The nurse uses the activities of daily living in a goal-directed way to foster adequate self-care and physical and mental well being of clients.

Standard 5D  Somatic Therapies
The nurse uses knowledge of somatic therapies and applies related clinical skills in working with clients.
Standard 5E  Therapeutic Environment
The nurse provides, structures, and maintains a therapeutic environment in collaboration with the client and other health care providers.

Standard 5F  Psychotherapy
The nurse utilizes advanced clinical expertise in individual, group, and family psychotherapy, child psychotherapy, and other treatment modalities to function as a psychotherapist, and recognizes professional accountability for nursing practice.

Standard 6  Evaluation
The nurse evaluates client responses to nursing action in order to revise the data base, nursing diagnosis, and nursing care plan. (American Nurses' Association, 1982)
Appendix B

Personal Assumptions
Personal Assumptions

Nurses' Perceptions of their Experiences Working with Patients in Inpatient Psychiatric Care Settings.

The following is a list of the personal assumptions I brought to the study. These include the themes of experience I expected would be revealed or hoped would revealed in the nurses' accounts.

1. That nurses would experience their relationships with patients in inpatient psychiatric care settings as rewarding and gratifying.

2. That nurses would describe their experiences with patients as challenging and exciting.

3. That nurses would reveal experiences of burn out, of low involvement with patients and a lack of enthusiasm.

4. That nurses would reveal experiences of feeling inadequate and incompetent.

5. That nurses would reveal feelings of anger at the lack of financial rewards and recognition for doing such a difficult job.

6. That nurses would reveal experiences of exhaustion and defeat in trying to help patients who choose not to change or who lack the capabilities to change.

7. That nurses would reveal experiences surrounding the deinstitutionalization of psychiatric patients from the Provincial Institution.

   a) anger at having to nurse increasing numbers of more difficult patients with the same amount of resources and skills.

   b) frustration at the lack of resources in the community thus leading to quicker decompensation of patients once discharged and more frequent and closer readmissions.

   c) a sense of uselessness at working hard to effect any long term change in chronic patients.

   d) a sense of powerlessness in being able to effect change in the mental health care system.
Appendix C

Hospital Letter: Research Study
Appendix D

Advertisement: Research Study
other questions you may have about the study. If you decide to participate in the study, I will ask you to sign a form consenting to your participation and giving me permission to audiotape the interviews. Thank you.

Linda Barratt RN, BA
UBC Counselling Psychology (MA) Student
Appendix E

Information: Research Study
Information: Research Study

Nurses' Perceptions of their Experiences Working with Patients in Inpatient Psychiatric Care Settings

I am a registered nurse working toward a master's degree in counselling psychology at the University of B.C. I am conducting a study to gain a better understanding of the nurses' perceptions of their experiences of working with patients in inpatient psychiatric care settings. I hope that by exploring and describing the experiences of nurses in their relationships with patients, the discipline of psychiatric nursing will be provided with clearer and more accurate descriptions of the nurse-patient relationship as it exists and what it means to nurse patients in psychiatric care settings. I hope that from these descriptions nursing concepts that are faithful to the real world of the nurse's experience will provide an accurate basis for theory development and further research.

The procedure of the study will involve at least two, 90 minute interviews scheduled at our mutual convenience. The interviews will take place at my home or yours according to your wish and the appropriateness of the setting. I would prefer not to interview in the hospital setting because I would prefer not to be
affiliated with any agency. During the interviews you will be free to comment as you wish about your experience working with patients in inpatient psychiatric care settings.

I will tape the interviews for convenience, but complete confidentiality with regards to your name and place of employment will be ensured throughout the study by coding names of participants.

I will transcribe all interviews verbatim and will look for common themes frequently mentioned in the interviews.

Should you choose to participate in my study, I will inform you of the results of my study. Your identity will remain confidential in published or unpublished material. You may be quoted verbatim in the results of the study.

You are under no obligation to participate in this study and are free to withdraw at any time. You also have the right to request erasure of any tape or portion of a tape at any time during the study. Participants in the study will be asked not to mention any names during the interviews and any names accidentally mentioned will be erased.

Linda Barratt RN;BA
UBC Counselling Psychology (MA) Student
Appendix F

Consent Form: Research Study
Appendix G

Sample Questions: Research Study
Sample Questions: Research Study

Nurses' Perceptions of their Experiences Working with Patients in Inpatient Psychiatric Care Settings

The following is a sample of trigger questions that will be used in the interviews. The phrasing of these questions may vary slightly during the interviews but the goal of the question will remain the same.

1. Could you tell me about your experiences in your relationships with patients on inpatient psychiatric care settings?

2. Could you tell me about an encounter or a relationship you've had with a patient?

3. Could you tell me about a patient that often comes to your mind; that stands out for you in some way?