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Malgorzata Brown BSc. (Hons)

# Therapeutic Relationships in Acute Inpatient Mental Health Settings

Section A: What can qualitative research and psychological theory tell us about the nature of therapeutic relationships on acute inpatient wards?

Word Count: 5660

Section B: Healthcare Assistants' experiences of providing therapeutic care in acute inpatient mental health settings.

Word Count: 8336

Section C: Critical Appraisal

Word Count: 2237

Overall Word Count: 16,233

A thesis submitted in partial fulfillment of the requirements of
Canterbury Christ Church University for the degree of
Doctor in Clinical Psychology

September 2013

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

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| SUBMISSION DATE | 02/8/13 |
| OVERALL WORD COUNT | 16,233 |

## Acknowledgments

I would like to thank Dr. Tracey Lintern who supported and encouraged me at the beginning stage of this research project. I thank my two supervisors for their support, enthusiasm and invaluable advice.

I would like to thank my friends, Jane, Stefan, Maina, Cathy, Jo, Ken, and Mariusz who helped me get through the personal challenges in my final year as a trainee.

Finally, I would like to thank all the participants who took part in my research.

I dedicate this work to my family, especially to my mother (RIP), who endured many family gatherings without me while I was completing my studies. Thank you for your patience and support.

**Summary of this portfolio of work**

This work considers the nature of therapeutic relationships between nursing staff and patients on acute mental health inpatient wards.

Section A is a literature review, exploring the psychological theories behind the care delivered by nurses through the medium of therapeutic relationships in inpatient settings and providing a meta-synthesis of studies investigating the nature of therapeutic relationships between nursing staff and patients from the perspectives of nurses.

Section B presents a phenomenological study in which nursing staff completed in-depth interviews providing descriptions of their therapeutic relationships with patients. The results suggest a great variance in the nursing staff ability to get to know and understand patients and their needs from a psychological perspective. The knowledge gained about patients through the medium of relationships did not seem to be shared by the staff team and did not seem to be integrated into a coherent treatment plan.

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Section A: What can qualitative research and psychological theory tell us about the nature of therapeutic relationships on acute inpatient wards?

Word Count: 5660

**Abstract**

Purpose: There is an increasing emphasis on the delivery of therapeutic care and the provision of psychosocial treatments in the acute mental health inpatient wards in the UK. The aim of this review was to explore the theoretical and empirical psychological understandings of therapeutic relationships between nursing staff and patients that form the everyday care provision in inpatient settings.

Methodology: Qualitative research studies investigating the nature of the therapeutic relationships between nursing staff and patients on acute mental health inpatient wards were identified through an electronic database search. The findings of the studies were extracted and synthesised.

Findings: Twelve studies satisfied the inclusion criteria. The synthesis of findings revealed two themes: personal involvement and nurse as an agent of the institution. Although the findings suggested that nurses can form close relationships with patients, such engagements carried an emotional cost for nurses and created tensions with nurses' professional identity. The second theme revealed that nurses also interacted in a more distanced way with patients and used organisational structures to avoid closer encounters.

Research implications: The review revealed that the state of qualitative research on this topic area is limited as most of the studies were problem orientated and presented topical and thematic survey findings rather than involving more complex data analyses. There is a need for further high quality research in this field.

# Introduction

## Context

Over recent years, there have been substantial policy developments in the UK mental health system. In particular, the provision of psychological treatments has been emphasized along with the development of psychological competencies throughout the mental health workforce (Department of Health, DoH, 2004, 2007; British Psychological Society, BPS, 2009). One of the consequences of this shift away from a medical to a psychological perspective is an increased relevance of psychological expertise in the provision of psychological therapies, staff training, as well as overall service developments (BPS, 2012).

In spite of policy developments, acute inpatient care continues to come under considerable criticism. Inpatient treatment has been described as unpleasant, unsafe, and non-therapeutic (Sainsbury Centre for Mental Health, 1998; DoH, 2002; MIND, 2004; The Schizophrenia Commission, 2012). The Health Care Commission (HCC; 2008) raised specific concerns regarding inpatient services failing to meet minimum standards and exhibiting examples of unacceptable practices. The particular problems with care in these settings identified by the HCC relate to the lack of personalized treatments, which form the basis of promoting recovery.

One of the principal factors identified throughout policy and literature requiring improvement is the interpersonal interaction between nurses and patients (e.g. Higgins et al., 1999; Mind, 2000; HCC, 2008). For instance, the Schizophrenia Commission report (2012) highlighted the need for improving the psychological skills of staff directly

involved with service users, especially in terms of their ability to interact with people experiencing psychosis.

In terms of psychological research in inpatient settings, the main area identified by the BPS (2012) as in need of urgent development concerns enhancing service user experience. An aspect consistently highlighted by service users as most important to their inpatient treatment regards the therapeutic relationships they form with nurses (e.g. Gilburt, Rose, & Slade, 2008). The present review presents a meta-synthesis of qualitative research findings investigating nurse-patient therapeutic engagement as perceived from the perspectives of nurses. The empirical research is set in context by an outline of Clarkson's (1995) integrative psychological framework of the therapeutic relationship. Psychological theory related to institutional functioning is also presented.

**Conceptualising the therapeutic relationship**

Clarkson (1995) conceptualised a comprehensive integrative framework of therapeutic relationship dimensions, which although described as if separate, may coexist and overlap as modes of relating within any therapeutic encounter. Since the framework was developed within a psychotherapeutic context, the language of therapist and client is used, although the assumption is that it can equally apply to any relationships formed in order to produce psychological changes (in cognition, feeling and behaviour).

First, *working alliance* is the basic foundation of any voluntary therapeutic intervention. The quality of the working alliance has been conceptualized as being "a function of the degree of agreement between therapist and patient regarding tasks and goals of therapy" (Bordin, p.255, as quoted in Clarkson, 1995). The central necessary aspects of

relating within the working alliance dimension are the facilitative conditions of the person-centred approach: empathy, unconditional positive regard, and congruence as conceptualised by Rogers (1980).

In cases of involuntary inpatient care, establishing working alliance in these settings may not be possible if the patient fundamentally disagrees with treatment. Another prerequisite for establishing a working alliance is that the therapist feels safe and not threatened by violence and harm to self or the infliction of self-harm by patients. Hence, the nature of acute care presents particular challenges to the establishment of the basic foundations of therapeutic relationships.

Second, *transferential/countertransferential relationship* is most strongly described within the psychoanalytic tradition. Evidence suggests that transference is unavoidable and is likely to occur within the realm of human relating whether or not it is acknowledged or accepted by either person in a relationship (Andersen &Miranda, 2000). Clarkson (1995) suggests a distinction between general transference and transference in therapy. General transference in ordinary relationships manifests itself in people's repetition of their early relational patterns, which at times can be painful and lead to a person feeling repeatedly rejected and/or victimized. Within the cognitive paradigm (see Andersen & Miranda, 2000) research has demonstrated the significance of transference phenomena, whereby mental representations of significant others, which are linked with affect and motivation, were shown to be frequently activated during one's interaction in new relationships. It was found that within such transference interaction, one may elicit from the newly met person to behave in a certain way in order to replicate one's experience with the significant other.

The difference with regards to therapeutic versus general transference is that in a therapeutic context, the patient is able to effectively work through their transference phenomena, which manifest themselves in the therapeutic relationship. Clarkson (1995) writes: "The healthy, adaptive use of transference can become an open system where information from the past is processed together with information from the present. Then it is no longer a symptom, but the vehicle by means of which symptoms can be undone" (pg.66).

Countertransference refers to the therapist's own feelings towards the patient. Within a therapeutic relationship, it is crucial that the therapist is able to sufficiently explore and separate their own personal material from their response to the patient's issues. Clarkson (1995) also notes the need for the therapists to be able to consider and separate out 'countertransferential conditioning' based on cultural and contextual issues, which "affects all therapeutic work with people who are different from us or defined as particularly different in a negative way by our societal expectations, rewards and narratives" (1995, p. 90). This consideration may be particularly relevant in the context of inpatient care, as people with mental health difficulties who require hospitalisation may be particularly vulnerable to experience social stigma, to which nurses are not immune.

Third, *reparative/developmentally-needed relationship* refers to the therapist intentionally providing a corrective or reparative parental relationship or action "where the original parenting was deficient, abusive or overprotective" (Clarkson, 1995; p. 109). Particularly relevant to this type of relating is the concept of regression as a crucial part of a healing process in therapy. Regression refers to the ability of an individual to "defend the self against specific environmental failure by freezing of the

failure situation" (Winnicott, 1954, p. 134). It is not necessarily a voluntary psychological process as people may frequently and repetitively regress to previous developmental stages or to events that they experienced as traumatic. Within a therapeutic relationship, the hope is that the patient may be able to re-experience the failure situation while in a regressed state within a carefully adapted new reality of the therapeutic situation and in the presence of a therapist (Guntrip, 1968). In order for the therapist to be able to provide such a new reality of a reparative relationship for the patient, it is vital that the nature of the developmental deficit or injury is clearly identified.

The fourth (*the person-to-person or real relationship*) and fifth (*the transpersonal*) dimensions outlined by Clarkson (1995) are highly complex and the most difficult to achieve modes of therapeutic relating. They are therefore outside of the scope of the current paper. Although not precluding that such modes of relating may be possible within inpatient settings, the brief nature of treatment and the acuity of presentations would render such relationships extremely rare. More relevant is the consideration of institutional functioning as an integral part of relationships formed in inpatient settings.

**Therapeutic relationships in institutional settings**

Therapeutic relationships in inpatient settings take place within an institutional context, within which group phenomena influence the interpersonal aspects of nursing care. Any consideration of therapeutic relationships in inpatient settings, therefore, must take into account not only intra-psychic realities, but also reality shaped by the inter-group dynamics of institutional life. Furthermore, as Hinshelwood (2001) states,

institutions are determined by the 'unconscious functioning in the individuals who make up the institution' (pg. 41).

A psychological theory of group processes postulates that "institutions are used by their individual members to reinforce individual mechanisms of defence against anxiety" (Jaques, 1955). Therefore, an institution can operate in a way that enables individuals to avoid their anxieties (Hinshelwood & Skogstad, 2000). The need of individuals to protect themselves against anxiety and to use the organisation within which they function in order to achieve this, leads to "the development of socially structured defence mechanisms, which appear as elements in the organisation's structure, culture and mode of functioning" (Menzies-Lyth, 1959, pg. 50). Among the defence mechanisms described in Menzies-Lyth's (1959) classic study, is the splitting up of the nurse-patient relationship, whereby the organisational structure attempts to protect the nurse from the anxiety associated with the closeness of relating with individual patients. In order to achieve this, nurses' tasks may be required to be performed in a way that reduces the amount of contact nurses make with any one patient. Furthermore, institutional functioning may discourage the establishment of personally meaningful relationships between nurses and patients by developing structures and a culture within which both nurses and patients are depersonalised and devoid of any individual distinctiveness. There may also be an implicit expectation that nurses remain 'detached' and keep their feelings under control while carrying out their nursing tasks. Such an expectation encourages the denial of difficult feelings that may arise in the context of nursing work.

Menzies-Lyth (1959) argued that one of the consequences of institutions functioning as social defence systems within which anxiety-provoking situations are eliminated, is that

individuals are not helped to learn and develop the capacity to work more effectively when faced with high levels of anxiety.

**Empirical Research**

Having explored the policy context and theoretical perspectives relevant to the consideration of therapeutic relationships between patients and nurses in inpatient settings, the review of empirical research will now be presented. Literature review has been previously conducted by Cleary, Hunt, Horsefall, and Deacon (2012). However, it contained significant weaknesses and differed substantially from the current one. For instance, Cleary et al's (2012) account of the method used to synthesize research findings was broad and not transparent. It seemed that the principal method followed was specific to primary data analysis rather than conducting a synthesis of qualitative research. Also, the review contained a large number of papers with a broad topical focus (e.g. containing studies from both nurses and service users perspectives), which had the potential to threaten the interpretative validity of findings (see Sandelowski, Docherty & Emden, 1997). Finally, six papers included in the present review were omitted from Cleary et al's (2012) paper.

The aim of this review was to synthesize the findings of qualitative research exploring the therapeutic work nurses conduct with patients as part of the everyday care provision in acute mental health inpatient settings. The focus was exclusively on qualitative research in order to present an in depth account of nurses' experiences. The principal focus of the review was on how nurses construct or understand the

interpersonal relationships they form with patients as part of the care provision in these settings.

## Methods

### Search strategy

The search strategy was informed by guidelines set out by Sandelowski & Barrosso (2007). At first the researcher conducted a broad search of the topic by consulting with colleagues, retrieving book materials and hand searching journals and specialist publications. Based on these, the topic and aim of the current review as well as the search terms were iteratively developed. The final search took place in July 2012 using electronic databases drawn from the following platforms: Ovid (Medline, PsychInfo), ProQuest (British Nursing Index, Applied Social Sciences Index and Abstracts), and EBSCO Host (CINAHL). The search strategy can be viewed in Appendix A.

### Selection criteria

Papers were selected if they satisfied the following criteria:

- They were reports of qualitative studies investigating therapeutic relationships between nursing staff and patients (concepts used could be interactions, engagement, contact, care, etc.) with the focus of the study clearly evidenced in the research aims/questions and/or results
- The focus of the studies was specifically on nurses' perspectives and/or experiences
- The studies were set within adult acute inpatient mental health settings
- They were written in English

- Published in peer reviewed journals

Papers were excluded if:

- The settings included long stay wards rather than acute inpatient care

- The studies involved mixed samples and the findings regarding nurses could not be separated from the findings regarding patients' views or other professionals (e.g. psychiatrists, psychologists, occupational therapists)

- The studies involved mixed methods and the qualitative and quantitative findings could not be separated

**Meta-synthesis**

In the current review, findings of the articles were extracted in order to carry out a meta-synthesis, following guidelines of Sandelowski & Baroso (2007) and a thematic synthesis method described in detail by Thomas and Harden (2008; see Table 1). The critique of the studies was based primarily on appraisal guidelines of Sandelowski & Barrosso (2007) as well as Yardley's (2000) criteria for conducting qualitative research.

Table 1: Meta-synthesis method

| Steps in analysis | Description |
|---|---|
| Familiarization with content of studies | <ul><li>Reading and re-reading of studies</li><li>Quality check of included studies</li></ul> |
| Extraction of data from studies | <ul><li>Extraction of contextual information into Table 1</li><li>Extraction of findings—the 'results' and 'discussion' sections were extracted onto separate word documents when electronic copies available</li><li>Extracted data was inspected and any fragments deemed as not relevant to the question or not data (such as citing other studies or describing implications) were removed from the analysis documents</li><li>Abstracts and Introduction sections were checked for any additional findings not included in the above sections</li></ul> |
| Thematic synthesis | <ul><li>Line-by-line coding of the findings in primary studies;</li><li>Attention given to whether findings were supported by primary data; in cases where there was lack of evidence for researcher's conclusions, findings were excluded from analysis or when appropriate, the lack of evidence incorporated within analysis;</li><li>Organizing of codes into related clusters to construct 'descriptive' themes</li><li>Translating of concepts from one study to another</li><li>Development of 'analytical' themes</li></ul> |

## Summary and Critique

A total of twelve studies satisfied the selection criteria. A summary of the papers is presented in Table 2. Although all of the studies contained findings relevant to the examination of the therapeutic nurse-patient relationship, only three had this as a specific aim of the study (Bray, 1999; Cleary & Edwards, 1999; Hem and Heggen, 2003, 2004). The remainder had a broader focus of investigating nursing practice, work, caring approaches, roles, or 'lived world'. One of the studies investigated nursing practice in relation to people who self-harm (O'Donovan, 2007a,b) and one focused specifically on carrying out observations (Rooney, 2009).

All of the studies were carried out by nurses, the majority of whom were affiliated with academic institutions. A significant weakness is that none of the researchers discussed

the potential impact of their academic status on their relationship with the participants, and how this may have influenced the research findings. It is possible, for instance, that being asked questions with regard to nurses' practices by academic nurses could invoke in the participants associations with being examined and needing to provide 'correct' answers.

Most of the studies used interviews as the data collection method. One of the studies (Deacon et al., 2006) which used participant observation did not describe the nature of researchers' participation, which is particularly noteworthy as the research was conducted over three year period. Hence, it is not known how embedded the researchers became within the settings and whether and how field notes were maintained. Also, the authors gave direct quotes from nurses without explaining what procedures were followed to gather verbatim data.

Although the information wasn't always clear, it seems that in the majority of the studies the participants were registered nurses, with only two studies including nursing assistants (Bjorkdahl et al. 2010, Rooney, 2009). The majority of the studies did not provide sufficient information regarding the participant selection process and in three studies, selection may have yielded a biased sample, as the participants were selected via the ward manager (Rooney, 2009), through professional networking and snowballing (Awty, 2010), and through recruitment of participants who were articulate and reflective (Cleary 2003ab, 2004).

Regarding the exploration of therapeutic nurse-patient relationships, the majority of the studies may fall into the problem-orientated, as opposed to theory-orientated, category of health research as described by Harding & Gantley (1998). Therefore, the scope of the research questions and methodology seemed defined by practical rather than

theoretical considerations in the majority of the studies. The problem identified in most of the papers was of the criticisms of the acute care in policy and literature and the difficulty of delivering high quality care in the challenging environment of inpatient settings. Some papers mentioned Peplau's (1952) theoretical framework for mental health nursing, however, findings were not linked to theoretical considerations in any depth. One notable exception is the Hem & Heggen (2003, 2004) study, which discussed findings in reference to theory propounded by the Danish moral philosopher Logstrup.

The majority of the findings produced by the studies in this review could be described, following the classification of Sandelowski & Barroso (2007), as falling between topical and thematical surveys, indicating that the transformation of data remained close to the primary data as given. However, Hem & Heggen (2003, 2004) presented findings in the form of conceptual/thematic description, which indicated that the data was interpreted in reference to theory and the researchers described the latent rather than manifest pattern in the data. This study could therefore be considered as representing a higher level of complexity and discovery as described by Kearney (2001).

In summary, the state of qualitative research on the nature of therapeutic relationships between nurses and patients in acute inpatient settings, based on nurses' perspectives, lacks depth of analysis, as most studies are problem orientated and present topical and thematic survey findings, rather than involving more complex data analyses. The surface treatment of the data was apparent in the way that meanings of terms were taken for granted by many authors. For instance, many researchers tended to use concepts such as 'containment', 'defensive practice' 'being with' or 'using oneself' as self-explanatory and not requiring any theoretical framework or explication in terms of

their precise meanings. Hence, this review can only provide a preliminary examination of the topic.

Table 2: Overview of studies

| Study | Country | Author affiliation | Participants | Question/Aim | Methodology |
|---|---|---|---|---|---|
| **Awty et al (2010)** | Australia | Nursing; | 10 QN | To explore mental health nurses' perspectives and expectations of providing psychodynamic therapeutic care | Naturalistic enquiry/ interviews |
| **Berg & Hallberg (2000)** | Sweden | Nursing | 22 QN | To reveal psychiatric nurses' lived experiences of working with inpatient care on a general team psychiatric ward | Interviews/ latent content analysis |
| **Bjorkdahl et al (2010)** | Sweden | Nursing; Social and forensic psychiatry; | 10 QN, 9 HCA | To describe nurses' caring approaches within acute psychiatric care; | Interviews/ interpretative description |
| **Bray (1999)** | UK | Nursing; | 15 QN | To investigate what is a beneficial relationship between the nurse and the patient; to construct the meaning of professional closeness for the trained nurse; | Ethnography/participant observation and interviews |
| **Chiovitti (2006)** | Canada | Nursing | 17 QN | To develop a substantive grounded theory of caring from the perspective of RNs; what is the RN's meaning of caring with patients | Grounded theory/ interviews |
| **Cleary (2003a, b; 2004)** | Australia | Nursing | 10 nurses | To examine cultural meanings and behaviours that underpin and guide nursing practice | Ethnography/participant observation/ discussion groups/ interviews |
| **Cleary, Edwards & Meehan (1999)** | Australia | Nursing | 10 QN | To explore factors that facilitate or/and impede nurse-patient interaction; | Interviews /thematic content analysis |
| **Deacon, Warne & McAndrew (2006)** | UK | Nursing | Not stated | To develop a methodical analysis of the work undertaken by nurses; | Ethnography/participant observations |
| **Fourie et al (2005)** | New Zealand | Nursing | 10 QN | To observe the range of activities that registered nurses engage in; determine the perceptions of registered nurses regarding their roles; | Qualitative descriptive exploratory approach/ nonparticipant observation & focus groups/ thematic analysis |
| **Hem & Heggen (2003, 2004)** | Norway | Nursing | 6 nurses | How nurses experience and interpret the contradictory demands of being a fellow human being and health professional in their work with patients? To shed light upon the complex phenomenon of rejection in the nurse–patient relationship | Ethnography/participant observation & interviews |
| **O'Donovan (2007a,b)** | Ireland | Nursing | 8 QN | To explore psychiatric nurses' approach and philosophical underpinnings to care;  to gain an understanding of the practices of psychiatric nurses in relation to people who self harm | Qualitative descriptive study/interviews/ content and thematic analysis |
| **Rooney (2009)** | UK | Nursing | 6 QN and HCA | To explore and amplify the experiences of nurses undertaking constant observations | Phenomenology/interviews |

QN=qualified nurses; HCA=healthcare assistants

<center>**Results of meta-synthesis**</center>

Two analytical themes were identified through the process of meta-synthesis: personal involvement and nurse as an agent of the institution. These themes are outlined below along with their sub-themes.

### Theme 1: Personal involvement

Some of the research findings indicated that nurses became personally and emotionally involved while interacting with patients. Hem and Heggen's (2003) study illustrated this theme most cogently. The impact of nurses' emotional involvement in their relationships with patients seemed to endure beyond the immediate contact. This was evidenced, for instance, by researchers remarking on the nurse becoming 'emotionally involved in the narrative' (Hem and Heggen, 2003, p. 104) or finding it difficult to speak about some of their engagements with patients during the research interview (Bray, 1999). Also, Bray (1999) described nurses becoming confronted with their own vulnerabilities while caring for patients.

This contrasted with the view presented in other studies, which stated that nurses felt they were able to leave the emotional impact of their work 'at the door' (Rooney, p. 83) or to start each shift with fresh outlook and bright attitude (Cleary & Edwards, 1999). This suggested that nurses expressed the ability and need to maintain a level of personal detachment.

**Emotional proximity.** Some of the findings described nurses being aware that patients' difficult feelings and thoughts were transferred onto them (Hem and Heggen, 2003), that they 'end up feeling what [the patient] is feeling' (Bray, 1999, p. 301), that the

illness 'kind of seeps into you' (Bjorkdahl et al, 2010, p. 514) or that the nurse "'holds' or 'carries' emotional tension" for the patient (Berg & Hallberg, 2000, p. 328). Furthermore, several studies referred to a particular way in which some of the nurses perceived their relating with some patients as a kind of 'mothering', which seemed to entail the nurse providing for the patients what they were not able to provide for themselves. In this way of relating, patients seemed to be perceived as fundamentally dependent on the nurse (Rooney, 2009) and the nurse experiencing a sense of overwhelming responsibility for the patient's well being or even survival (Fourie et al, 2005).

Several studies remarked how relating to a patient in such a personal and intimate way, carried an emotional cost for nurses. Nursing in inpatient settings was described in the majority of the studies as stressful, as well as painful and emotionally draining, particularly as it left nurses more aware of and vulnerable to their own emotions.

**Tensions between the personal and the professional realms.** Several studies described the personal involvement in inpatient nursing work as creating tensions with the nurse's professional identity. For instance Bray's (1999) findings described an expressed dissonance, whereby nurses felt that the way they wanted to connect with patients in a personal and intuitive manner 'was not accepted by either institution or supported by known theory' (p. 302) and that they viewed such interaction as 'frivolous' and 'not real' work (p. 303). The researcher's observations indicated that when nurses did interact with patients intuitively and in a way they regarded as being at their most therapeutic, they simultaneously thought that this was not what constituted professional conduct. Similarly, Hem and Heggen's (2003) findings describe how while the nurse's personal involvement with a patient revealed therapeutic

potential and facilitated a greater understanding of the patient 'on his own terms', it was viewed by the nurse as being unprofessional.

### Theme 2:  Nurse as an agent of the institution

In contrast to personal involvement, an alternative mode of relating to patients was described in the research studies and could be conceptualized in terms of the nurse functioning as "the agent of the institution" (Hem and Heggen, 2004, p. 59) or as "a part of a machine" (Fourie et al., 2005, p. 137). This way of operating was expressed by nurses in one study as creating barriers to the provision of therapeutic care and as "putting the needs of the system before those of patients" (Awty et al., 2010, p. 110) and in another study as practice being "driven more by the needs of the organization than the patient" (Fourie et al., 2005, p. 139).

**Relating within organizational structures.** One feature of this mode seemed to be that the interventions with patients were viewed as prescribed by the organizational structures as opposed to arising from patient's treatment needs and personally meaningful nurse-patient encounters.

For instance, the primary nursing system was described in terms of the nurses spending 'one to one' time with patients as well as taking a leading role in coordinating patient's care. Although Cleary (2003a) remarked that "nurses are mindful of each other's capabilities" (p. 217) when allocating patients, this was not illustrated in the data. It seemed that forming nurse-patient dyads within the primary nursing system was not based on any clear clinical rationale but seemed to be based on purely pragmatic considerations, for instance the already existing nurse-patient ratios (Cleary & Edwards, 1999). Hence, the way that the primary nursing system was described in research,

implied that within it, both nurses and patients were regarded in generic terms. That is, every nurse seemed to be viewed as expected to provide, and each patient viewed as requiring, nonspecific care. No individual variations of skills, knowledge, or such factors as personality characteristics or the potential for forming a working therapeutic alliance by a particular dyad, was evidenced in the research studies to be taken into consideration. Furthermore, some findings indicated that nurses perceived that there was a lack of unifying philosophy and aim of psychosocial care in general (Awty, 2010, O'Donovan, 2007a, 2007b; Berg and Hallberg, 1999).

Another illustration of this sub-theme was described with reference to the task of carrying out formal observations. It was perceived that nurses were not directly involved in and aware of the decisions and the reasoning behind engaging in formal observations of patients (O'Donovan, 2007a; Bray, 1999). It seemed that the task of observations was externally imposed on the two directly but passively involved persons and its primary focus was on monitoring the patient's external behaviour. Therefore, findings indicated that rather than having a therapeutic aim, observations were viewed as having the purpose to keep patients physically safe (Rooney, 2009). This was also reflected in the nurses in the study acknowledging that it required no training of any kind and that it was carried out mostly by the least experienced and/or temporary staff (Rooney, 2009; Bray, 1999).

**'Actual' versus documented reality.** An important characteristic of a nurse operating as an agent of an institution seemed to be that even while nurses described recognizing the existence of multiple perspectives on what constituted reality, they seemed to be able to give credence primarily to the one privileged by the institution. An example of this was described in one study where nurses perceived that what they did 'would be

judged by what they documented and not necessarily by the actual quality of the nursing care delivered' (Fourie et al., 2005, p. 139). It seemed that the task of documenting practice was perceived as having an important function of protecting nurses against potential litigation rather than being an integrated part of actual clinical practice. For instance, nurses expressed an awareness that their written reports did not always correspond to their own judgments, but what they felt they were expected to think and say (Cleary, 2003a; Fourie et al., 2005).

**Position of objectivity and certainty.** While functioning as agents of the institution, nurses seemed to take a particular position of certainty and objectivity. One of the explicit ways in which this was illustrated in the findings, was in the description of the nurse's role of providing information and educating patients about their behaviour and 'illness' (e.g. Cleary, 1999; Chiovitti, 2006; Fourie et al., 2005). A crucial characteristic of this mode of interacting was illustrated by one-way communication, within which meanings and interpretations did not seem to be intersubjective and mutually negotiated between the nurses and patients. Rather, knowledge about and interpretation of observed reality seemed to be located exclusively within the nurses as the representatives of the wider professional system. Therefore, the nurse was often viewed as the holder and provider of knowledge and the patient as the receiver or object of that knowledge. For instance, Hem and Heggen (2004) described how a patient's communications about her view of her experience were not taken up and explored as relevant by the nurse. The reality as perceived by the patient was deemed by the nurse to be fundamentally different from the reality and knowledge which the institution valued. As a consequence, the patient's contributions to knowledge about her experience did not seem to be considered as pertinent to the patient's treatment. The

dynamic between the patient and the nurse was described as one in which the patient's invitation for the nurse to get to know her, is rejected by the nurse, who creates a boundary and avoids becoming deeply involved in the patient's experience.

Another illustration of this theme was in the descriptions of the way in which nurses perceived the task of observations, which were characterised by nurses 'watching' patients and interpreting their behaviours without recourse to the patients' internal worlds and without negotiating their concluded meanings with patients (e.g. Rooney, 2009).

## Discussion

The findings of the present review suggest that the state of qualitative research exploring the nature of therapeutic relationships formed between nurses and patients from a psychological perspective is limited. None of the papers explicitly considered the key dimensions as outlined by Clarkson (1995). For instance, the importance of agreement on the treatment tasks and goals of the therapeutic encounters between nurses and patients, which according to Clarkson (1995) determines the quality of the therapeutic alliance, is not explored in any of the papers. However, some of the findings of the current review suggest that the organizational structures may in fact function in a way that makes the consideration of agreement on the goals of the therapeutic work of nursing staff irrelevant (e.g. primary nursing seems to be a pragmatic arrangement rather than one which considers the psychological factors of the nurse-patient relationship).

The meta-synthesis of research findings based on data provided by nurses indicates that there are two modes of relating between patients and nurses. The findings suggest

that nurses may become closely involved and deeply affected in their relationships with patients, whereby they become aware of the feelings that are transferred onto them from patients. However, only one study (Bray, 1999) discussed this in terms of transference phenomena, based on psychoanalytic theory. However, the author noted that the nurses themselves did not articulate their experiences with reference to theory and that no links were made between transference phenomena and nursing practice. There was no evidence in any of the papers of nurses using information from patients' past experiences as manifested in their relationships in the present for therapeutic purpose of change. Also, none of the papers considered the crucial role of countertransference in their therapeutic relationships with patients and the need to sufficiently explore and separate nurses' own personal material from their responses to patients' issues as explicated by Clarkson (1995).

Similarly, nurses' experiences of patients' dependence and the need of providing a kind of 'mothering' was not explored, either in the research or by participants in the studies, in terms of Clarkson's (1995) dimension of reparative or developmentally-needed relationships. Although the evidence is preliminary, this seems to indicate that the psychological process of regression and the need for the therapeutic response to be based on a clear identification of the developmental deficits patients may be experiencing were not considered as part of the psychosocial care delivered by nurses. It may not be surprising that nurses found the responsibility associated with the patients' dependence overwhelming. Indeed, personal involvement as outlined in the current review was associated with considerable stress for nurses, which may not be unanticipated, if one considers that this mode of relating seemed to be carried out without the grounding of explanatory theoretical framework, which could provide nurses with ways of making sense of their experiences.

Based on the findings of the present review, it seems that inpatient care involves certain institutional defensive practices, which may serve to protect nurses from certain anxieties related to the personal involvement with patients. This was illustrated in the second theme, within which the institutional structures, such as primary nursing and carrying out of observations, seemed to involve depersonalization of both nurses and patients, similar to the one found in Menzies-Lyth's study (1959).

A clear limitation of the current review is that it included only studies from the perspectives of nurses. The examination of the topic would benefit from considering similar studies from the perspectives of patients. Furthermore, the data represented primarily the views of qualified nurses, whereas psychosocial care is performed also by nursing assistants. It remains unknown whether the mode of relating by nursing assistants is similar or varies from that of their qualified colleagues. Future research should therefore explore the nature of psychosocial care as experienced specifically by nursing assistants. In addition, only two of the studies in this review were specifically designed to focus on the nature of nurse-patient relationships. There is therefore a need for more research on this topic, adopting a more theory-orientated approach and employing methodology enabling greater depth of analysis.

## Conclusion

The lack of an in depth exploration of the nature of the interaction between nurses and patients in terms of its therapeutic dimensions in the majority of the studies in the present review precludes drawing any firm conclusions about the psychological

processes that take place while nurses undertake their everyday caring interventions with patients.

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Section B: Healthcare Assistants' experiences of providing therapeutic care in acute inpatient mental health settings.


Word Count: 8336

**Abstract**

There is a paucity of empirical research exploring the nature of the everyday psychosocial care delivered by staff in acute inpatient mental health settings. The therapeutic relationships nursing staff form with patients is the main medium of care delivery on inpatient wards. There is a need for a greater psychological understanding of the experiences of staff delivering psychosocial care in settings where patients experience high levels of distress. The aim of this study was to explore what constitutes the nature of the everyday care relationships formed between nursing staff and patients as experienced by healthcare assistants (HCAs). In the current study phenomenological methodology was utilized to collect and analyze the data. Six HCAs were interviewed and thirteen descriptions of their relationships with patients were elicited. Four themes emerged describing the constituents of the relationships staff formed with patients: knowing the person and identifying the problem; meeting the need; patient characteristics; contextual issues. The results suggest that there are great degrees of variance in the level of HCAs abilities to utilise psychological thinking and skills in their interactions with patients. There was often a lack of evidence of psychosocial care being coherently integrated within the whole team's approach to care delivery.

## Introduction

Acute mental health inpatient services aim to provide 'a high standard of humane treatment and care in a safe therapeutic setting for patients in the most acute and vulnerable stage of their illness' (Joint Commissioning Panel for Mental Health, 2013, pg. 5). The crucial medium of therapeutic care delivery in inpatient settings are the relationships nursing staff form with patients. Based on psychotherapy research literature indicating that the quality of therapeutic alliance is the best predictor of outcome in therapy, Holmes (2002) argued that an improvement in skills necessary to establish a therapeutic alliance among nursing staff on wards would improve patient outcomes. Working alliance is considered to be the basic foundation of any voluntary therapeutic intervention, the quality of which is determined by the degree of agreement between the therapist and patient on the tasks and goals of treatment (Clarkson, 1995). Acute inpatient settings, where there may be little or no agreement or contract between patients and nursing staff, pose a fundamental challenge for the establishment of therapeutic relationships in their most basic form.

Psychological literature also addresses more complex psychological processes that arise in the context of therapeutic relationships. Transference phenomena are viewed as unavoidable psychological processes occurring in the realm of human relating (e.g. Andersen &Miranda, 2000) and are bound to present challenges for the psychosocial care delivered in inpatient settings. One such challenge, for instance, is when within a transference interaction a patient may elicit a behaviour from a nurse that would replicate the patient's experience with his/her significant other. Gabbard (1992) attributes such process as being a part of a concept of projective identification, which he describes as operating unconsciously, automatically, and with compelling force. Segal

(1973) defines the mechanism of projective identification as a process in which 'parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts' (p. 27). Gabbard (1992) proposes that projective identification has important implications for the consideration of countertransference experienced by inpatient staff, which can be understood as arising from unconscious identification with projected aspects of the patient's internal world. Crucially, nursing staff may need to distinguish their countertransference as attributable to the patient's internal world from their emotional reactions to patients based on their own past experiences.

Apart from the consideration of intra-psychic processes, the treatment task in inpatient settings is further complicated by inter-group dynamics that influence the nature of therapeutic relationships. A psychoanalytic theory of group processes and organisational functioning (e.g. Menzies-Lyth, 1988) emphasizes that dynamic processes are more important than content in institutions at both conscious and unconscious levels. For instance, based on naturalistic research findings, Hinshelwood (2001) argued that the nature of acute care involves the need to deal with high levels of anxiety, disturbance and suffering, which is often unbearable and therefore requires the utilisation of defensive protection by individuals. Due to this process, the hospital may become a defensive system, where therapeutic work is impossible and, in the worse cases, where the interpersonal dynamics can become harmful to both staff and patients. Menzies-Lyth's (1959) classic study described various defensive mechanisms embedded in organisational structure that attempt to protect nurses from the anxiety associated with the closeness of establishing relationships with individual patients. For instance, by developing structures and culture that encouraged depersonalisation of

both patients and nurses, whereby any individual distinctiveness remained unacknowledged.

Therefore, the provision of psychosocial care in acute inpatient settings is bound to pose challenges for nursing staff. Despite considerable literature on the topic, principally from the psychoanalytic perspective, and research evidence consistently identifying relationships with nursing staff as the most important aspect of inpatient treatment for patients (e.g. Gilburt, Rose & Slade, 2008; Moyle, 2003; Stenhouse, 2011) there is a dearth of research investigating the nature of nurse-patient interaction. In particular, there is a lack of psychological understanding of the processes involved in the modes of relating between nursing staff and patients in acute inpatient settings. Although there is a drive to ensure that inpatient settings are therapeutic, little is known about the nature of the everyday psychosocial care provided by nurses. For instance, how is the therapeutic potential of interpersonal interaction utilised by nurses?  How are the challenges inherent in the enterprise of human relating, particularly in institutional settings, managed? Furthermore, although some research has been conducted on the experiences of nurses, there are currently no studies investigating solely the Healthcare Assistants (HCAs) experiences of working with patients on acute ward. HCAs form a large proportion of nursing staff on inpatient wards and although they may spend considerable time in direct contact with patients, no formal training is currently required to perform this role. Hence, HCAs may be particularly ill equipped to manage the inevitably complex interactions with patients. The aim of this study was to elucidate the lived world of Healthcare Assistants (HCA) engaging in relationships with patients and to gain a greater understanding regarding relationships formed in the context of high distress associated with acute inpatient

mental health settings. The question addressed was: What is the nature of the everyday care relationships formed between nursing staff and patients as experienced by HCAs in acute inpatient settings?

## Methodology

### Participants

This report of findings is based on six participants employed as HCAs. Anyone employed as nursing staff was invited to take part in the research project and there were no exclusion criteria. Two participants were in their early twenties and three were in their forties. Two were men, and four were women. Three of the participants were White British and two were of Black and Minority Ethnic origin.

### Recruitment and procedure

Participants were recruited from one psychiatric hospital comprised of five separate wards (three general adult acute psychiatric wards, and two mental health older adult wards). The project was developed in consultation with a special interest research group comprised of clinical psychologists and other mental health professionals in a mental health trust in London. In addition, the managers and charge nurses of one psychiatric unit in the trust were consulted and following a positive response, information about the project was disseminated to nursing staff through posters as well as visits to handover meetings. Nursing staff interested in taking part in the study were given information (Appendix B) and consent (Appendix C) forms. Participants were able

to contact the researcher directly via phone or email to elicit further information and to arrange the interview.

**Interviews**

Interviews were carried out within the work settings of nursing staff, in private areas away from the wards themselves when possible. Interviews lasted from fifty to seventy minutes and were digitally recorded and transcribed verbatim. Each participant described two or three instances of the phenomenon (relationships with patients), which totalled thirteen instances being analysed for the current report.

The interview schedule (Appendix D) was developed in collaboration with clinical psychologists supervising the research project, who were working on acute inpatient wards and in direct contact with nursing staff, after which it was piloted and finalised in collaboration with nursing staff.

**Design and Analysis**

The data were collected and analyzed according to the phenomenological approach outlined by Giorgi (1985). This method allowed for the gathering of rich descriptions from HCAs who had first-hand experience of the phenomenon under investigation (therapeutic relationships with patients on acute wards), as lived and understood by HCAs (Giorgi, 1985; Giorgi, 2008). Through phenomenological analysis of the data, the researcher sought to elicit the psychological meanings that constitute the phenomenon.

The phenomenological analysis followed the principles outlined by Giorgi (1985) and further explicated by Wertz (1983,1985). Giorgi (1985) emphasised the attitude of the phenomenological reduction, which was designed to ensure rigour in the process of analysis and entails two things. Firstly, the researcher brackets all knowledge that is

not part of the given phenomenon including both theoretical knowledge and his/her beliefs based on the researcher's own past experiences. Bracketing means that the researcher does not engage the previously gained knowledge in a way that it has an influence on the process of analysis. As argued by Giorgi (2006) bracketing involves recognising any potential biases in the very process of analysis rather than reflecting upon biases before the actual analysis. The importance of bracketing is that full attention is given to the instance of the phenomenon that is appearing to the researcher's consciousness as part of the research endeavour. Secondly, no claim is being made that the phenomenon actually exists in the way that the researcher experiences it.

In order to determine the essence of a phenomenon, the researcher uses imaginative variation, whereby all constituents, distinctions, phases, relations, and themes are interrogated to ascertain whether they could be different or even absent without altering the psychological reality of the phenomenon (Giorgi, 1985; Werts, 1983). Therefore, imaginative variation is a type of mental experimentation through which the researcher purposefully and imaginatively alters various aspects of the experience in order to arrive at only the essential aspects of the phenomenon under investigation (Polkinghorne, 1989). For instance, in an exploration of the phenomenon of learning, Giorgi (1985) presented an example of the process of applying imaginative variation, whereby in a given meaning unit he determined what was truly essential for the psychological understanding of learning. When a research participant described giving a chest set to his son, Giorgi (1985) described reflecting and critically evaluating whether the fact that the gift was a chest set was an essential aspect of the dynamics of learning as presented in the data. Drawing from the knowledge of the whole description, Giorgi

concluded that stating that the participant gave his son a gift was sufficient for understanding the phenomenon of learning.

The analysis involved the following steps:

1. The researcher assumed the attitude of the phenomenological reduction and a psychological perspective while remaining sensitive to the phenomenon under investigation: experiences of therapeutic relationships with patients. This phenomenological attitude was maintained throughout the analysis process.

2. Each participant's description of the phenomenon was read in order to get a general sense of the whole (see Appendix E for an example of raw data). The researcher attempted to put herself in the subject's shoes and to live through the experience from the inside rather than being a mere spectator.

3. Once the general sense of the whole was grasped, the researcher carefully reads the description again with the aim of demarcating "meaning units" in the data, which were ascertained through noting shifts in meaning in the description. "Meaning units" are understood to be context-laden constituents, rather than separate and independent elements of the description. This step resulted in the entire description being broken down into parts, which then facilitated the analysis. The carrying out of this step is idiosyncratic to the researcher and has no theoretical significance.

4. The "meaning units" were then regrouped according to their intertwining meanings and in accordance to a temporal order in a way that accurately expressed the pattern of the original event (see Appendix F for the transformed description).

5.  The researcher then transformed the "meaning units" into expressions that contained psychological insight related to the phenomenon under investigation (see Appendix G).

6.  Finally, the researcher determined the individual psychological structure of the experience, which guided further analysis of the diverse individual cases of the phenomenon until a general psychological structure was established, which was organised into themes and sub-themes.

**Ethics**

The study obtained ethical approval from the National Health Service Ethics Panel (Appendix H) as well as the Research and Development Management of the site on which the research was carried out (Appendix I). The researcher adhered to the BPS Code of Conduct (BPS, 2006). The appropriateness of the interview questions was ascertained by a consultation with nursing staff and two pilot interviews were conducted before the interview schedule was finalised. Consideration was given to the provision of clear information for participants, the anonymisation and storage of data, and ensuring confidentiality throughout the research process. Participants were provided with a debriefing form (Appendix J), which contained a proposed course of action in case a participant became distressed as a result of participating in the study.

<center>**Results**</center>

The results are reported through a presentation of four themes: (1) Knowing the person and identifying the problem; (2) Meeting the need; (3) Patient characteristics; (4) Contextual issues. They are presented below along with corresponding sub-themes. Given the small sample size, all participants are referred to in the results in the third person, gender non-specific "he/she" pronoun in order to ensure anonymity.

<center>**Theme 1: Knowing the person and identifying the problem**</center>

**Knowledge about the patient.** The relationships that HCAs formed with patients are characterized by a varying degree of HCA's gaining knowledge about the patient and his/her difficulty. Within some relationships, the patient's core problem that necessitated inpatient admission in general and the HCA's response in particular, was clearly identified by the HCA, both in terms of diagnostic categories, as well as the HCA's idiosyncratic understanding of what the problem may have signified for the patient. The HCA's knowledge was profoundly intimate, with a high level of coherence, whereby the patient's current experience of distress was contextualised within his/her past as well as an overall life situation.

*Patrick is suffering quite a severe depressive episode. It has been brought about by, primarily I think from his change of role within the family. The loss of his job had a major impact on his life... He came in almost a helpless state where he couldn't do anything for himself. When he first came in, he was a guy who was just a shell.... And you could see that he was unable to cope for himself... This is a guy, who is good looking. He showed me*

*pictures of his laugh when he was well and really bright. He's got a lovely family. He was*

*good at his job. From the outside everything was going for him.*

The HCA was aware of the importance of the distinction between his/her outsider's view and how the patient's reality was experienced by the patient himself.

At the other end of the spectrum of the HCA's ability to grasp the psychological meaning of the patient's difficulties were descriptions of relationships which evidenced diminished aptitude towards understanding the psycho-social dimension of inpatient care, whereby the encounters with patients seemed to be characterised as having a custodial nature. Any thinking about the patient's difficulties was relegated by the HCA as the task of the consultant or qualified nurses.

*I would have thought that her nurse would compare with what dr.[name] has written*

*before, what he knows about the same story she was telling, so... he is the consultant, he*

*has his own findings, so we would know whether that is as a cause, as a route of maybe*

*someone being ill or something. So I have not done that because there's a particular nurse*

*in charge of that situation ... Like I'm saying I have not seen dr. [name]'s notes. I have no*

*idea about that. It was apparently, she used to refuse medication, and that could have been*

*part of her presentation when she is down. And probably dr. [name] could have thought,*

*let's try to see if she can stay in the hospital and take her medication.*

Therefore, the HCA's descriptions of his/her relationships with patients appeared vague and indicated little psycho-social understanding as to the patients' difficulties. The only reference with regards to treatment was viewed in terms of providing medication.

The majority of the relationships were between the two ends of the spectrum and were characterised by the HCA having a more ambiguous picture of the problem, of which

she/he wrestled to make sense. Such engagements were associated with strong emotional responses, which were difficult for the HCA to know about and understand, and which produced the desire to withdraw from the contact with the patient.

*She left my head spinning a little really. I wasn't able to sort of wrestle with.... when I say wrestle, I mean place them somewhere in my little internal category ... I couldn't place her anywhere. It left me with difficulties as to how to interact with her. I never refused to engage with her, but I was very cautious and would sometimes after a few minutes of talking bring our engagement to a close and back up, because I found that she was having an effect on me that I couldn't really understand myself. It was as if she was a very powerful person. Finding empathy with somebody, I wrestled with that with her... because I just couldn't work out the direction... her drive ... or... anything really.. And that's why... because I thought she was having an effect on me, when she sought me out, I would find myself after a few minutes, getting out of the door...*

There was a sense that the HCA felt overwhelmed by the affect elicited in him/her by the contact with the patient as it was both powerful and incomprehensible.

**Witnessing versus distant observation.** Relationships were characterised by a varying degree of HCA's involvement. On one end of the spectrum was the HCA 'bearing witness' to the patient's situation in a holistic manner. Bearing witness means that the HCA acknowledged and attended to the patient's current crisis situation, which he/she attempted to grasp from the patient's perspective. In this process, the HCA maintained an attitude of genuine curiosity that allowed him/her to persevere despite challenges and the slow nature of the work. The HCA's ability to engage in the process of witnessing relied on the degree to which the HCA held hope for the patient's recovery. Through witnessing, the HCA was able to gather evidence for an alternative state of

mind and being that was possible for the patient. The HCA was entrusted with an aspect of the patient's identity and life, which seemed lost to the patient.

*And I've got to know Patrick over the last period of time, when by his body language I can tell how his day is going and when he is better you can see from his eyes, he's more of a sparkle there, more alive, his posture and everything. And he's got quite a good sense of humour as well and these things come out. I've got to sort of know these things now… So, I think it's just tapping into Patrick or for anybody, what's important for them in their lives. If they were better, what would they like to be doing, and try to get them to visualise that sort of life again… With Patrick it was almost a very gentle investigation into what his life was before coming into the hospital, things that maybe used to make him happy, the good, positive things in life and trying sort of to bring those back to him.*

Witnessing implied an empathic connection with the patient's experience—the HCA was affected by what he/she sees and by his/her participating in the patient's world (e.g. feelings of sadness evoked by a profound sense of loss). The understanding of the patient's situation was deeply felt.

*To see a guy that age, he is 56, to think that that was the end of his life. It really is sad… I felt a lot of pity for the guy.*

As being involved in the patient's situation in this way required substantial resources from the HCAs, they used their judgment to ascertain the limits of how intimately they were able to participate in the patient's world and his/her suffering. There may have been areas of the patient's life that the HCA perceived as being outside of what she/he could come to understand or know about the patient and which remained unexplored. For instance, one nurse intuited that the patient did not wish to talk about his

relationships and hence he/she avoided asking questions about it. In other cases, with certain patients the HCAs remained an entirely distant observers in the patient's care overall, whereby the majority of the patient's experience was outside of the HCAs' realm of comprehension or what they felt they could become emotionally connected with.

*… those are the situations where you see them being discharged and you think, it would have been nice to have contributed to their recovery. But for whatever reason… that's always a little bit …. oh, that's a shame…that's the one that got away really.*

HCAs reported that those patients, with whom they were not able to form a relationship or have any impact in their care, received care or formed relationships with other nursing staff. However, this was spoken about in a speculative way rather than with a conviction and knowledge that every patient became known and understood in terms of their difficulties and needs.

### Theme 2: Meeting the need

**HCA's agency.** The level of engagement seemed to be determined by the perception of whether the patients' needs could be met as part of the acute inpatient admission in general and by the HCA in particular. Having a clearly understood mental health problem provided the HCA with a focus and direction for the engagement with the patient. The perception of the HCA's own capacity to influence the patient, which was indirectly acknowledged, combined with the perceived patient's openness to the HCA's involvement was a context within which positive relationships occurred.

*…At the very beginning the patient found it easier to speak to me so, because of her easiness it actually made it easier for me as well, to speak back….*

Although the perception of the HCA's own capacity to influence the patient in his/her recovery seemed significant for the relationships HCAs form with patients, the conscious recognition of their own agency was problematic. For instance, one HCA while describing a relationship with a patient, with whom he/she worked on managing self-harming behaviour with a positive outcome, attributed the positive impact to chance rather than her/his own skills and agency within the engagement. Throughout the description of the relationship the HCA searched for the factor (e.g. being non-judgmental, the right timing, saying the 'right' thing) that enabled the positive therapeutic engagement to take place, being left uncertain about her influence in the patient's recovery. In another example, where the HCA gave an account of a relationship within which the patient progressed with the HCA's support and care, the HCA concluded that the patient's recovery can only occur as a result of some future medical intervention.

*And you just hope, you pray, that one day things will become easier for him. With the right medication and the ECT, something will happen.*

It was implied that if the HCAs were to admit their own agency with those patients with whom they were able to form intimate relationships and whose recovery they were able to influence,  it would leave them open to a sense of responsibility for other patients, with whom such engagements were not possible and who did not recover. The way in which HCAs prioritised their engagements with patients based on how hopeful they felt about their recovery, was associated with difficult feelings.

*With certain patients I have got to a point where I sort of said, we can only … not that you don't get along with them, because you're not here to get along with people… but you can't necessarily help everyone… This is going to sound awful but not that she is a lost cause, but*

*I can't do anything, I don't feel like I can do anything for someone, so... I just stop worrying about it now.*

Despite the HCA's verbal communication, the non-verbal cues and the manner in which he/she communicated indicated that not being able to help some patients was worrisome for the HCA. The implication of this seems to be that drawing satisfaction from the work with patients, whom HCAs were able to help, could be experienced as tainted by feelings of loss and helplessness with regards to those patients who were not helped.

**Reassurance.** There were different ways in which 'reassurance' could be conceptualised. It could be an all-encompassing attitude, a kind of an overarching presence of the HCA in the patient's world and a gentle and thoughtful attendance to the patient's perceived need. Hence, the patient was gently led by the HCA, who was mindful of the patient's current level of abilities and carefully responded to subtle cues from the patient and adjusted her/his approach through trial and error, paying close attention to what seemed to connect with the patient's experience. This approach facilitated the patient's recovery through gradually increasing her/his involvement with the world and increasing his/her perception (from the HCA's perspective) of what change may be possible.

*With Patrick, he needed so much reassurance, from day one that he was going to be alright. There are still times when you need feeding that into him…. And it was trying to always turn the negatives into positives for him, because every time he was asked for something he would turn the answer into a negative. For instance, "Let's go and have some lunch, Patrick." He would reply: "I don't think I can make it."… It was then a case of just gently taking him by the arm and saying: "Come on, let's see what's for lunch." Almost*

*selecting the dinner for him because he was unable to do that, sitting him down initially in his own room to have his food because he couldn't cope with being in that atmosphere.... And then he would end up eating the whole dinner as if he had never eaten in his life. He was obviously hungry but he couldn't make those decisions for himself...*

Such reassurance was conceptualised as a form of feeding the patient, figuratively providing the patient with sustenance in a way that facilitated the patient being able to take in and digest what is given to him/her by the HCA.

A different kind of reassurance was an instance of verbal communication to the patient as a way of responding to the HCA's sense of pressure to come up with a solution to the patient's distress. The HCA hoped to achieve a lasting change in the patient's level of distress by providing the patient with an external view of reality, as it was perceived by the HCA, without recourse to the patient's subjective experience. This was a more distanced approach taken by the HCAs, whereby rather than gaining an understanding of the patient's predicament, they felt under pressure to 'push' the patient towards a less distressed state.

*Once you reassure her she's: 'ok, thank you; I understand, I'm silly.' And you say: 'No, you're not silly, that's how you're feeling but, it doesn't need to be. You have a lovely son and you should be working to get out of here....' But you'll say all that and she says: 'Oh, thank you, thank you.' And then half an hour later she'll say: 'Elizabeth, can I talk to you?' and I'll say: 'But I've just spent half an hour with you...*

This form of reassurance did not have the desired outcome as the patient appeared firmly positioned in his/her experience. The HCA was then left with a sense of being

locked into a pattern of repetition that rendered the engagement futile, which was experienced as demoralising for the HCA.

There were also instances when coercion masqueraded as a form of reassurance, whereby the HCA acted on behalf of someone else (e.g. consultant, other HCAs) to elicit the patient's cooperation with regards to a course of action that has been decided upon without the involvement of either the HCA or the patient. For instance, as one patient was losing her home, reasons for which were partly related to her mental health difficulties and partly to the conflicting interests of family members, the HCA was given the task to influence the patient so that she was more willing to move to supportive housing.

*I wasn't sure how to sort of get that shift of her doing it for others to her doing it for herself... I still feel like I sort of repeated myself so much and given her as much reassurance as I can, and pointed out the good parts of it that I don't know what else to say to her to make her feel that much more confident about making the change. But that's the thing, you do feel just a bit powerless, to be honest.*

Within this relationship, the HCA was not responding to the need that he/she perceived in the patient, but was following directives related to a decision with respect to the patient's life that he/she was not convinced was in the patient's best interest. The ethical implications of his/her actions were not directly recognised, although the HCA was left feeling uneasy, which was manifested in the conflicting account with regards to the HCA's agency in influencing the patient's acceptance of her new living circumstances.  While the HCA was working hard to help the patient accept the move to supportive housing, he/she concluded that the patient came to this decision entirely on her own. The implication is that in this process, the HCA chose not to consider an aspect

of reality that was highly anxiety provoking—his/her own responsibility in influencing the patient's decision.

**Dependency.** Relationships varied in the level of the patient's dependence on the HCA. Some of the patients' regressed states of functioning necessitated a high level of basic care, related with bodily functioning in cases of patients with depressive presentations, or with boundary settings to ensure patients' safety in cases of patients presenting with psychosis. High level of patient's dependency need engender maternal-like response as the HCA substituted his/her own will and agency for the patient's. As the patient's participation in the world diminished or was disturbed due to mental health difficulties, he/she was no longer able to recognise, meet or communicate his/her needs. The HCA, through intimately getting to know the patient, recognised his/her needs and responded in a way that allowed for these needs to be met. Hence, at times, the HCA was being entrusted with the patient's very survival.

*I thought he was quite thankful, because initially I sort of looked at him and thought, oh…. Nobody wanted to touch him because he smelled…the stench; and of course his leg was… we weren't sure if it was going green at the time…. He came in and he was very self-neglected. His hair was down to his bottom, his toe nails were curling down. That's how bad he was…*

The highly sensitive nature of looking after another adult's intimate and basic care needs was recognised by the HCAs, who approach the care with a gentle but matter-of-fact attitude: the patient is unable to care for himself/herself and hence it was vital to provide this level of care.

The inherent power dynamic in the way that patients' were often dependent on the HCA for their basic needs, which elicited parent-child relating, had the potential to be abused to enforce rules of behaviour that are unrelated to the patient's care. For instance, one HCA described a relationship within which he/she needed to adhere to the ward rule towards one patient to enforce polite behaviour of saying 'please' and 'thank you' as he requested and received basic supplies such as tea and sugar. The patient in turn treated the HCA as a child and refused to recognise him/her as a member of staff.  Rather than reflecting on the significance of the tension engendered by the issues of dependence for the patient, the ward team seemed to enact a cycle of interactions with the patient that were characterised by a sense of humiliation and the need to assert power and authority by both sides. The HCA's experience of the relationship was described as 'locking heads' with the patient, whereby no constructive communication was possible and which was attributed solely to the patient's mental state.

### Theme 3: Patient characteristics

Within relationships that were perceived as more positive, the patient's were perceived as likable and eliciting a genuinely helping response from the HCA. There were also some characteristics that the HCA could relate to, such as similar life experiences or shared cultural background. An interaction with such patients was described as being easy, characterised by a sense of patient's openness and responsiveness to the HCA.  In contrast, within relationships described as difficult, the patients were viewed as more complex to relate to and/or inherently less likable. For instance, in one relationship, the HCA perceived the patient's non-verbal communication as exhibiting an attitude of contempt, which he/she took as a communication for him/her to stay away.

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*She was quite hostile, not like in an aggressive way but she was defensive. You would ask*

*her a question and she would just kind of look at you like 'who are you to be talking to me?'*

*And it was like, oh god, it's not very pleasant.*

However, the HCA later found out that the patient feared rejection from him/her, hence both the HCA and the patient made assumptions about each other's intentions, perceiving contempt and fearing rejection, which could only be disconfirmed by engaging in a verbal open dialogue with each other. However, their initial assumptions constituted a powerful barrier for such a dialogue to take place.

Some patients were perceived in more negative light, which at times could not be articulated by the HCA apart from having a sense that something was awry or awkward about the nature of the interaction with them. Difficult engagements also seemed to happen with patients, who were perceived as disingenuous, manipulative or having ulterior motives rather than a genuine mental health need, or those who continually returned to the ward without showing much improvement in their mental health.

### Theme 4: Contextual issues

**Uncertainty.** The context of the HCA's work was characterised by a high level of uncertainty, which the HCAs perceived as being an inherent characteristic of mental health.

*Because what I've been saying to quite a few patients recently it's like, it's not like a broken*

*bone where you've got to go get your x-ray and we know exactly what to do for you to fix*

*it.*

Working with another person's mind and emotions was recognised by HCAs as something that required individualised, sensitive and intuitive approach of trial and error. However, HCAs often felt under pressure to provide answers and solutions.

**Perceptions of reality.** At the time of crisis, patients' perceptions of reality may have been impacted upon by their distress, which in turn could be experienced as challenging and disturbing for HCAs. The HCA's response to being confronted with patient's unusual beliefs was to present the patient with an objective view of reality. For instance, a patient who believed she was pregnant was given a pregnancy test, which although proved otherwise did not change the patient's belief. Another patient believed that the ward was a submarine was shown the view of the car park from the window, to which the patient replied that the view was false. There were also examples of patients relating to HCAs based on a perception that they were someone they were not, for instance, someone from the patient's past, who was either loved or hated by the patient. The patients' radical interpretations of reality, which challenged the HCA's own perceptions, were a source of frustration and anxiety for HCAs, who struggled to find a meaningful way of engaging with patients in such a context.

**Limited resources.** HCAs existed within a context of fierce competition for both material and psychological resources between patients, which curtailed their capacity to fulfil their caring tasks. The acute environment was such that at times the individualised needs of one patient had to be compromised to accommodate other ward demands or the needs of another patient.

*There was a time when he was becoming incontinent and he didn't have his own bathroom and shower. So that was a difficult thing to cope with. And it was confusing for him as well because, why was he being moved from room to room? But unfortunately that's what*

*happens on the ward. There are factors beyond your control that you have to make the best of a situation.*

The HCAs seemed to passively accept the limited resources over which they felt powerless, while at the same time recognising the detrimental effect this had for patients. In another relationship, the HCA perceived the patient's isolation as the core problem, leading to deterioration in his mental health. The HCA's attempts to work with the patient on increased social integration on the ward were thwarted when he/she was called off to attend to another task.

**Working in isolation.** Although nursing staff worked as a team, many relationships occurred while HCAs worked in isolation, whereby their understandings of patients and what they perceives as the goals of their involvement did not form a part of an integrated care plan. For instance, one HCA worked with a patient from his/her own cultural background, which created tensions for him/her between the expectations and modes of behaviour towards the patient dictated by his/her cultural values and the norms of the ward. The dilemma was not shared with the rest of the team and the HCA had to grapple on his/her own with such decisions as whether to speak to the patient in her native language, which he/she worried may have created a false sense of confidentiality for the patient and may have been experienced as excluding to other members of staff.

Within another relationship, the patient formed a strong attachment with the HCA and refused the care being offered by other nursing staff. The HCA took on the responsibility for the interactions between the patient and the rest of the staff and attempted to influence the patient's behaviour. The issue of the patient's dependence on the HCA was not thought about as something that concerned the whole team and that could have

informed the overall patient care. Furthermore, the HCA was strongly impacted by his/her powerful contribution to the patient's recovery, while at the same time grappling with feelings of guilt that his/her strong attachment with the patient may have been responsible for his refusal of paramount care from others. The experience of such complex and conflicting feelings had to be held by the HCA without appropriate support or supervision.

**Knowing your own mind.** The most important way of coping with challenges that arose in relationships with patients was described by one of the HCAs as a sense of conviction that one was doing the right thing.

*I think if you know in your own mind what you're doing is good, and you're doing it to the best of your ability, I think you can cope with things and have a clear conscience.*

There were ample instances when the HCAs seemed uncertain about their own knowledge, which was manifested by making firm statements about patients, which were then quickly withdrawn or contradicted by stating the opposite view. For instance, one HCA felt strongly that the patient was feigning mental health difficulties in order to avoid a criminal conviction.

*Perhaps I'm being a little bit hard on him, whether [the voices] exist to that extent and whether they were a big influence over his actions or was he just saying them, so it's difficult to make judgments. That's the thing about mental illness, you cannot make these judgments, you have to listen what's going on for the patient. I might be a little bit hard on him but as you say, as you build up a relationship you do get to know people. It's very difficult because you have to remain as professional as you can and not tell exactly what*

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*you feel. And obviously, in his case, you would be aware of the backlash from his mother, if there was the suggestion that he shouldn't be on the ward.*

On the one hand the HCA was convinced, based on careful consideration of evidence gathered through his/her engagement with the patient, that his mental health difficulties are disingenuous. On the other hand, the HCA realised the weight of his/her conclusion and felt wary of the responsibility of making such a significant judgment. Therefore, this could be seen as an example of the HCAs struggling to know their own mind and communicate their conclusions in a way that could be thought about and made sense of by the whole team.

The way in which HCAs struggled to know their own mind was also manifested in the perceived need to maintain team solidarity. HCAs often made statements about everyone in the team feeling and thinking the same thing, which seemed comforting. In contrast, acknowledging diverse or conflicting opinions provoked anxiety. The apparent solidarity of thought, however, seemed to be an easily dismantled façade. For instance, one HCA described conforming to a set way in which he/she was told to interact with a patient based on a rationale that his problem was 'behavioural'. However, upon reflection, the HCA concluded:

*I mainly just do it because I was told and you're meant to show a united front... I don't really mind.*

The importance of maintaining a 'united front' seemed to overrule the HCA's need to be able to form her own judgments and made it impossible for him/her to raise concerns about his/her interactions with the patient.

## Discussion

The study set out to examine the lived experiences of Healthcare Assistants (HCA) engaging in relationships with patients in acute inpatient settings and to explore the nature of these relationships. The results suggest that there are great degrees of variance in the level of HCAs abilities to get to know and understand patients in terms of their current crisis and that the knowledge that HCAs gain about patients is often not integrated into coherent treatment plans shared by the whole team. The variance in HCAs' abilities to think about patients in psychological terms has important implications for the psychosocial care in inpatient settings, as it can contribute to the confusion over the role HCAs have within the nursing team and the decisions and tasks they are able to undertake. Menzies-Lyth (1988) pointed out that not having clearly defined roles within the institutional structure can lead to people becoming disappointed, frustrated and disillusioned with their work and developing attitudes that aim to defend them against such feelings, which makes carrying out the caring task difficult.

The results indicate that HCAs often experienced ambivalence with regards to the direction and purpose of their engagements with patients, as they lacked clarity as to the core problems faced by patients and were uncertain of the realm of their influence. Given that the agreement with regards to the treatment focus and goals forms a key aspect of working alliance (Clarkson, 1995) this finding suggests that in many nurse-patient relationships, the most basic foundation of any therapeutic intervention, the working alliance, is not established.

The ambivalence over the purpose of relationships relates to Hinshelwood's (2001) argument that confusion about the function of the hospital is a common occurrence, characterized by a conflict between viewing the hospital as a place of providing primarily medical treatment and as a place where psychosocial treatment can be delivered. Therefore, the HCAs' sense of ambiguity over the goals of their engagements may relate to the general ambiguity over the purpose of the institution as a whole. Hinshelwood (2001) warned that confusion or conflict between different purposes in an institution leads to apathy and demoralization. This seems to have been confirmed in the current study, as relationships within which HCAs struggled to find meaning and purpose for their engagements were associated with feelings of futility and resignation.

The findings point to the way in which HCAs relationships with patients seemed to be defined by the need for certainty and unity of judgment among the nursing team, leaving little threshold to tolerate uncertainty and the exercise of differential judgments by individual HCAs. The HCAs often felt they had to ignore their own thoughts and feelings in order to conform to a majority view or act based on the decisions made outside of the immediate relationships with patients. This seemed in opposition to the concept of 'safe uncertainty' as espoused by Mason (1993). He argued that working from a position of premature certainty may preclude professionals' ability to see alternative possibilities when engaging with patients. The position of 'safe uncertainty' on the other hand, is not fixed and allows for new explanations to emerge alongside the understandings that both professionals and patients bring. The current findings suggest that HCA's premature certainty or acting based on decisions made by others without understanding the rationale behind it or not having a more personal conviction for their actions in their relationships with patients may result in patients' needs not being

appropriately identified and addressed within the system, and in the worst case scenario lead to nursing staff feeling they are employing coercive treatments.

The findings of the current study also highlight the problematic nature of responsibility in the context of caring for patients in inpatient settings. Yalom (1980) argued from an existential perspective that the awareness of responsibility is necessarily associated with anxiety, to which individuals respond by seeking relief through avoidance of decision-making or autonomous action and by seeking structure, authority or magical solutions that appear bigger than themselves. Such defensive responses seemed evident in the findings as HCAs struggled to acknowledge their own accountability for the therapeutic work they undertook and attributed changes in the patients' mental states as due entirely to external factors such as medication.

Based on his work in socio-analytic work in industry, Jaques (1970) linked the exercise of discretion (in the sense of making judgments) as requiring the capacity of individuals to tolerate uncertainty while awaiting the outcome of their decisions and possible failure. He argued that because the use of discretion is dependent upon both conscious and unconscious mental functioning, it is associated with anxiety aroused by 'having to depend for success upon the coherence and availability of unconscious mental life' (pg. 81). He postulated that what is experienced as psychic effort in work related to the intensity and weight of responsibility depends on the length of time that uncertainty and anxiety about the final outcome must be tolerated, as well as on the amount of the unconscious material that must be made conscious. It seems that the therapeutic task of HCAs in their everyday interactions with patients is associated with the need to account for a substantial amount of unconscious material and must therefore be associated with considerable uncertainty and anxiety. If the resources, in terms of individual's capacities

and those arising from organisational structures, are inadequate for the completion of the therapeutic task, it is likely that the working experience of nursing staff may cause significant levels of stress. Jaques (1970) argued that the work that is beyond an individual's capacity is typically manifested by the person becoming either anxiously indecisive, or unwise and impetuous in decision-making, or paralyzed. Instances of such responses by HCAs in the current findings indicate that staff may at times need to perform beyond their capacities, which puts them at risk of experiencing their work as highly stressful.

One aspect of the unconscious work inherent in forming therapeutic relationships with patients is within what Clarkson (1995) described as transferential/countertransferential relationship dimension. Although evidence of the phenomenon of transference transpired in the data, the participants did not seem to relate their experiences with patients in terms of the way in which early relational patterns can become repeated in relationships in the present. Hence, transferential phenomena did not seem to be used for a therapeutic purpose as explicated by Clarkson (1995), whereby information about a patient's past is processed together with information from the present, in order to inform care planning.

Some of the clinical implications of this research are that there is a need to clarify the roles and tasks to be undertaken by HCAs, which is consistent with current policy calling for a more consistent accreditation programmes (House of Commons, 2010). There is a considerable role for the use of psychological formulation within staff teams as a way to integrate the psychological thinking and guide specific psychological interventions and more general everyday psychosocial care. The use of formulation in multidisciplinary team working is viewed as a promising tool in improving the quality

of clinical services provision (Christofides, Johnstone, & Musa, 2012) and in having the potential to lead to more effective management approaches, particularly when staff are faced with having strong responses to patients that may be perceived as disturbing (Steinberg & Cochrane, 2013). Also, the findings highlight the need for HCAs' therapeutic tasks with patients to be supported by the overall system, perhaps through the provision of appropriate psychological supervision. The anxiety associated with the responsibility that must be assumed when forming relationships with patients experiencing severe psychological crisis requires the provision of psychological support and containment for frontline staff.

**Limitations and further research**

The present study has several limitations. Firstly, it is important to acknowledge possible selection bias. Participants were self-selected and therefore those that felt more confident about their engagements with patients may have been more likely to volunteer.  Moreover, participants who did volunteer may have had a particular interest in psychosocial approach to patient care, which was evidenced by the fact that two of the participants were psychology graduates and one was about to commence training in occupational therapy. The study is also limited in that it may have been difficult for participants to disclose negative interactions for fear of potential judgment and having to face negative consequences.

Further research could use the psycho-social research model, which was developed specifically "to consider the unconscious communications, dynamics and defences that exist in the research environment" (Clarke & Hoggett, 2009, pg. 2-3). Although the phenomenological method can to some extent address the implicit meanings in the participants' accounts, psycho-social methodology could further explore the social

defensive mechanisms of nursing staff in their everyday work in acute inpatient

settings.

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Section C: Critical Appraisal

Word count: 2237

<div align="center">**Overview**</div>

In this section of the Major Research Project, a critical appraisal of and reflections on the process of undertaking this research are provided.

**Question one: What research skills have you learned and what research abilities have you developed from undertaking this research project and what do you think you need to learn further?**

Before undertaking my studies in psychology, I completed a degree in philosophy, through which I became familiar with philosophical phenomenology and the writings of Husserl and Heidegger. As I was completing my philosophy thesis on the topic of suffering, I became more and more interested in the field of psychology and the use of phenomenological approach as a psychological research method. I was able to learn the method when conducting my undergraduate psychology research project on the topic of creativity and was encouraged by its investigative potential. In the process of carrying out the current research project, I needed to learn precisely the difference between Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) and the phenomenological methodology as outlined by Giorgi (1985). Majority of phenomenological methodology used in psychology and health research is IPA and many people assumed that this was the method I was using. I needed to go back to the literature on phenomenology and satisfy myself that I knew the theoretical underpinnings and rationale for using Giorgi's method. By doing that, I felt more grounded, knowing the principles and following the rigour of the method.

Whilst carrying out the current project I became aware of my countertransference (see Heimann, 1960) in relation to the project. It seems to me that one reason for being able to recognise this process in relation to a task, was my increased knowledge of psychodynamic model gained during the training. Also, as opposed to my previous project on creativity, which was a relatively dispassionate subject, the topic of the current project was associated with particularly strong emotions. Searles (1979) described a similar process he encountered while writing about a 'schizophrenic' individual's experience  and links his feelings of anxiety, confusion, and despair as reflecting similar feelings of the individual about whom he was writing. In the process of undertaking this project I often felt myself experiencing powerful feelings of anxiety and despair, which after reflection and through the use of supervision I was able to learn to utilise to inform the process of analysis.

Learning to recognise the process of countertransference formed a crucial aspect of the process of bracketing during the analysis. Giorgi (2006) argues that bracketing involves recognising any potential biases in the very process of analysis and he does not support the exercise of recording of the researcher's potential biases before the research process, which can then be referenced during the analysis. My experience of conducting this research supports this stance, as I learned that it is important to recognise and monitor not only the conscious biases but also the unconscious processes that affect the researcher's thinking.  Being supported by my supervisors throughout the analysis process helped me to work through and separate what was my response to the project based on my own personal issues and what was likely to emanate from the data itself and how it should be used in the process of analysis. For instance, throughout conducting the analysis of data, I often felt a deep sense of hopelessness and despair, as

if the completion of the project was a futile aspiration. I was aware that those feelings were hugely exaggerated and therefore were more likely to reflect the dynamics of the phenomenon I investigated. Through discussions with my supervisors I was able to separate my own feelings from what could be evidenced as being a part of the phenomenon in the data. Through this process I noted how my feelings closely mirrored the hopelessness often expressed by the participants in the data with regards to working with patients who exhibited severe and enduring mental health difficulties, which seemed immune to change.

Carrying out the interviews was an interesting and challenging process. I found I needed to learn the similarity and differences between conducting clinical interviews and semi-structured interviews as a data gathering strategy. Particularly within phenomenological approach, where the researcher must remain sensitive and open to the direction the participants are taking in describing the phenomenon, whilst also paying attention to the implicit meanings and the non-verbal communications, I found that conducting interviews required a skill I was only starting to develop. As I carried out the interviews and discussed the process with my supervisor, I began to feel more confident with my abilities to facilitate the participants to be able to provide rich data while maintaining the boundaries of the research project.

For the first time as part of this project, I carried out empirical literature review based solely on qualitative research. As part of this process I learned about the debates and issues associated with synthesising and utilising the knowledge gained through qualitative methods, which is a new and stimulating area of research. The process of reviewing qualitative research studies has also made me think critically about the methodology of qualitative research and I was able to explore the general principles by

which various qualitative methods can be evaluated, which in turn has strengthened the research skills with regards to my chosen method for carrying out the research project.

Reporting of the results is something that I need to improve. The scope of this project allowed for a limited exploration of all of the theoretical and practice implications of the findings. I intend to think carefully with my supervisors on how to communicate the findings to the trust where it was carried out, as well as to psychologists working in acute care settings in order to make the most of the theoretical considerations and practice implications.

I found conducting this research project challenging as I needed to work between and manage the boundaries of two professional fields: psychology and nursing. The research I reviewed was conducted by nurses and I needed to remain mindful of my psychological focus and distinguish the nursing expertise from the expertise of psychology. In literature, nurses often highlight that mental health nursing is a scientific field in its own right and fervent attempts are often made to separate nursing from psychiatry and psychology. I wanted to respect this view, while at the same time bring my psychological thinking, which I thought could enrich the topic of therapeutic care carried out on acute wards. I think the dilemma of how to conduct a fruitful dialogue across the professional boundaries about crucial care issues within services is something that I would like to work on throughout my professional life. I think multidisciplinary working is highly complex and challenging whilst being the only way through which care within services can be improved.

**Question two: If you were able to do this project again, what would you do differently and why?**

If I was able to do this project again, I would recruit participants from several different sites, as it seemed to require considerable resources from nursing teams on one unit to make staff available for interviews. Conducting the research on different sites may have been initially more difficult for the researcher to gain the necessary support from staff and managerial commitment for the project, but would have distributed the need for staff to be called away from the wards in order to take part in the study over several different units.

However, I also wondered whether conducting the interviews in the participants' private settings, away from the working environment altogether would have made a difference to the data elicited. If I was doing this project again I would explore the possibility of paying the participants for taking part in the study and conducting the interviews in their own time.

Through conducting this research I learned to liaise with professionals in mental health services at a research level by making use of the research network in the trust, as well as gathering feedback and advice from stakeholders. However, because of the competing demands of the course I did not always give the priority to the research task, particularly in the first and second years of training. If I conducted the research again, I would have made a bigger effort to maintain regular links with the local mental health research network and would have followed more closely the developments of acute care forums in order to maintain the relationships with research colleagues and service users and to stay in touch with the ongoing issues in the field.

If I was able to do this project again, I would have liked to be able to allow more time to write up the report of the results. Conducting the analysis was an incredibly time consuming process and I think I may have slightly underestimated the amount of time that the writing of the results would take.

**Question three: Clinically, as a consequence of doing this study, would you do anything differently and why?**

The main influence this study will have on my clinical practice is in the area of working as part of multidisciplinary teams. Before carrying out this project I did not fully realise the potential of using psychological formulation, especially as a tool when working with teams.

Through carrying out this project I have learned that multidisciplinary working requires sensitivity and skill in order to be able to support nursing staff whilst they take on their everyday therapeutic tasks with patients. Knowing the hurdles and challenges that nursing staff encounter has increased my own empathic potential in recognising the staff needs and being able to facilitate my psychological expertise to support staff in utilising their psychological skills and thinking. When working with staff teams in the future, I am aware of the importance of recognising the psychological processes that play out in group dynamics and which may also reveal significant information about the internal world of patients. Linking and making sense of the complexity of these psychological processes is a crucial role for psychologists, who can use their expertise to increase the mutual understanding about both the problems of individual patients, as

well as the difficulties encountered in carrying out the carrying task in any settings, not only acute inpatient wards.

**Question four: If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?**

I am interested in two areas that could be further explored in relation to the psychosocial care in acute inpatient settings. Firstly, it would be beneficial to further explore the psychological processes that take place within the relationships between nurses and patients, using an approach that has the potential to tap more in-depth into the unconscious processes at play. The psycho-social research model was developed specifically to aid the research endeavour to reach beneath the surface and beyond the purely discursive, in order "to consider the unconscious communications, dynamics and defences that exist in the research environment" (Clarke & Hoggett, 2009, pg. 2-3). Whilst conducting my project, I became aware of the level of defensiveness of the research participants and the difficulty of making sense of the contradictory accounts that were at times described in the data. Although phenomenological method can to some extent address the implicit meanings in the participants' accounts, psycho-social methodology would be more suitable to the study of what has been termed "the 'defended' subject—understanding the effects of defences against anxiety on people's actions and stories about them" (Hollway & Jefferson, 2000, pg. 4). Hence, further research using the psycho-social methodology could examine the social defensive mechanisms of nursing staff in their everyday work in acute inpatient settings. Through

the use of free associative narrative interviews and biographical-interpretative method (Hollway and Jefferson, 2000) as key methodological resources, the researcher would be able to arrive at interviewees' meaning-frames that facilitates taking into account the unconscious factors.

Secondly, further research could explore the discourses that operate in the written reports and verbal communications that nursing staff produce and in which they engage as part of their everyday documentation and practice. The literature review conducted as part of this research project revealed that nurses felt that their documentation differed from the reality of their caring practices. Foukaldian discourse analysis is concerned with language and its role in the constitution of social and psychological life (Willig, 2001). Research could be conducted using the framework and principles of Foucauldian discourse analysis, whereby both the written and verbal communication could be investigated in terms of the relationships between discourse and how people think and feel, how it relates to practice (what people do) and the material aspects of the conditions within which the discourse takes place. As I conducted the current research project, I was aware of the interface between various disciplines that operate and lay claim to knowledge and meaning making within inpatient settings, i.e. psychiatry, psychology and nursing. There is a scope to investigate the significance of this disciplinary diversity through Foucaldian approach, which conceptualises 'discipline' as a technique of power that provides procedures for training and coercing collective and individual bodies (Donaher, Schirato & Webb, 2000). Further research could elucidate the ways in which the disciplines of nursing, psychiatry and psychology each exert their influence to map the discursive worlds the nursing staff inhabit and to trace possible ways-of-being afforded by them (Willig, 2001).

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Section D: Appendices

CINAHL: 24 papers extracted for full text investigation

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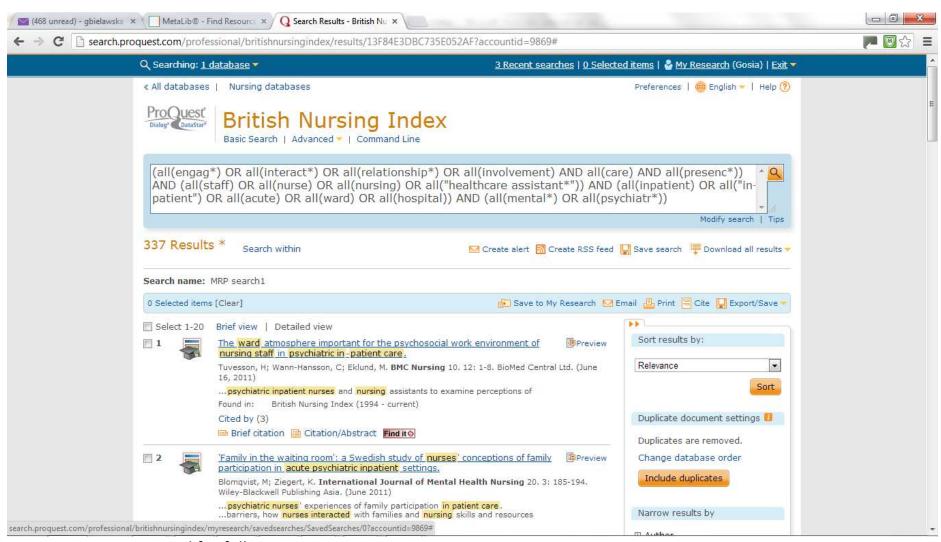| | # ▲ | Searches | Results | Search Type | Actions |
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| ☐ | 8 | acute.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] | 57554 | Advanced | Display   More ≫ |
| ☐ | 9 | ward*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] | 12248 | Advanced | Display   More ≫ |
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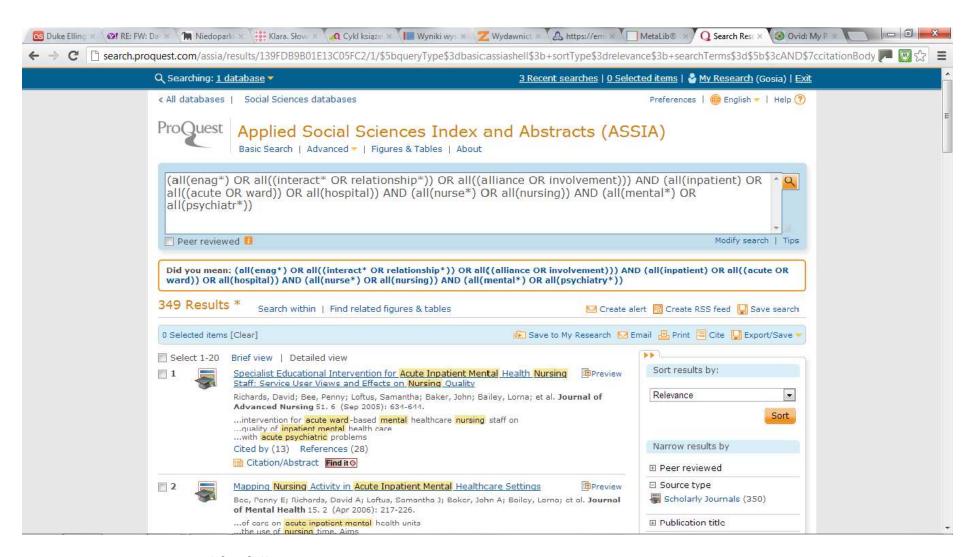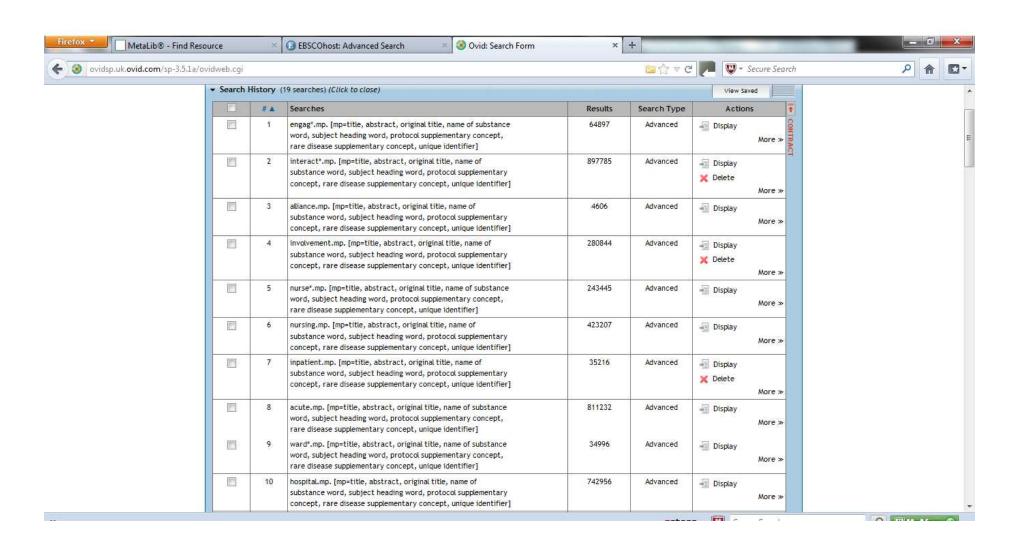zotero   Secure Search   McAfee

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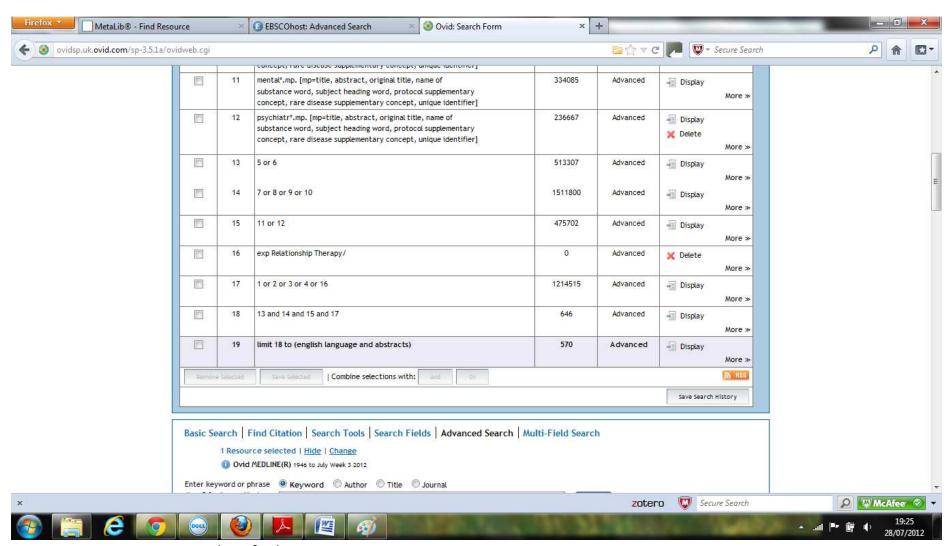
PsychInfo: 22 papers extracted for full text investigation

BNI: 14 papers extracted for full text investigation

ASSIA: 5 papers extracted for full text investigation

MEDLINE: No new papers identified.

INFORMATION SHEET

**<u>The experience of therapeutic relationships on acute in-patient wards.</u>**

You are invited to volunteer to take part in a research project which aims to develop a better understanding of the experiences of forming therapeutic relationships with service users in an acute in-patient setting. Since contact with service users forms the majority of your working time, we would like to gain a better understanding of what your experience is like.

If you decide to take part you will arrange an interview time with the researcher. The interview is going to take place on the premises of ████ ██████████ (unless you wish otherwise), away from the wards to ensure privacy and no interruptions. During the interview you will be asked the following questions:

1) Describe a process of any relationship with a patient in detail. (It could be the last one you can remember, the one that you see as the most unique, important, etc.)

2) Describe a relationship with a patient that you would consider as good or successful (from the very beginning till the end or present). What in particular made it good?

3) Describe any relationship with a patient that you would consider as difficult. What made it particularly difficult?

4) Would you like to add anything more to what has already been said?

The researcher will record the interview and immediately after the interview is completed, the recording will be transferred onto a computer (the original recording will be deleted) to be later transcribed and analysed. There will be no personal information attached to the data, which will only be accessible to the researchers so that your confidentiality can be protected. When the research project is completed, all the data, including the recordings and transcriptions, will be kept for three years, after which it will be destroyed. Once we complete the analysis of the data, you will be invited to comment on the results and contribute to any adjustments that would capture your experience more accurately. We are hoping that the findings of this project will help us reflect on and appreciate the therapeutic work that takes place at Green Park House, as well as identify areas which require additional attention and support.

We are hoping that participating in this project will be a positive experience for you, giving you a space where you can reflect on the therapeutic aspect of your work. However, if you change your mind at any point of the research process you may withdraw without any consequences and without stating the reason for doing so. Also, if as a result of taking part you feel distressed, please, do not hesitate to approach the supervisors of this project, as well as any of the contacts we list on the debriefing form.

Thank you for taking the time to read about this project. If you are interested in taking part or have any questions about it, please, do not hesitate to contact us.

Sincerely,

Malgorzata Brown ███████████████████████
        Email: ████████████████████
        Phone: ████████████████

Dr. ███████████████████████████████████████
        Email: ███████████████████
        Phone: ████████████

Dr. ████████████████████████████████████
        Email: ████████████████
        Phone: ████████████████

# Consent Form

**The experience of therapeutic relationships on acute in-patient wards.**

Please, read the statements below and initial those with which you agree:

1. I have been given Information Sheet, which informed me of the purpose of this study as well as the interview process, including the recording of the interview.

2. I understand that everything I say is confidential, however, I have also been informed that the disclosure of any abusive or unethical practices will have to be dealt with appropriately.

3. I understand that I do not have to reply to any questions I do not feel comfortable answering.

4. I understand that I can withdraw my participation from this study at any point of the research process without giving any explanation for doing so.

5. I am a full time permanent nursing staff working at Green Parks House.

6. I have worked on the ward for at least the past six months.

7. I volunteer of my own free will to share my experiences with the researchers.

8. I have been given contact numbers of the supervisors of this research project, as well as information about whom to contact in case I experience distress following the participation in this project.


Name of the participant:………………………………………………………..

Signature:……………………………………………………….Date………......

Name of the researcher:………………………………………………………

Signature:……………………………...............................Date………......

Interview Schedule

1) Describe a process of any relationship with a patient in detail. (It could be the last one you can remember, the one that you see as the most unique, important, etc.)

2) Describe a relationship with a patient that you would consider as good or successful (from the very beginning till the end or present).

3) Describe any relationship with a patient that you would consider as difficult.

4) Would you like to add anything more to what has already been said?

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**Debriefing form**

**<u>The experience of therapeutic relationships on acute in-patient wards.</u>**

Thank you for taking part in our study. The information you provided during the interview will help us find out more about the therapeutic environment of the in-patient wards at ▇▇▇▇▇▇▇▇▇▇. Your contribution will be stored under a pseudonym and no personal details will be revealed in either the transcripts or final report. After the analysis of data is completed you will be invited to discuss and confirm the findings with the researchers, so that we can make sure that they reflect your experience of therapeutic relationships.

If you have any questions or would like to discuss anything relating to this research project, please contact the project supervisors. Also, **if you experience any distress as a result of participating in our study, please do not hesitate to contact any of the persons listed below.**

*Clinical psychologists available at* ▇▇▇▇▇▇▇▇▇▇:

**Dr. ▇▇▇▇▇ (Clinical Psychologist, research supervisor)**
    **Email:** ▇▇▇▇▇▇▇▇▇▇
    **Phone** ▇▇▇▇▇▇▇▇)
**Dr. ▇▇▇▇▇▇▇ (Clinical Psychologist, research supervisor)**
    **Email:** ▇▇▇▇▇▇▇▇▇▇
    **Phone:** ▇▇▇▇▇
Dr. Melanie Place (Clinical Psychologist)
    Email: ▇▇▇▇▇▇▇▇▇▇
    Phone: ▇▇▇▇▇▇

*Employee Counselling and Support Scheme,*
*The Centre for Applied Social & Psychological Development, Solomons*

Dr ▇▇▇▇▇▇▇▇▇▇, Chartered Clinical Psychologist,
Practice Consultancy Director
    Email: ▇▇▇▇▇▇▇▇▇▇
    ▇▇▇▇▇▇

▇▇▇▇▇▇, Practice Consultancy Administrator
    Email: ▇▇▇▇▇▇▇▇▇▇
    Phone: ▇▇▇▇▇

Sincerely,

Malgorzata Brown
Email: Malgorzata.Brown@▇▇▇▇▇▇

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Xxxxxxxx

Xxxxxxxxx

Xxxxxxxxx

Xxxxxxxxxx


RE: Executive Summary of Research Findings


Dear xxxxx,

Please find enclosed the summary findings of my research project "The experiences of therapeutic relationships on acute inpatient ward", which you approved on 13/03/2009.

The results should inform the psychological care delivery practice on inpatient acute mental health wards.

Thank you for reviewing the project and please feel free to disseminate the findings.


Yours Sincerely,


Malgorzata Brown

Trainee Clinical Psychologist

Canterbury Christ Church University

Salomons, Broomhill Road

Tunbridge Wells, TN3 0TG


Project Title: The experiences of therapeutic relationships on acute inpatient ward

Executive Summary

The therapeutic relationships nursing staff form with patients is the main medium of care delivery on inpatient wards. The aim of this study was to explore what constitutes the nature of the everyday care relationships formed between nursing staff and patients as experienced by healthcare assistants (HCAs). Phenomenological methodology was utilized to collect and analyze the data. Six HCAs were interviewed and thirteen descriptions of their relationships with patients were elicited. Four themes emerged describing the constituents of the relationships staff formed with patients: knowing the person and identifying the problem; meeting the need; patient characteristics; contextual issues. The results suggest that there are great degrees of variance in the level of HCAs abilities to utilise psychological thinking and skills in their interactions with patients. There was often a lack of evidence of psychosocial care being coherently integrated within the whole team's approach to care delivery. The variance in HCAs' abilities to think about patients in psychological terms has important implications for the psychosocial care in inpatient settings, as it can contribute to the confusion over the role HCAs have within the nursing team and the decisions and tasks they are able to undertake.

The findings of the current study highlight the problematic nature of responsibility in the context of caring for patients in inpatient settings. The awareness of responsibility is necessarily associated with anxiety, to which staff responds by engaging in defensive practice and struggle to acknowledge their own accountability for the therapeutic work they undertake, even when such care has a successful outcome.

The clinical implications of this research are that there is a need to clarify the roles and tasks to be undertaken by HCAs, which is consistent with current policy calling for a more consistent accreditation programmes. There is considerable role for the use of psychological formulation within staff teams as a way to integrate the psychological thinking and guide psychosocial interventions.