An interpretive phenomenological study of nursing insights into the formation of the therapeutic nurse patient relationship within acute psychiatric wards

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Abstract

This study has concerned itself with the therapeutic nature of the relationship between psychiatric nurses and the inpatients of acute psychiatric wards. In particular it sought the insights that those nurses held in relation to their strategic endeavour to form such a relationship. Existing theory was considered and a comprehensive review of the literature was undertaken; this identified a paucity of research and theory into how therapeutic relationships are formed between nurse and patient within a contemporary acute psychiatric ward.

In order to answer the research question, this study adopted an interpretive phenomenological methodology. The convergent interview; with its inter-interview analytical process (Dick, 2017) was utilised as the method. The research was undertaken across four wards that make up the acute inpatient facilities of a single NHS site. A maximum variance sample was sought and seventeen interviews were conducted. Six major themes emerged from the responses of the participants: making a connection and relating to one another; the utilisation of values; appraising the situation and manoeuvring; using and working with boundaries; managing the challenges and pressures of acute psychiatric work; and work as a team.

Themes were re-reviewed in the light of theory, literature and contemporary commentary and then conclusions and recommendations are made. The study concluded that the endeavour to form a therapeutic relationship is a boundaried, reflective, and altruistic driven social endeavour. One that utilises the opportunities that arise out of the relational intensity of sharing a living space, whilst one party experiences an episode of acute psychiatric illness. Such intensity requires nurses to engage in self-sustaining strategies, and to adopt a team approach if their endeavours are to be successful.

The study made recommendations for recruitment practices that enable the identification of individuals with pre-existing social skill, altruistic values, an ability for personal reflection

and a degree of personal resilience. Recommendations are also made for training that supports an examination of the relational impacts of power imbalances, psychiatric symptoms, professional boundaries and professional values.

Additionally, the study presents it is the establishment of a relational bond alone, which most closely resembles acute psychiatric nurses' understanding of therapeutic relationship. Hence a recommendation is made to rethink the framing of future research or measurement of the phenomena based on the tri-partite definition of bond, goal and task agreement that defines psychotherapy understandings of therapeutic relationship (Bordin, 1979). The study also makes recommendations for both further research and theoretical development.

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Table of Contents

List of Tables

List of Figures

List of Appendices

Chapter 1

Introduction

1.1 Introduction

This study has concerned itself with the therapeutic nature of the relationship between psychiatric nurses and the inpatients of acute psychiatric wards. In particular, it sought an understanding of the strategic endeavour, the labour, by which acute psychiatric nurses form such relationships.

This thesis has acknowledged the dearth of literature and theoretical commentary that supports a view of the centrality of the therapeutic relationship to psychiatric nursing practice. However, it identified a gap in knowledge that relates to an understanding of the mechanisms by which those therapeutic relationships of psychiatric nursing are established; in particular the establishment of those relationships within a contemporary acute psychiatric ward. An environment characterised by high levels of acuity and disturbance associated with the delivery of enforced treatment and risk management regimes. Without such an understanding, and an ability to articulate such relational labour, the contribution of acute psychiatric nurses' risks becoming lost within a healthcare economy that demands transparency in relation to activity and its purpose (McAndrew et al., 2014).

Zugai et al., (2015) notes that without a concerted focus and an active discourse surrounding the therapeutic relationship, the concept was being annexed in deference for the concrete language and concepts of expertise, risk management, illness assessment, and medical stabilization. Furthermore, if postmodern linguistic, and social constructivist beliefs in the importance of language in the construction of reality are to be engaged with (Derrida, 1976; Wittgenstein, 2002), then the significance of a loss of 'therapeutic relationship' from the discourse of psychiatric nursing, potentially offers an existential threat to its future as a central concept of acute psychiatric nursing.

Also in recognition of Benner's (1984) seminal work, detailing the development process of expert nursing practice; from novice to expert, unless psychiatric nurses can give voice to their

actions it becomes difficult to identify the specialist training and development needs of future generations of ‘expert’ nurses.

It could be argued then; that it is of significant interest to psychiatric nursing to understand and record the expert insights and skills they hold with respect to their relationship endeavours. This thesis presents an interpretive phenomenological study that utilised the medium of video linked interviews to collate those insights.

The interest in this phenomenon, and the desire to investigate it, has not been grasped from thin air. To use Darlington and Scott’s (2002) analogy; the question has arisen out of the mire of a personal and political identity and of the researcher’s clinical nursing practice, and it is has gained a sufficient hold on firmer ground to present an opportunity for an investigation. This introductory chapter initially presents a narrative of that convergence of the personal, political and professional. In part, this is to enable the reader an insight into the frame of reference of the researcher by which the work may be appraised (Mills, 2000); but also, in part to offer the context by which the research question has been asked, investigated and findings interpreted.

This thesis is presented systematically within chapters that cover this introduction (Chapter 1); the theoretical underpinnings (chapter 2); a systematic search of the literature (chapter 3); methodology and methods (chapter 4); findings (chapter 6); discussion (chapter 7); and finally the conclusion and recommendations (chapter 8). This introductory chapter will offer an overview of what to expect from each.

1.2 The convergence of the personal, professional and political

Lomas et al (2003) observed that the development of a research interest, and the choice of mechanisms by which that might be answered, are shaped as much by the convergence of a political, personal and a professional identity, as much as they are from the clinical conundrums encountered. As Mills (2000) purported the researcher and their unique personal narrative shapes the lens from which a research question is formed, is investigated, and ultimately will

direct the narrative of the answer to that question. Mills (2000), Freeman (2001), and Darlington and Scott (2002) went on to observe that such reflexivity; the interplay of the researcher and the research subject and processes are both an asset, in terms of enabling enriched accounts of the phenomenon to be presented; but equally present a concern of subjectivity that warrants consideration. Darlington and Scott (2002) suggested an introduction to the researcher and their identity within the context of the research question is an essential requisite. Such an introduction allows the reader an insight by which the research narrative can be understood and appraised with reference to the researcher's filters, or possible blinkers (Mills, 2000).

Whilst there are multiple and entwined narratives that surround the researcher's identity, two particular narratives have emerged from a personal reflection (Fieldhouse, 2017) that have had an impact in developing the research interest:

The development of a political and philosophical frame of reference

The development of a clinical interest in human relationships in the context of psychiatric nursing

1.2.1: The development of a political and philosophical frame of reference

The researcher was born in the sixties, schooled in the seventies and post school educated in the early eighties, and those formative years have undoubtedly shaped the frame of reference that was to continue developing throughout a nursing career.

Life through the late 1960's and 1970's was characterised by the rise of individualism in society and the post war rejection of a state led collectivism (Cranfield, 2012; Farrell, 1997; Gitlin, 1987). A time, as Gitlin (1987) and Cronkite (2004) suggested, saw the rise of civil rights movements representing the rights of the individual and the rejection of an unquestioning acceptance of the current order of society and of state supremacy. A post war society that rejected state collectivism in favour of individualism, a message fuelled by the ever increasing

mass media outlets of the time and of the portrayal of individual wealth and of the individual consumer based future.

Ironically whilst such a rise in individualism and the purchasing power of the individual was central to a changing societal order, it gave rise to other forms of social unions, or subcultures (Pearson 1983, Gelder 2005). These took the forms of activist groups; music affiliations; fashion affiliations and football tribalism to name a few. In the gap of state identity, a social identity based on group membership developed. Social commentary offered descriptions of in-house group norms, accepted values, identity built on the emphasis of similarities within the group and the difference with others outside of that group (Ellemers and Haslam, 2012; Hofstede, 1980; Hogg, 2006; Tajfel and Turner, 1986; Triandis, 1995). A phenomenon that drove the creation of an 'Us and Them' discourse within western society (Hogg et al. 1990, Coy and Whohrle 2000). A discourse and phenomenon that was later to be observed on a grand scale in an ever increasing divide in society; culturally, financially and socially between 'those that had' and 'those that did not' (Whitehead, Townsend, Black, and Davidson, 1988).

Both discourses of individualism and the creation of subgroup identity were very much evident through the formative years of the researcher, and was very much driven by the socio-political world that surrounded those years: brought up in a working-class family, based in an industrial city of miners, steelworkers and potters; and as a failed eleven plus candidate who went on to attend a punitive, unambitious, catholic secondary comprehensive school. A school that was primarily populated by other failed 11 plus children, and by the sons and daughters of miners, pottery and steel workers, who expected to leave school into similar employment. All of which provided fertile ground for the development of such an "us and them" view of the world and the Marxist ideologies; of the class struggles of the proletariat and the bourgeois certainly resonated (Leutas, 2012; Westwood, 2014).

Marxism, although unnamed at that time, offered an emerging political identity that was only to grow as formal schooling came to an end in 1980 amidst the great restructuring of civil society

(Dahrendorf, 1990). Thatcher had been elected as prime minister, following the labour government's perceived failure to manage the unions and in turn prevent the social disruption surrounding an angry and bitter 'winter of discontent'. A winter characterised by multiple strike actions, as workers sought government support, in the face of the challenges of an increasing global economy. Thatcher had appealed to the masses; based upon a perception of her individual strength of character to stand up to the unions, along with a conservative mantra that emphasised individualism and the opportunity for personal wealth (Lopez, 2014).

Thatcher's neo-liberalism policies that favoured free-market capitalism and the 'survival of the fittest' route to prosperity introduced ever increasing competiveness in the market place (Luxton and Braedley, 2010; Navarro, 2007; Stevenson and Waite, 2017), allowing the entrepreneur to flourish, but increasingly caused others to fall by the wayside (Harvey, 2007; Saad-Filho, 2005; Steger and Roy, 2010; Ventura, 2012). This survival of the fittest policy, resulted in the wholesale closure of inefficient large state owned industries and in particular those that were struggling to remain profitable within a developing free global market (Weiss, 2011). In the researcher's home city of Stoke on Trent, this related to closures of the major employers of the area; the potteries, coal mines, and the steel works. Thus creating mass unemployment, and the researcher's and his peers' own inevitable unemployment on leaving school.

Those experiences led both to the neo-liberal capitalist business approach, and in particular Thatcher, an assured notoriety within the researcher's developing Marxist discourse. The researcher's youthful wisdom at that time saw "The Business Man" and the politics of business, being added to 'The Management' as the mechanisms and outlets by which the bourgeoisie oppressed, and in turn became the objects of political resistance. A positioning that only hardened further when the conservative government extended neo-liberal policies into healthcare at an early stage of the researcher's nursing career (Department of Health, 1989). Neo-liberalist healthcare policy was based upon the belief that an internal market created through the introduction of local purchasers of healthcare, would result in competitive tendering

between providers of healthcare thus driving efficiencies (Department of Health, 1989). Inevitably providers were required to demonstrate efficiency, cost containment and measured outcomes; as a result, the positivist sciences and the 'proof' of the random controlled trial carried disproportionate weight with purchasers, and thus marginalised concerns with concept such as care, compassion, love and relationships that are not easily measured or articulated (McAndrew et al., 2014).

The marginalisation of such concepts in deference for performance outcomes was reported within the Francis Inquiry into the care failures in Mid Staffordshire (Francis, 2013) and the following Berwick Report (Berwick, 2013). Both highlighting the loss of notions of care, compassion, responsibility and commitment amongst a drive and discourse for other more measurable outcomes. The marginalised nursing 'care' voice regained some air time for a while and was published in the high profile report by the chief nursing officer (Cummings and Bennett, 2012). In the more recent times of austerity, post the 2008 financial collapse (Baker and Filbeck, 2015), neo-liberal policy seems to have only resulted in harder business policy, and the value of the apparently unquantifiable has quickly become lost again (Burke et al., 2015; Reeves et al., 2014). Indeed a cursory read of the Department of Health (2015) paper on 'Culture Change in the NHS: Applying the Lessons of the Francis Inquiry'; will reveal that whilst the term 'compassionate care' is used frequently, the action statements very much relate to hard business practices of measures, outcomes and productivity. An observation that has certainly added to the researcher's motivation to continue to give voice to the concepts of nursing practice that have been marginalised. A stance that is arguably as much political, as it is altruistic.

The commencement of a psychiatric nursing career in North Birmingham in 1984, was also instrumental in the development of a conscious political identity and a frame of reference. That experience was of a hospital based training, which served the North Birmingham inner city heartlands of Handsworth and Lozelles, bordered by the prison district of Winson Green and some of the less salubrious areas of Edgbaston and Hockley. These areas to this day are

renowned for their high levels of black and ethnic minority populations, poverty and social deprivation; living evidence at that time (and to this day) of an ever widening societal gap. (Kawachi et al., 1999; Marmot, 2012; Preda and Voight, 2015; Wilkinson, 1996; Whitehead, Townsend, Black, and Davidson, 1988). An experience that hardened the sense of injustice within the researcher, and a concern with the unheard and oppressed voice; of the alternate story that needed to be told.

The transient nature, younger age profile and dis-enfranchised nature of the inner-city populations, was also very much in evidence in the staff profile of the training hospital, and as a result it attracted a dynamic and vociferous workforce eager for the changes and the 'revolution' of the era. A culture of the riot in the streets was very much metaphorically alive within the psychiatric training institution; creative ideas, change and at times very eccentric staff and ideas, was very much the norm. Within the training hospital and amongst the researcher's peers that discontent and desire for change was expressed through the voice of the antipsychiatry commentary offered by Lacan (Lee, 1990), Szasz (1987), Laing (Thompson, 2015) and Goffman (1968). This challenge to the established knowledge bases of psychiatry was very much the cultural discourse of the hospital at that time. A message that was ripe for the researcher's hearing, giving voice to a growing suspicion and mistrust of formal power and the tools of knowledge, education and professional discourse by which it was exercised. Commentary that was supplemented much later through the researcher's Master's degree studies, with an introduction to the post-modern critique (Leffell, 2000; Lyotard, 1984), borne out of the linguistic turn, (Derrida, 1976), and of social constructivist insights (Wittgenstein, 2002) and inevitably to the Foucauldian commentary around power and discourse (Foucault, 1979, 1988).

Such personal narrative paints a picture of an active Marxist and Foucauldian influenced revolutionary, but such an image is far from the relative reality of the researcher's positioning; a general contentment with life, and a more overriding concern with family, has always consigned such political and philosophical ideology to merely a cognitive frame of reference,

or at most a simmering pot on the back burner. None the less it is the frame of reference from which knowledge, politics, science and healthcare provision are appraised by the researcher; the base and viewpoint from which commentary is offered. It is the frame of reference from which this study is developed, both in the initial interest in the research subject, but also in the means by which the phenomena has been investigated and undoubtedly as Mills (2000) would have observed, in how the findings have been perceived, analysed and reported.

1.2.2 The development of a clinical interest in human relationships in the context of psychiatric nursing

The great contrast to the civil and political unrest and the divisions surrounding the researchers formative years, was found in the home life of a settled, large and very extended family; a family that was connected, content and very much concerned itself with the care and relationships within it. Experiences that perhaps belie a more altruistic concern with investigating the research subject, than it does the political. Thus, whilst society fought for individualism, civil rights and scrambled for business wealth and prosperity, the researcher's concerns were always much more attuned to feminist and collectivist commentaries of the importance and influence of relationships, of the more scientifically abstract concepts such of those of care, compassion and love (Ellemers and Haslam, 2012; Gillingan, 1982; Held, 2006; Hofstede, 1980; Kittay, 1999; Noddings, 1984; Ruddick, 1983; 2002; Tajfel and Turner, 1986).

Unremarkably then on entering into a nursing career; the professional insight offered that the relationship between nurse and patient held potential therapeutic value was of no surprise to the researcher. As such there was an early draw and attunement to the theoretical models of nursing that emphasised the therapeutic impact of the nurse –patient relationship; Barker (2001); Newman (1994); Parse (1997), Peplau (1952), Travelbee (1971) Watson (1979). Of all the models, it was the UK centric writings and availability of Peplau's (1952), and later Barker's (2001) writings, that particularly struck a chord with the researcher's predilection

towards relationship based care and treatment, with their assertions that it was the use of the relationship itself, by which nursing influenced health change,.

Throughout an extended career, technical modes of interaction were explored and utilised: From behaviourism and its translation into the token economies of the rehabilitation wards in the early 1980's (Baker, 1988; Watson, 1997); supporting the implementation of psychoanalytical interventions in the work of interpretative art and dream therapy colleagues (Elliott, 2015); observing the humanist informed approaches in supporting the discovery of a Self (Maslow, 1943; 1999) and in turn the utilisation of the non-directive counselling style of Rogers (1965). Theories of cognition and processing were explored and cognitive behaviour therapy techniques learnt (Herbert and Forman, 2011; Wills, 2013). Then much later the post-modern, social constructivist interventions of narrative therapy (White, 1990) and solution focused brief therapy (Berg, 1994; De-Shazer, 1985; De-Shazer et al., 1986; McAllister, 2007) were added to the technical armoury of intervention.

Throughout that history, whilst there remained an awareness of the need for a nurse-patient relationship to be formed, it was the interventional technique of the therapy and the subsequent technically driven interaction that was always emphasised. It was the skills of implementing that technique that occupied the training manuals and the professional focus. The nurse-patient relationship, despite an early career attunement towards it, had seemed to lose its centrality in the consciousness of the researcher, amongst the technicalities of learning various psychotherapy techniques. Given an ever increasing plethora of reportedly successful techniques it inevitably became suspected that there were common factors at play, and the work of Hubble Duncan and Miller (1999); Kirby, (2003); Norcross, (2002); Norcross and Lambert, (2006); and Sampaio et al., (2015) confirmed such suspicions. Unsurprisingly, one key common factor was, as Peplau (1952) and Barker (2001) had noted, was the establishment of a relational bond that was one of the key predictors of therapeutic change. Whilst much of this research activity had considered the psychotherapy encounter, rather than the psychiatric nurse-patient encounter within an acute psychiatric ward, the resonance with an early

attunement to the therapeutic benefit of a meaningful relationship was clear, and an interest and focus on the relationship itself was reignited.

There was a re-engagement with the assertions that the therapeutic relationships between psychiatric nurses and service users is the cornerstone of the work that they perform (Brown, 2013; Chambers, 2005; Gardner, 2010; Hewitt and Coffey, 2005; Wright, 2021; Wyder et al, 2015). Furthermore, it became increasingly clear that service users expect and note the value of such therapeutic relationships, and have described it as an essential component of their recovery (Hopkins, Loeb and Fick, 2009; Wyder et al., 2015). However, it is noted that the ability of psychiatric nurses within the context of contemporary acute psychiatric inpatient services to form such relationships has been questioned in more recent years (Nolan, et al., 2011; McAndrew et al., 2014; Shatwell et al., 2008; Wright, 2021). Broader changes in psychiatric care towards a community orientated service, has led to a reduction in acute psychiatric hospital beds, resulting in a higher throughput and a concentration of those with higher levels of acuity and those requiring compulsory detention (Brown, 2013; Cleary, 2003; Wyder et al 2015). This changing picture appears to have subsequently driven a problem focused approach to nursing research; research that has systematically focused upon the identification of the barriers to the establishment of a 'therapeutic relationship' (Brown, 2013; Cleary et al., 2012a). Hewitt and Coffey (2005) observed that such language had in turn led to the development of a negative and dominant discourse, that therapeutic relationships cannot exist within an acute psychiatric setting; and yet they go on to observe that despite this, reports of their existence still prevail and are regularly recounted in both service user and nursing commentary (Cleary et al, 2012b; Wyder et al. 2015). Such a negative discourse on the impossibility of such relationships is overshadowing an understanding on the nature and process of how those therapeutic relationships are indeed formed, and subsequently developed within a contemporary acute inpatient settings (Cleary et al (2012b). As Pazargardi et al. (2015) observed they have become hidden from view, or as Cleary et al. (2012b) noted; the everyday achievements of skilled acute psychiatric nurses in forming therapeutic

relationships have become unrecognised, undervalued and undermined. A concern, if as O'Brien (2001) had observed, it is the way in which the therapeutic relationship is articulated that will determine the meaning of the therapeutic relationship for future generations of psychiatric nurses.

Zugai et al. (2015) went on to note that without a concerted focus and an active discourse surrounding the therapeutic relationship, the concept was being annexed in deference for the concrete language and concepts of expertise, risk management, illness assessment, and medical stabilization. Furthermore if postmodern linguistic, and social constructivist beliefs in the importance of language in the construction of a reality are to be engaged with (Derrida, 1976; Wittgenstein, 2002), then the significance of a loss of 'therapeutic relationship' from the discourse of psychiatric nursing is indeed of concern, if the centrality of therapeutic relationships and its place in the reality of acute psychiatric nursing and service users is to prevail.

Additionally, without an ability to describe and articulate the relational activity, arguably the specific labour of nurses; arguably the contribution of acute psychiatric nurses to treatment, risks becoming lost within a healthcare economy that demands transparency in relation to activity and its purpose (McAndrew et al., 2014).

Furthermore, in recognition of Benner's (1984) seminal work detailing the development process of expert nursing practice; from novice to expert, and if indeed the therapeutic relationship is the cornerstone of psychiatric nursing practice (Hewitt and Coffey, 2005) unless psychiatric nurses can give voice to their actions it becomes difficult to identify the specialist training and development needs of future generations of 'expert' nurses. It is therefore of significant interest to psychiatric nursing to understand and record the expert insights and skills they hold with respect to their relationship endeavours. The rationale for this study is rooted within these three contemporary and relevant issues and is summarised in the aims and objectives of this study in table 1.1 overleaf.

Table 1. 1 Aims and objectives of this thesis

Aim	**To shed light on the insights nurses have into the formation of the therapeutic nurse- patient relationship within acute psychiatric wards**
Objectives	To give voice to an acute psychiatric nursing discourse of the therapeutic relationship
	To articulate the labour of acute psychiatric nurses in respect of the therapeutic relationship
	To identify the skills and competencies associated with the formation of the nurse-patient relationship in acute psychiatric settings in order to inform the future development of expert practice within acute psychiatric care

1.3 Theoretical understanding (Chapter 2)

Chapter 2 commences with a consideration of the ontological and epistemological debates that surround the patient-nurse relationship, and presents an argument that there exists a dynamic movement amongst nurses, from the realist to the relativist, which is dependent upon the relational challenges facing them. Therefore an argument for ontological pluralism is made. Additionally, nurses are then as equally diverse and dynamic in how they seek to understand their relationships. It is observed that there is an equal engagement with scientific explanations of their relational endeavour as there is the social and intuitive. Or at least any engagement with the scientific is then subject to an appraisal and reconstruction based on social and cultural factors. An observation of an epistemological stance that approximates to that of the critical realist is offered.

The chapter moves on to consider the interwoven relational theories of psychotherapy and clinical psychology with those of psychiatric nursing. An observation is made that

psychotherapy research has demonstrated that common factors exist within a relationship that is considered to be therapeutic: noting a tripartite arrangement of relational bond, goal and task agreement (Bordin, 1979). It is noted that it is a definition that has freely been adopted into the discourse of what constitutes a therapeutic relationship within psychiatric nursing (Wright, 2021). That is despite an observation of some notable differences in the therapeutic functions and objectives of acute psychiatric nursing, and in spite of the adoption of much broader relational roles in nursing than those within psychotherapy; for example roles akin to that of a parent or custodian of safety (Peplau 1952). As a result of such an observation, an argument is presented that a simple transfer of psychotherapy informed tripartite definitions of the therapeutic relationships of acute psychiatric nurses is potentially misplaced, and it is perhaps the more singular Rogerian (Rogers, 1965) notion of the intrinsic therapeutic benefit of a relational bond that offers a closer fit with acute psychiatric nursing's understanding of the defining characteristics of the therapeutic relationship.

Nursing theory is considered, and two major paradigms are observed, those of nursing task and those of the interpersonal elements of nursing. Within such an interpersonal paradigm, the contribution of the nursing theorist are noted, and in particular the contribution of Peplau's (1952) theory of interpersonal relationships. A theory that purported that the relationship between patient and nurse was instrumental in the patient's recovery from psychiatric and psychological illness. A position which Barker (2001) built upon, suggesting the therapeutic benefit of the relationship was beyond merely that of a recovery from illness but developed the patient's narrative, sense of understanding and personal meaning of what constitutes illness and wellness. As a result, it is argued that a combination of the two is required to frame a contemporary notion of the interpersonal relationships of nursing.

Despite a developing theoretical frame from which the therapeutic relationship may be considered, the how of the formation of such relationships, appears much less represented within theoretical texts. Therefore a proposal is made, that it may be possible to frame those endeavours within the theoretical constructs of interpersonal communication, and its reference

to two broad domains of verbal and non-verbal behaviour and the sub categories within each. Or alternatively through the interventional strategies employed by nurses, and to this end Heron's (2001) six category intervention model is offered as a potential frame by which the 'how' can be further understood or framed.

1.4 Literature search (Chapter 3)

A comprehensive literature review was undertaken to identify the extent of existing research in relation to the phenomenon of how acute psychiatric nurses establish a therapeutic relationship and this is presented in chapter 3.

The most pressing theme from that search was that there was a paucity of research that records how acute psychiatric nurses establish a therapeutic relationship within an acute psychiatric inpatient setting. In particular, in terms of the United Kingdom the contribution is indeed meagre. It is this theme in particular that has set the focus for this study. Mostly the studies originated from other parts of Europe, Australia, America and Canada. Also, of the limited studies identified (twelve), three were meta-synthesis whose focus was much broader than that of the relational endeavour of nurses, and offered more a scrutiny of what acute nurses do within an acute psychiatric ward, with a subsection detailing the therapeutic relational activity. The chapter goes on to present that when those subsections were examined more closely, it was clear that conclusions were being drawn from the same very small number of studies that had also been identified in the literature search presented within this paper, or they included studies based on a much wider inclusion criteria in terms of date, which raised questions as to their relevance to a contemporary setting.

A presentation of the systematic approach to data extraction is described, and the findings are then presented within categories based on frames offered both from the literature search itself but also based on potential categorisation frames that emerged from the review of theory. All present an opportunity to reference the state of knowledge to date in relation to the phenomena, and offer a reference point for the findings of this study.

Of the primary research studies from the literature analysis all are noted to be relatively small scale and highly contextual to one or two ward environments, and undoubtedly the country of origin. Whilst this is often the nature and pragmatism of qualitative study (Streubert and Carpenter, 2011), as indeed it will be with this study, knowledge grows from the insights of a multitude of such studies (Tappen, 2016). Given the very limited number of studies to date, that have examined the phenomena within a contemporary acute inpatient setting, the literature search concludes with an assertion that there is a clear gap in an understanding of how acute psychiatric nurses set about forming a therapeutic relationship, and concurs with Delaney and Johnson (2014) assertion, that the relational efforts of acute psychiatric nurses remain poorly understood and insight remains to a large extent with those with lived experience of the phenomenon, and further exploratory work into the phenomenon is required; and in particular research which seeks to give voice, to the lived experiences of acute psychiatric nurses themselves.

1.5 Methodology and methods (Chapter 4)

Descriptions of the ontological and epistemological positioning of the research, the methodology and methods, and the rationale for the choices made are offered within this chapter.

An ontological argument is offered that presents a relativist stance and in turn an epistemology that suggests the need for a full engagement with the human lived experience and the human understanding and constructs of the phenomenon. A phenomenological methodology is presented, because of its particular focus upon collating and giving voice to the lived experience of participants (Denzin and Lincoln, 2005; Parahoo, 2014). In turn the paper will contrast the two traditions of Heideggerian and Husserlian phenomenology, presenting an argument for the decision to utilise a Heideggerian interpretive phenomenological approach.

Given the exploratory nature of the research; an interview format is proposed that allows individuals to explore and express their views and perceptions in depth, to interact with the

researcher and the data, to mutually clarify and interpret information, and through discussions arrive at a mutually constructed perspective of the phenomenon (Laverty, 2003; McConnell Henry, 2009).

The chapter goes on to describe an interviewing method pioneered by Dick (2017), entitled convergent interviewing. An introduction to the method is offered alongside a description of the analytical strategy that is integral to the method. The discussion moves ever into greater detail of the research strategy and informs the reader that the location of the study is the acute psychiatric wards of a single NHS organisation, and the defined population as the registered psychiatric nurses within those wards. A purposeful maximum variation sample is offered as a descriptor of the sample taken, and the means by which that was achieved is recorded.

Further details of the operational and function elements of data capture, recruitment, data storage, participant welfare, quality control and the mitigation of bias are all offered, before the chapter concludes with a summary of the key components of the research strategy

1.6 Results (Chapter 5)

The results are presented to the reader with a narrative account of the raw data, divided into the six major themes and associated sub themes that emerged from that account. Whilst that account is interpreted, and attaches meaning, in order to bring that narrative to life, it remains close to the raw data and retains the words of the participants to offer an account of the phenomenon as it unfolded to the researcher through the research process.

1.7 Discussion (chapter 6)

The discussion considers the major themes identified in the light of existing literature, theory and contemporary commentary. As a result, an assertion is offered that the major themes identified from this study are unlikely to be idiosyncratic findings. Although a need for further consideration and affirmation is suggested in respect of two particular findings; the notion of prioritise steps to manage and form a team orientated therapeutic relationship over the one to

relationship; and how the revelation of an active management of the pressures and challenges of acute psychiatric wards fit as a strategic component of forming the relationship.

This chapter also revisits the theoretical perspectives in the light of the research, and presents an argument that the therapeutic relationships of acute psychiatric nurses are more accurately defined by the singular notion of the presence of a relational bond, than they are by the tripartite arrangement observed in the psychotherapy relationship of relational bond coupled with both goal alignment and task agreement (Bordin, 1979). Furthermore, it is suggested that a theoretical understanding of how acute psychiatric nurses form a relationship remains underdeveloped and knowledge remains at a concept/construct identification stage, of which this study contributes further.

Finally, the limitations of this exploratory study are considered, and a suggestion is made that the findings should be accepted as a tentative account of how acute psychiatric nurses understand how they form the therapeutic relationship. Suggesting the need for further appraisal and synthesis across a much wider context than the localised nature of this study.

1.8 Conclusion and recommendations (chapter 7)

Finally, this thesis draws together the main conclusions from this study and makes recommendations for future practice, education, theory development and of the need for further study and the focus of such investigations.

Chapter 2

Theoretical and Philosophical Underpinnings

2.1 Introduction

In keeping with the subject material of this thesis; this chapter explores the theoretical perspectives associated with the therapeutic relationship between psychiatric nurses and patients within acute psychiatric wards; arguably the very cornerstone and central tenant of the work that they perform (Brown, 2013; Gardner, 2010; Hewitt and Coffey, 2005; Wyder et al., 2015).

This examination commenced with a broad iterative review of theory and commentary utilising library catalogues and subject searches, locating broad theoretical perspectives in relation to the subject material. Like Browne et al. (2012) and Bender (2018) noted, this quickly reveals, that at any level of theoretical investigation into the relationships of acute psychiatric nurses, it is very clear early on, that there is a degree of complexity that is bewildering, and is often theoretically contradictory. Very broad and contradictory ontological perspectives are presented within the general texts that surround the nurse-patient relationship, with descriptions of the interpersonal roots of nursing planted both within the philosophy of modernism and its link to the bio-psychological sciences, and at the same time recording a wide acceptance of the post-modern critique, and its relationship to constructivism (Munhall, 2001). Equally the construction of knowledge of the nurse-patient relationship is said to borrow freely from the sciences of medicine and psychology (Munhall, 2001), whilst at the same time offering liberal references to the knowledge of nursing being derived from intuition, art, socialisation and culture (Benner, 1984; Carper, 1978; Jenner, 1997; Finfgeld-Connett, 2008; Weaver and Mitcham, 2008).

Nursing theorists have presented multiple models of interpersonal work that have reflected the complex social, health or scientific commentary and the values of the era of their inception (Murphy et al., 2010), and have attracted criticism that such commentary has been more of a reflection of personal interests, a statement of values and of wished for practice, as much as they are a reflection of actual practice (Draper, 1990; Kenny, 1993).

Never the less, these are indeed the theoretical commentaries that surround the interpersonal work of acute psychiatric nurses, and despite such complexity, Rodgers (2011) insisted that nurses did indeed need to locate their research endeavours within the wider knowledge base of the profession, its philosophies and its theoretical understandings, if the profession is to systematically grow the 'science' of nursing. Rodgers (2011) went on to note that otherwise both practice and research, become isolated individualistic endeavours. Therefore, this chapter with reference to theory and contemporary literature, interpreted through personal reflection, will present a proposal of a theoretical frame that includes reference to:

- The ontological and epistemological perspectives of the therapeutic relationships of nursing
- The contribution of the sciences of psychotherapy and psychology to the nursing discourse of the interpersonal relationship
- Nursing's theoretical accounts of therapeutic relationships
- A consideration of a theory by which the 'how to' of the therapeutic relationship may be considered and framed

2.2 Acute inpatient psychiatric nurse-patient relationships: ontology and epistemology

The progression of nursing knowledge and enquiry into the interpersonal nature of nursing and psychotherapy has been influenced by the grand philosophical perspectives of modernism and post modernism (Johnson and Webber, 2010). Earlier studies of nurse-patient relationships, in keeping with a scientific era, examined the phenomena from a modernistic perspective, a perspective characterised by an underlying assumption that scientific methods would uncover, and ultimately describe the underlying and universal truth of phenomena (Rolfe, 2000). Such a scientific perspective very much resonates with the bio-medical and psychology influences that acute psychiatric nurses are exposed to in their day-to-day nursing practice, an

environment characterised by the universal truths of what constitutes illness and wellness (McAndrew et al., 2014; Munhall, 2001).

For example Peplau's (1952) pioneering model of the interpersonal relationships of nursing, founded her understanding of the purpose and nature of the relationship on the universal truths offered by the sciences of developmental psycho- analytical therapy (Barton-Evans, 1996; Sullivan, 1953) and of the attachment deficits associated with Human Attachment Theory (Bowlby, 1969; 1975; 1981), therefore the therapeutic nursing relationship was seen as correctional in nature, that required the adoption of roles such as guides, teachers and parents until the patient recovered sufficiently to work alongside (Alligood, 2014). Whilst acute psychiatric nurses may work in an environment where relationships are influenced by the correctional aims of their work (Bolsinger et al., 2020); contemporary notions of individualism, autonomy, choice and personally defined views of good health and recovery, also remain a key reference point in psychiatric nursing work (Barker, 2001; Caldwell et al. 2010; Lloyd, 2007). In the current millennia both patients and nurses interact and exist within a health service which demands care reflects the patients' unique needs, goals and visions of recovery (Cody and Mitchell, 2002; Department of Health, 2011).

Such individualistic notions, and the concept of a personally constructed account of recovery, are at odds with the universality of a scientific perspective of wellness (Bolsinger et al. 2020). Such perspectives of personally constructed accounts of recovery resonate much more with the postmodern critique of the sciences; a critique which has argued that reality is not scientifically uncovered but is socially constructed (Wittgenstein, 2002) through language (Derrida, 1976), and bound by culture, history and the dominant discourse of that culture (Foucault, 1988). Johnson and Webber (2010) observed that the therapeutic endeavour of the nursing relationship has shifted from the correctional to reflect such insights, and many interpersonal models of nursing since Peplau (1952) has gone on to emphasise the nature of the relationship, in terms of a partnership, of personal connectivity, mutual respect, equality and at times a transpersonal or spiritual understanding. All of which serve in a mutual

endeavour to co-construct personal understanding and meanings of illness, recovery and notions of wellbeing (Barker, 2001, 2009; Parse, 1997; Travelbee, 1971; Watson, 1979).

Thus, the nature of the nurse –patient relationship and its therapeutic purpose as Cody and Mitchell (2002) observed is ontologically pluralistic, and at times appears to be unstable in its' state of being, moving from the corrective to the facilitative and vice versa. This instability within the nature of the relationship, has been observed to be evident within the relational behaviours of nurses within the acute psychiatric inpatient environment (Cleary, 2003; Cleary et al., 2012b), the behaviours have been described as multifaceted and quite often contradictory in their display and nature; moving from supportive and facilitative to correctional and containing (Dziopa and Ahern, 2009; Thibeault, 2016). Browne et al (2012) offered a view that such a multifaceted nature to the nursing relationship was a necessity born out of the great need for a variety of roles and relationships within nursing, in order to match the multitude of situations encountered, and any attempt to rigidly define the nurse relationship would cause greater confusion. Nurses themselves also appear inconsistent and contradictory in respect of offering a definitive ontological positioning on the therapeutic relationship; they will simultaneously report how the relationship is utilised to enhance the success of a bio-medical agenda through expanded roles of prescribing, diagnostic assessment and application of the Mental Health Act (1983) and then will equally report such endeavours offer a barrier to the establishment of the relationship (Coffey and Hannigan, 2013; Hudson and Webber, 2012; Hurley and Linsley 2006; Jones et al., 2011; Latter et al., 2011; Luker et al., 1998, Nolan et al., 2001; O'Brien and Kar, 2006; Patel et al., 2009). Furthermore Tschudin (2006) questioned whether nursing in its day-to-day practice actually concerned itself with any defined philosophical stance, and observed that along with codes of conduct, laws and models of practice it is given very little consideration in comparison to the intuitive response nurses make to any given situations. Turner (2012) has described such multiple 'modes of being' as a position of ontological pluralism. Indeed an acceptance of the ontological plurality of nursing has been seen as a necessity if the complexities of nursing are to be understood fully (Kim, 2007; Omery, Kasper and Page, 1995).

Such observations of the ontological complexity of the patient-nurse relationship appears to mirror the same ontological dissonance that has been observed to be inherent within the contemporary bio-psychosocial/ spiritual model of healthcare (Ghaemi, 2010; McManus 2005). A model that has become the overarching model of healthcare by which nurses have now practiced within for the last 40 years (Bolton and Gillett, 2019). McManus (2005) observed that the molecular, chemical and physics of the bio are not ontological comfortable bed partners of the mind, social and spiritual. Bolton and Gillet (2019) observed that shifts in the state of being within healthcare staff frequently occurred as a result of such ontological dissonance. Bolton and Gillet (2019) went on to observe that how nurses then made a decision to shift between the differing modes of being was mostly unclear, but went on to note that such shifts, probably related to some internal evaluation of the nature of the condition being treated or the stage of that condition. Such is the dynamism between the states of being in actual practice, Bender (2018) concluded, that to try and definitively fix the nature of nursing to a single reference point was a mistake, and that it is such relational dynamism that is in itself a defining feature of the patient-nurse relationship.

In keeping with the ontological pluralism of the patient-nurse relationship, the way in which nurses understand the nature of their relationships, would appear equally pluralistic. For example; Carper (1978) argued that nursing creates knowledge through four patterns of contradictory learning, science, art, ethics, and personal knowledge. White (1995) also suggested a fifth mechanism of the socio-political pattern of learning. Meanwhile Munhall (2001) drew on the work of Kneller (1971), who identified five types of knowing, the revealed, the intuitive, the rational, the empirical and the authoritative. Munhall (2001), like Benner (1984) also made reference to how the intuitive and expert nature of nursing developed through a process of socialisation, enculturing and an internalisation of the personal experience of their work. Vinson (2000) also observed the pluralistic nature by which knowledge was imparted within nursing, noting that knowledge development occurred equally through the medium of social learning and apprenticeship, as much as through the formal teachings of the institutes

of higher education. Munhall (2001) concluded that nursing's way of knowing and constructing knowledge was from the freely borrowed truths of other scientific disciplines but equally from socially constructed notions of the art of nursing.

Olsen and Gjevjon (2017) in reporting a debate of whether nursing had a claim to epistemological and ontological uniqueness, presented an argument that it could not; as all knowledge was borrowed from, and shared with other scientific disciplines. The counter argument presented, was that it was indeed unique, and that uniqueness stems from how nurses integrated and constructed such a diversity of borrowed knowledge into a nursing discourse. Mortimer-Jones and Fetherston (2018) reflecting such a notion, constructed the term 'nursification', in an attempt to describe how nurses constructed nursing knowledge, based upon subjecting the bio-scientific to an active association with nursing theory, culture and their lived experience of practice; as Issac (1990) noted: a scientific ontology with a constructivist epistemology.

These notions of 'nursification' resonate very much with descriptions of the Heideggerian hermeneutic commentary (McConnell-Henry et al. 2009). Heidegger (Cooper, 1996; King, 2001) presented that knowledge of phenomena (of the mind) could not be understood through the natural sciences in the same way as that of the body. Heidegger's arguments centred on a belief, that knowledge of a universal truth of such matters was impossible because of the influence of the surrounding culture, existing knowledge and the interaction with any method by which it was uncovered and interpreted (King, 2001). Knowledge is thus constructed following the interpretation of concepts in the light of existing understanding, culture and discourse, and through the interactive process of uncovering that knowledge in the first instance (McConnell-Henry et al 2009). A position that reflects Habermas's philosophical presentation of critical theory, a viewpoint that accepts there indeed may be underlying 'truths', but the social construction and interpretation that surrounds them make it impossible to reveal such truths (Lafont, 2016). A philosophical perspective that resonated with the critical realism of Bhaskar (1979)

In essence Heidegger (McConnell-Henry et al., 2009) and Habermas (Lafont, 2016) offers a philosophical description of Mortimer-Jones and Fetherston's (2018) observation of a 'nursification' of the bio-scientific and thus the critical realist perspective offers an epistemological frame of reference by which knowledge of the therapeutic relationship of nursing and the state of being is understood and can be revealed. Indeed the critical realist or hermeneutic perspective has increasingly been utilised to offer insights into complex nursing phenomenon (Littlejohn, 2003).

Accepting Maxwell's (2013) suggestion of constructing visual aids to add clarity both for the researcher and the reader, a summary table of both the ontological and epistemological perspectives adopted for this study is presented below; see Table 2.1 overleaf.

Table 2. 1 Ontological and epistemological perspective underpinning this study

Ontology		
The relationship is characterised by dynamic movements between positions of authority, within a modernist /scientific frame of health and that of a mutuality, influenced by post-modern /social constructive views of health and well being		
Modernism		**Post Modern**
The bio-medical and psychology informed function and the nature of nursing work influences practice and in turn the nature of the patient-nurse relationship There is a language and discourse of diagnosis, illness, professionalism, expertise and deficit correction	**Situational Influencers** Condition being treated, the stage of the condition and the nature of the task at hand. The personal intuition of the nurse, their socialisation and enculturing.	Informed by the psycho -social and spiritual functions of nursing practice There is a language And a discourse of the personal construct of illness, recovery and wellbeing.
Therapeutic relational behaviours are firmly boundaried, parental, or teacher focused, correctional in nature, exercised through legitimate authority. Driven by defined notions of illness and recovery.	Dynamic shifts in the nature of the relationship ⟷	Therapeutic relational behaviours are characterised by mutuality, and driven by notions of personally constructed goals of wellness
Epistemology		
Knowledge is drawn from the biosciences of medicine and psychology which is subjected to “nursification” presenting an approximation of the critical realist perspective		

2.3 Psychotherapy, and psychology influences

It has been suggested that the interpersonal theories of psychiatric nursing have been inextricably linked to the theoretical positioning and understanding of psychology and psychotherapy; interwoven like a double helix, and to understand those relationships requires a consideration of their influence (Kirby, 2003; Winship and Hardy, 2013). Although it has been observed that whilst psychiatric nursing in its broadest sense, may have widely subscribed to the technical and relational skill sets of the various psychotherapies (Delaney and Handrup, 2011; Ryan and Hurley, 2018), contemporary acute psychiatric nursing has been observed to remain an outlier in that respect, and has not so freely engaged with the discourse of psychotherapy (Whittington and McLaughlin, 2000; Winship and Hardy, 2013). Awty et al. (2010) observed that the psychotherapies seem to have had little representation or impact in the day-to-day work of the inpatient psychiatric nurse, and such technical endeavours are often seen as the responsibility of the visiting expert, rather than the domain of the acute psychiatric nurse themselves. Despite that, acute psychiatric nursing has not been immune to the impact of the wider association of psychiatric nursing discourse with that of psychotherapy.

In the light of various modes of psychotherapy demonstrating their effectiveness, psychotherapy research turned its attention to identifying the common factors across the therapies that are associated with the therapeutic benefit observed. A consensus appears to have emerged that a tripartite arrangement of the establishment of a relational bond between participants alongside the establishment of task and goal agreement are the greatest predictors of therapeutic change within the psychotherapy encounter (Hubble Duncan and Miller, 1999; Kirby, 2003; Norcross, 2002; Norcross and Lambert, 2006; Sampaio et al., 2015). Whilst the research offers a tripartite description of the therapeutic relationship, it is the much more measurable concepts of task and goal agreement (the alliance); that has gathered traction and focus within psychotherapy research; perhaps unsurprisingly so within a western health economy that holds great store, and value in the measurable (Bordin, 1979; Elvins and Green, 2008; Hougaard, 1994; Luborsky, 1984; McAndrew et al., 2014). It has since been observed

that the descriptions of this ‘alliance’ or ‘working alliance’ has entered contemporary discourse as an interchangeable reference to the therapeutic relationship itself (Moreno-Poyato et al., 2017; Wright, 2021) and arguably the concept of relational bond is potentially being lost from the discourse of what constitutes a therapeutic relationship. Indeed in Wright’s (2021) contemporary review of the concept of therapeutic relationship in psychiatric nursing, it is noted that measures of the therapeutic relationship are focussed upon the degree to which such alliance exists.

Priebe and McCabe (2006) noted that the relationships and the function of it within acute psychiatric settings differ considerably to those found in the sessional psychotherapeutic encounter. McAndrew et al. (2014) noted that in response to the dominant bio-medical treatment ethos within acute psychiatric settings, nurses were required to be involved in coercive treatment regimes, legal detention, and the requirement to respond to behavioural symptoms of acute mental illness. Such realities have made it difficult to translate such psychotherapeutic notions of the working alliance into the therapeutic relationships of acute psychiatric nursing (McAndrew et al., 2014; Priebe and McCabe, 2006), and with such a discourse emphasis upon such an alliance, this has inevitably led to a developing discourse that therapeutic relationships cannot exist within an acute psychiatric ward (McAndrew et al., 2014). Cleary et al. (2012a) argued, that this negative, but increasingly dominant discourse on the impossibility of a therapeutic relationship, is over shadowing the everyday achievements of skilled acute psychiatric nurses in forming a therapeutic relationships with acutely ill patients in very difficult circumstances. Hewitt and Coffey (2005) also observed that the testimonies of both patients and staff offered evidence of a continued existence of positive and therapeutic relationships, between patients and nurses, despite this growing discourse that suggests otherwise. It is arguably pertinent to revisit the interchangeable use of ‘working alliance” as a term for therapeutic relationship, and perhaps re-state the initial Rogerian concept of the establishment of a relational bond, as also being a central tenet of the therapeutic relationship (Rogers, 1965). Indeed a concept that Wright (2015) suggested may stand up as the singular

defining characteristic of therapeutic relationship within the more acute psychiatric practice settings. Certainly Cutcliffe et al. (2015) observed, that for acute psychiatric nurses, the dominant discourse adopted from psychotherapeutic commentary is indeed that of the humanist, person centred perspective; of a belief that an individual's recovery is supported through the intrinsic value of a relational bond built upon an unconditional, empathic and trusting relationship (Maslow, 1999; Rogers, 1965). Indeed the notion of establishing and maintaining a relational bond is the frame that has been argued to most characterise acute psychiatric nurses' own understanding and definition of the therapeutic relationship and their endeavours (Barker, 2001; Cutcliffe et al., 2015; Wright, 2015).

Acute psychiatric nursing differs in its contexts to psychotherapy, and in particular in the wide role functions that nurses undertake within their day-to-day practice. Peplau (1952) recorded a number of contrasting but therapeutic roles undertaken by nursing, from care giver, parental, teacher, advocate, guide and co-worker amongst others. Howk (1998) was later to describe roles of stranger, surrogate parent, resource person, teacher, counsellor, and leader. Clarkson (1995), whilst offering a wider commentary than nursing also suggested five types of therapeutic relationship: the working alliance, the transferential/ counter-transferential, the reparative / developmentally needed (parental), and the interpersonal and the transpersonal (affinity and connectedness). This notion of complexity, fluidity and at times opposing relational roles resonates considerably with the observed practice of nurses within the acute psychiatric environments reported by Thibeault (2016). This questions further whether the defining characteristics of task and goal agreement, identified within the therapeutic relationships of psychotherapy, can equally translate to a defining characteristic of the therapeutic relationship between acutely ill psychiatric patients and nurses, who adopt a variety of relational roles to satisfy a multitude of purposes. In conclusion, the therapeutic nurse-patient relationship within acute inpatient settings is perhaps better represented and underpinned by the more singular characteristic of relational bond, than the tripartite definition offered from psychotherapy theory (Bordin, 1979) .

In summary, it would seem that whilst Kirby (2003) observed an interconnectivity of the psychotherapy and psychology theories into the wider practice of psychiatric nursing, for the acute psychiatric nurse, the influence of such theoretical perspectives is limited. It is observed that it is the theoretical stance of the humanist school of thought, and the intrinsic value in establishing and maintaining a relational bond (Maslow, 1999; Rogers, 1965), that seems to underpin and define the therapeutic relationship within acute psychiatric nursing (Cutcliffe et al., 2015; Barker, 2001; Wright, 2015). Furthermore, it is observed that this concept of establishing and maintaining a relational bond potentially transcends the multitude of relational roles adopted by nurses, much more readily than the concepts of establishing goal and task agreement.

2.4 Nursing Theory

Fawcett (1984, 2000) argued that four paradigms had emerged from an observation of the isolated research interests of nursing; consisting of the Person, the Environment, Health and Nursing Care. These paradigms have offered anchors for the development of nursing theory. This has been further simplified into two broad paradigms of nursing interest: The health tasks of nursing and the interpersonal relationship elements of nursing (Crossan and Robb, 1998; Meleis, 1985; Rodgers, 2011). Whilst such a broad vision is an abstract and artificial process, it does, as the editors of nursing theory texts purport, offer an overview from which to start and build an understanding of a theoretical framework for nursing (Alligood 2014, Basford and Slevin 2003, Butts and Rich 2011, Fawcett 2000, George 2014).

The health tasks of nursing appear to include such concepts as; diagnosis, investigation and testing, direct interventions, assisting to do, environmental management, the nursing process, team-working and the multidisciplinary pathway. For example, Roper et al (1990) emphasised the tasks of nursing, describing its purpose is supporting individuals in achieving a range of daily living activities. Orem's (2001) self-care model also emphasises the interventionist nature of nursing in a model based on diagnosing and meeting self-care deficits. Whilst it is clear that

such models of nursing all include interpersonal relationship elements, the emphasis and detail of such models lie within the paradigm of the health tasks and outcomes of nursing.

More in line with the focus of this study, other nursing theorist have emphasised the establishment, therapeutic use and maintenance of the interpersonal relationship as the central component of nursing and its drive to effect health related change and wellness (Barker, 2001; 2009; Barker and Buchanan-Barker, 2005; Newman, 1994; Parse, 1997; Peplau, 1952; Travelbee, 1971; Watson, 1979).

In terms of nursing models relevance to nursing within the acute psychiatric wards of the United Kingdom two theorist stand out; Hildegarde Peplau (1952) and Phil Barker (2001). Peplau emphasised and brought to the fore a theoretical stance that it is the interpersonal relationship between nurse and patient that is the mechanism by which nursing therapeutically contributes to the delivery of health outcomes (D'Antonio et al., 2014). For Peplau (1952) those notions of health goals relate to the achievement of the objective states of wellness that have been presented by the psychoanalytical and attachment theorists of her time (Wheeler, 2008, Winship et al. 2009). More contemporaneously the bio-medical has replaced psychoanalytical and attachment discourse with its own notions of a restorative route to an objective state of wellness. Such ontological similarity has ensured that her theoretical stance remains relevant and very much in the consciousness of today's acute psychiatric nurses (Cutcliffe et al., 2015; D'Antonio et al., 2014; Hagerty et al., 2017; Thibeault, 2016).

However setting the therapeutic relationships of today's acute psychiatric nurse solely within supporting objective views of illness and health, ignores contemporary beliefs and demand for patient defined goals, personalised accounts of recovery, and the development of personal meaning and growth (National Institute for Health and Care Excellence, 2011). Such observations suggest that Peplau's (1952) model alone, is insufficient in framing the nature and purpose of the relationships of contemporary acute psychiatric nurses. If such

individualistic notions are indeed features of the therapeutic relationships of acute psychiatric nurses, it is necessary to consider nursing theory beyond Peplau.

Such notions of individualism; personal growth; meaning; and spirituality have been a growing concern in psychiatric nursing practice since the observations of Goffman (1970) and the antipsychiatry commentaries of Szasz (1965, 1987) and Laing (Kotowicz, 1997) alongside an increasing awareness of eastern spiritual philosophies ((Barker and Wilkin, 2006; Elder et al., 2009; McKenna et al., 2014). For example, Parse's (1997) model of human becoming, emphasises the function of personal growth; Watson's (1979) caritas based model identifies the spiritual care required of nursing practice; and Barker's (2001) tidal model of nursing offers an account of how the compassionate relationships of nursing helps an individual to discover and give voice to a personal narrative of their situation, and of the innate competencies they hold through their personal expertise of living their own lives. Barker influenced by his own philosophical investigations into constructivism and influenced by notions of individualism and the antipsychiatry commentary of Laing, very much saw mental illness as a personal spiritual crisis that required support to resolve through the medium of a meaningful relationships (Elder et al., 2009).

The adoption of both Barker's (2001) Tidal Model and its emphasis on the personal construction of meaning through the medium of the nurse-patient relationships; alongside Peplau's (1952) model in identifying how interpersonal relationships and roles are utilised in a process of recovery from ill-health, allows a comprehensive and United Kingdom centric, frame of theoretical reference that acknowledges the observed complexity, and at times apparent contradictory nature, of the therapeutic relations of nurses with patients within a contemporary acute psychiatric ward.

Whilst such a theoretical frame offers an anchor and reference point to this study, both models lack detailed reference of the 'how' in terms of how nurses go about forming such relationships. Bender (2018) noted that generally descriptions of the actualisation of the therapeutic

relationship remain absent from the literature and research field. Delaney and Johnson (2014), in reference to this, observed that the nature of how nurses form therapeutic relationships is poorly recorded and for the most part remains in the heads of the nurses and the teams in which they work. Indeed this observation is one of the principle rationales for the need to conduct this study. Despite the lack of such specific details of the how, there is a general consensus over time, that it is the non-verbal behaviours and communications alongside the verbal communications of nurses that enables the construction of a therapeutic relationship (Arnold and Boggs, 2019; Grazybowski et al., 1992; Kornhaber et al. 2016).

2.5 Interpersonal communication and the nurse-patient relationship

Much of the nursing literature attributes the building of the therapeutic relationship to the personal and professional qualities and attributes of the nurse (Buller and Butterworth, 2001; Dziopa and Ahern, 2009). For example, a simple review of the index pages of Kneisl and Trigoboff's (2014) account of contemporary psychiatric nurse practice, reveals references to such concepts as; respect, genuineness, availability, spontaneity, hope, acceptance, sensitivity, assertiveness, vision, accountability, advocacy, spirituality, empathy, critical thinking, self -awareness, trustworthy, listening, cultural competence, emotional intelligence, compassion, and social skill.

Whilst Buchanan- Barker and Barker (2008), with their description of the competencies required of the Tidal model, went some way to identifying how such constructs may be enacted; Browne et al. (2012) and Moreno-Poyato et al. (2017), assert that generally there is poor understanding and insufficient instruction of how such constructs are played out within the context of nursing practice. Despite such criticisms of this lack of specificity, a search of nursing practice texts will generally describe the verbal and nonverbal communication of nursing practices as the mechanism by which nurses enact such constructs, as they seek to establish the therapeutic relationship (Arnold and Boggs, 2019). This arguably in its simplest terms offers

a potential reference framework by which the 'how to' of constructing a therapeutic relationship could be viewed, but such a broad, two construct frame (verbal and non-verbal skills) is an over-simplified account of the phenomenon. Verbal communication itself can be subdivided into the spoken word and the para verbal; which can be further subdivided into; tone, volume and cadence (Adams et al., 2017).

Equally Birdwhistel (1952, 1973); Darwin (1965); and Mehrabian's (1972, 1981), seminal writings on non-verbal communication identified sub division of the non–verbal elements of communication, which were summarised by Hans and Hans (2015) into three essential concepts of non-verbal communication:

- Proxemics, the use of space and environment
- Kinesics, the use of body posture, eye contact, and gestures
- Haptics, the use of touch and body contact

Indeed, reference to such a framework of verbal and non-verbal communication is utilised to support acute psychiatric nurses in framing and reflecting upon their interactions in situations of actual or potential aggression (Crisis Prevention Institute, 2017). Utilising the theoretical concepts of verbal and non-verbal communication, not only offers a theoretical reference point for framing the 'how to' of the therapeutic relationship, it potentially offers a frame that has familiarity and existing meaning for the target audience of this study.

In order to refine the practice of such communication skills nurses have been encouraged to understand, refine and articulate the use of their interpersonal skills through clinical supervision (Bond and Holland, 2010; Butterworth et al., 1998; Care Quality Commission, 2013). The nursing literature predominantly identifies several models of such supervision (Bowles and Young, 1999; Farrington, 1995; Sloan and Watson 2001a). Most models offer a generalised view of the mechanism by which skill acquisition is acquired through the reflective process (Bernard and Goodyear, 2014), however Heron's (2001) Six Category Intervention Analysis

Model allows a focus upon examining and understanding interpersonal practices through a process of categorising the relationships strategies that are utilised in the helping relationship. Heron (2001) describes two broad domains, that of the authoritative and the facilitative; a striking resemblance to the two relational and contrasting domains of the acute psychiatric nurse noted earlier in this chapter. Heron (2001) then went onto describe a further three categories, within each of the domains respectively: the prescriptive, informative, confronting and the cathartic, catalytic and supportive. Burnard and Morrison (2005) offered the following synopsis with descriptors of each to add further clarity; see Table 2.2 below;

Table 2. 2 John Heron's (2001) Six Category Intervention Model

Domain	**Category**	**Nature of Intervention**
Authoritative	Prescriptive	To offer advice, make suggestions etc.
	Informative	To give information, instruct, impart knowledge etc.
	Confronting	To challenge restrictive or compulsive verbal or non-verbal behaviour
Facilitative	Cathartic	To enable the release of emotions through tears, angry sounds etc.
	Catalytic	To be reflective, to 'draw' out through the use of questions, reflections etc.
	Supportive	To offer support, be validating, confirming

(Adapted from Burnard and Morrison, 2005)

Tennant and Butler (2007) observed the influential nature of Heron's (2001) six category intervention analysis model in helping psychiatric nurses to understand and articulate their relationships with patients. Furthermore, reference of the model being used extensively as a mechanism for nurses to reflect upon the nurse–patient relationship, particularly within psychiatric settings, has been noted (Sloan and Watson, 2001b). Additionally, the use of the model, as a theoretical frame for investigation into the interpersonal nature of nursing has been

evident over a period of time (Ashmore and Banks, 2004; Burnard and Morrison, 2005; Digan, 2014; Toth et al., 2006; Morrison and Burnard, 1989)

Thus it is offered that Heron's model (2001) of six category intervention analysis offers a familiar theoretical framework; with an emphasis on examining the relational aspects of the interpersonal, whilst acknowledging the complexities and at times contradictory, nature of the interpersonal relationships that occur within acute psychiatric wards.

2.6 Conclusions

This review has argued that the nature (ontology) of the nurse-patient relationship within acute psychiatric settings is complex; that the relationships are often driven by contradictory purposes and the nature of them inevitably changes to reflect this (Cleary et al., 2012a). They may equally reflect the authoritative nature required of the corrective aims of healthcare, derived from the sciences definitive positions on health and illness; whilst equally displaying a facilitative relationship that strives to support individually and spiritually constructed version of health and illness. Thus, it is presented that the ontology of the relationship between nurse and patient is pluralistic. Nurses move freely between the states of being; driven either by intuition or by an unexpressed socially constructed schema that relates to notions of what is required in response to the condition or the stage of the condition being treated (Barker, 2001; Peplau, 1952).

Whilst nurses may look to understand those relationships through reference to the sciences (Munhall, 2001), any such reference is in turn subjected to a process of interpretation and alteration, a 'nursification' of those facts (Mortimer-Jones and Fetherston, 2018). It has been presented that nursing epistemology in relation to their relationships reflects both Heidegger's hermeneutic insights into how knowledge is constructed (McConnell-Henry et al. 2009) and approximates to a description to the critical realist perspective described initially by Bhaskar (1979)

This theoretical review observed the significant influence psychotherapy insights and practices have had across the wider field of psychiatric nursing, in terms of both the nature and the enactment of the therapeutic relationship. For the contemporary acute psychiatric nurse within an environment dominated by the bio-medical model of treatment, it has been argued that the contribution has been limited to an acceptance of the humanist belief in the intrinsic value of a establishing a relational bond based upon trusting and empathic relationship (Cutcliffe et al. 2015).

An observation is offered that therapeutic relationships are still reported by both patients and nursing staff within acute wards, despite the challenges that the nature and functions of contemporary acute psychiatric practice presents to the formation of an alliance (Hewitt and Coffey, 2005). As a result, it has been argued that a sole focus, or overemphasis on the working alliance between acute psychiatric nurse and patient as a defining characteristic of the establishment of a therapeutic relationship is potentially misplaced (Wright, 2015). It is suggested that the singular concept of establishing a relational bond is a more appropriate defining central concept of the therapeutic relationship within acute psychiatric settings than the tripartite concepts of relational bond alongside goal and task agreement (Bordin, 1979).

The multiple roles and objectives of nurses is acknowledged and in turn a multitude of relational types is a possibility and it is suggested that Clarkson's (1995) Therapeutic Relations model and its five classifications of therapeutic relationships: the working alliance, the transferential/counter-transferential, the reparative/ developmentally needed and the interpersonal/ transpersonal offer a more inclusive theoretical frame from which to observe those relationships than would a psychotherapy informed frame with a primary focus upon the working alliance.

It has been presented that nursing theory can be divided into two major paradigms, that of the tasks of nursing and that of the interpersonal. Theoretical models of nursing have been constructed that reflect both paradigms, but in terms of the interpersonal aspects of nursing,

two theorists within the United Kingdom have been particularly influential: Barker (2001) and Peplau (1952). Peplau's theoretical stance was influenced by the scientific 'truths' of the psychoanalytical and attachment perspectives, and it implicates that health and illness has a degree of a pre-defined status. Peplau (1952) described nursing as a relational process that enabled movement towards that position of health, identifying four phases, orientation, problem identification, working alliance and termination. This review presented that whilst the psychoanalytical and attachment discourse does not hold much sway within modern day acute psychiatric nursing, the model remains translatable into a contemporary acute ward dominated by the defined positions of health presented by the bio-medical model.

Although in a contemporary healthcare system that also contradictorily stresses the importance of individualism and the centrality of personal constructs of health and illness it has been presented that Peplau's (1952) model of interpersonal relationships in nursing is insufficient to capture the complexity and contradictory nature of the realities and expectations of acute psychiatric nurses. Therefore this review went on to identify the utility of Barker's (2001) tidal model of nursing, and its emphasis on personal meaning, spirituality and understanding as an adjunct theoretical frame to reflect contemporary nursing demands of the nurse-patient relationship.

As the focus of the intended research concerns itself with the 'how' of the therapeutic relationship, this review has proposed that this 'how' can be framed within the theoretical constructs of interpersonal communication, and its reference to two broad domains of verbal and non-verbal behaviour, subdivided into the concepts of the spoken word, the para-verbal, kinesics, proxemics and haptics. Furthermore, it is proposed that these interpersonal communications can be can be understood within Heron's (2001) two broad interventional functions of the authoritative and the facilitative, subdivided into 3 concepts each respectively: prescriptive, informative, confronting and the cathartic, catalytic and supportive.

Accepting Maxwell's (2013) suggestion of the need to illustrate theoretical frames that utilise interconnecting theories for clarity of understanding, a diagrammatic representation of the theoretical underpinnings of this intended research study is presented; see table 2.3 overleaf.

Table 2. 3 Emergent theoretical frame of the therapeutic relationships of acute psychiatric nurses

Ontology	The nature of the relationship is characterised by dynamic movements between positions of authority based on universal understandings of illness and equally a facilitative endeavour to explore and construct meanings of illness and recovery, resulting in an ontological pluralism surrounding the relationship	
Epistemology	Bio-psychological insights are subjected to a process of "nursification", resulting in a socially constructed nursing account of the relationship. Reflective of hermeneutic and critical realist commentary	
Defining Characteristic	There is a presence of a relational bond between nurse and patient akin to humanist perspectives of the intrinsic value of such a bond. (Rogers,1965)	
Purpose and Orientation	Restoration of psychiatric or psychological health (Peplau, 1952) The construction of new narrative of the meaning of illness and recovery alongside spiritual growth (Barker, 2001)	
Relational Roles	Nurses enact a number of differing roles (Peplau,1952) characterised by five relational types: The working alliance, the transferential/counter-transferential, the reparative/ developmentally needed and the interpersonal/ transpersonal (Clarkson, 1995)	
How	Nurses utilise verbal and non-verbal interpersonal skills to establish therapeutic relationships	
	Verbal	**Non-Verbal**
	Verbal Paraverbal	Kinesics Proxemics Haptics
Interventional Strategy (Heron 2001)	**Authoritative**	**Facilitative**
	Prescriptive Informative Confrontative	Cathartic Catalytic Supportive

Having explored the theoretical and philosophical underpinnings that relate to the nurse-patient relationship within acute psychiatric wards in this chapter, the next goes on to review the research literature pertaining to the phenomena.

Chapter 3

Literature Review

3.1 Introduction

McAndrew et al (2014) noted that acute psychiatric nurses are routinely unable to demonstrate and describe their relational labour with patients. McAllister et al., (2019) also observed that the therapeutic relationship within acute psychiatric nursing was very poorly conceptualised and articulated within the literature, or as Delaney and Johnson (2014) concluded the relational efforts of acute psychiatric nurses remain poorly understood or reported, and remain largely within the minds of the inpatient psychiatric nursing community. Given such a reported paucity of knowledge, this literature search has considered the question of "what does contemporary research literature tell us, of how registered psychiatric nurses establish a therapeutic relationship within a psychiatric inpatient setting?" Additionally, this literature review will consider how those contemporary studies set out to examine the phenomena and what is the merit of those studies?

Grant and Booth (2009) offered a typology of literature searches, describing both the purpose and function of each, these range from the systematic reviews associated with the Cochrane collaboration, through to broad scoping searches at the other end of the spectrum. The systematic review attempts to identify, appraise and synthesize all the empirical evidence that meets strict pre-specified eligibility and quality criteria (Higgins et al., 2020). This type of review is most useful where there have been sufficient studies conducted, that meet the stringent inclusion criteria (Grant and Booth, 2009). Whereas the broad scoping exercise at the other end of the spectrum; takes an inclusive view of the literature for the purpose of identifying ideas, opinions and the terms and concepts associated with the subject question (Pham et al., 2014).

In light of an indication that there would be a paucity of high quality, topic specific research, of the empirical nature associated with Cochrane style reviews (Grant and Booth, 2009), this literature review choses a review strategy that is closer to the 'scoping' end of that spectrum. But as the focus of this study is ultimately of a research nature, and the literature review

question is concerned with identifying existing research and examining the merit of that research; a critical literature review of existing research was undertaken. This is described by Grant and Booth (2009), as a strategy that provides an opportunity to take stock, not only of what is reported in the research literature, but what is the value of that previous body of work and the methods utilised to arrive at those conclusions. The focus of such a review is upon existing research literature (rather than broad subject texts), and appraising the quality of that work, involving a degree of analysis and synthesis with the presentation of some conceptual insights based on the understanding gained. This literature review chapter offers an account of that critical literature review process, and presents the findings and the understandings generated.

3.2 Literature review methods

Initially a broad iterative review of theory and commentary on the subject material was undertaken, utilising library catalogues and subject searches to identify both the concepts and terminology commonly used in the literature that relate to the phenomena. This in turn enabled the construction of a list of terms and phrases that were in common use within the literature (Aveyard, 2014; Maxwell, 2013). To add focus, a strategy that identifies the population; the issue; the context and the outcome (PICO), as suggested by O'Connor et al., (2008), was utilised. Please see Table 3.1 below.

Table 3. 1 PICO in relation to the intended research question

"How do registered acute inpatient psychiatric nurses articulate what they do to establish a therapeutic relationship?"	
Population	Psychiatric Nurses
Issue	Psychiatric Nursing Practice
Context	Acute Psychiatric Unit
Outcome	Therapeutic Relationship

Electronic databases were considered for their various merits, in terms of their potential for content that relates to the subject material; thus ensuring that the databases chosen, would offer access to the necessary breadth of available research literature on the subject matter (Aveyard, 2014). Four databases were chosen in order to offer a cross sectional account of the subject material. For its focus on nursing and allied healthcare from North America and Europe; CINAHL was selected; Medline; because it offered an extensive medical and nursing database. Also in order to focus the search a little more in terms of psychology, psychiatry and psychological care Psychinfo was selected. Finally, the Web of Science was utilised because of the inclusion of the social services citation index. Librarian assistance was sought in interrogating and searching the electronic data bases, to ensure the search was not compromised through any lack of experience on behalf of the researcher. The terms generated through the application of the PICO strategy were entered into the various data-bases thesaurus, or MeSH terms function, in order to generate a broad and inclusive list of terms. It became clear from this process, that the identified population, psychiatric nurses, and the issue; nursing practice, were often falling within the same thesaurus and MeSH term categories, and could be simultaneously searched. Table 3.2 overleaf demonstrates the original search topics generated through PICO, alongside the finalised search terms that were generated following the use of the thesaurus and MeSH functions. Additionally for clarity they are presented along with any word expansion keys that were utilised to maximise those results. A copy of each of the data base searchs can be viewed in appendix 1.

Table 3. 2 The original search topics and their associated search terms		
Initial Search Topic (Generated through PICO)	Database	Final search terms (generated from the thesaurus and MeSH term fucntion) presented with any word expander keys utilised
Psychiatric Nursing / Nursing Practice	CINAHL	"Nurses" nurs*
	Medline	"Nurses" nurs* "Psychiatric Nursing"
	Psych Info	"Nurses" "Nursing" nurs*
	Web of Science	"psychiatric nurs*" "mental health nurs*"
Acute Psychiatric Unit	CINAHL	"psychiatric hospital*" "psychiatric ward*" "psychiatric unit*" "mental health unit*" "mental health hospital*" "Hospitals, Psychiatric" "Psychiatric Units"
	Medline	"Hospitals, Psychiatric" "mental health unit*" "mental health ward*" "mental health hospital*" "psychiatric unit*" "psychiatric ward*" "psychiatric hospital*"
	Psych Info	"Hospitals, Psychiatric" "mental health unit*" "mental health ward*" "mental health hospital*" "psychiatric unit*" "psychiatric ward*" "psychiatric hospital*"
	Web of Science	"psychiatric hospital*" "acute psychiatry*" "acute admission" "admissions psychiatry*" "admissions mental*"

Therapeutic Relationships	CINAHL	“therapeutic relation*” “therapeutic alliance*” “Therapeutic Alliance” “Nurse-Patient Relations”
	Medline	“therapeutic relation*” “therapeutic alliance*” “Therapeutic Alliance”
	Psych Info	“therapeutic relation*” “therapeutic alliance*” “Therapeutic Alliance”
	Web of Science	“therapeutic relation*” “therapeutic alliance*” “Interpersonal relation*”

Initially within each individual database the Boolean phrasing “OR” was utilised to combine the results generated from the terms associated with each search topic. The Boolean phrasing “AND” was then utilised to identify only the literature that held the combination of all three search topics. Figure 3.1 below shows the initial numbers of articles generated from each database following this process.

Figure 3. 1 Number of Articles that were initially identified for each database

CINAHL	**297**	
Medline	180	
Psych Info	68	
Web of Science	12	Total = 557

Informed by instructional texts on literature searching and managing the data that such searches generate; a series of filters and exclusion criteria were applied to enable a focused and detailed scrutiny of the most relevant articles (Aveyard, 2014; Machi and McEvoy, 2016; Oliver, 2012; Ridley, 2008; Siu, 2013). In order to offer an initial quality check on the information offered within the literature, as suggested by Kelly et al. (2014), only peer reviewed literature was utilised, where the conclusions and any opinions offered had been scrutinised by peers to ensure they were arrived at through reasonable examination of the subject. Additionally, as there was likely to be a number of cultural language subtleties and nuances in describing a therapeutic relationship, the scrutiny of non-English articles would require the use of a native speaking individual with some cultural understanding of how those nuances translate both into English and the context of the environment to which they are referring (Nes et al., 2010). This is not only beyond the capabilities of the researcher but also as Neimann-Rasmussen and Montgomery (2018) had noted, proved beyond the resources of many studies, as indeed it did with this study. As a result, articles not published in English have been excluded.

This review sought to identify what is already known through research studies, and what is the quality and extent of the knowledge generated from those studies. Rather than what current thoughts are being expressed about the phenomenon of interest; hence opinion-based articles have also been excluded from the literature search. Furthermore, as Mills (2000) had suggested the frame of reference and the lens with which a phenomenon is observed and experienced, is dependent upon the social and cultural experience that surround it, and as this study is particularly interested with the lens and understandings of acute psychiatric nurses; studies that mostly drew their conclusions based on either a wider nursing perspective or non-nursing perspectives were excluded.

Also in keeping with the focus of the research to uncover the positive endeavours of acute psychiatric nurses, rather than the identification of barriers to those relational endeavours; barrier identification focused research into the therapeutic relationship between acute inpatient psychiatric nurses and patients have been excluded. A decision that did account for the

majority of studies that were excluded from the in-depth literature review. In order to retain a contemporary view of the literature pertaining to the phenomenon of interest a date range was considered: Healthcare policy since 2000 has increasingly focused on providing acute psychiatric care within the community setting, resulting in increasing levels of acuity in the remaining beds (Bee et al., 2006; McAndrew et al., 2014; Nolan, Bradley and Brimblecombe, 2011). Hence it is highly likely that the relational endeavours of the nurses within contemporary acute psychiatric wards will have changed in accordance with such an increase in acuity since this time. Hence research studies published pre 2000 have been excluded.

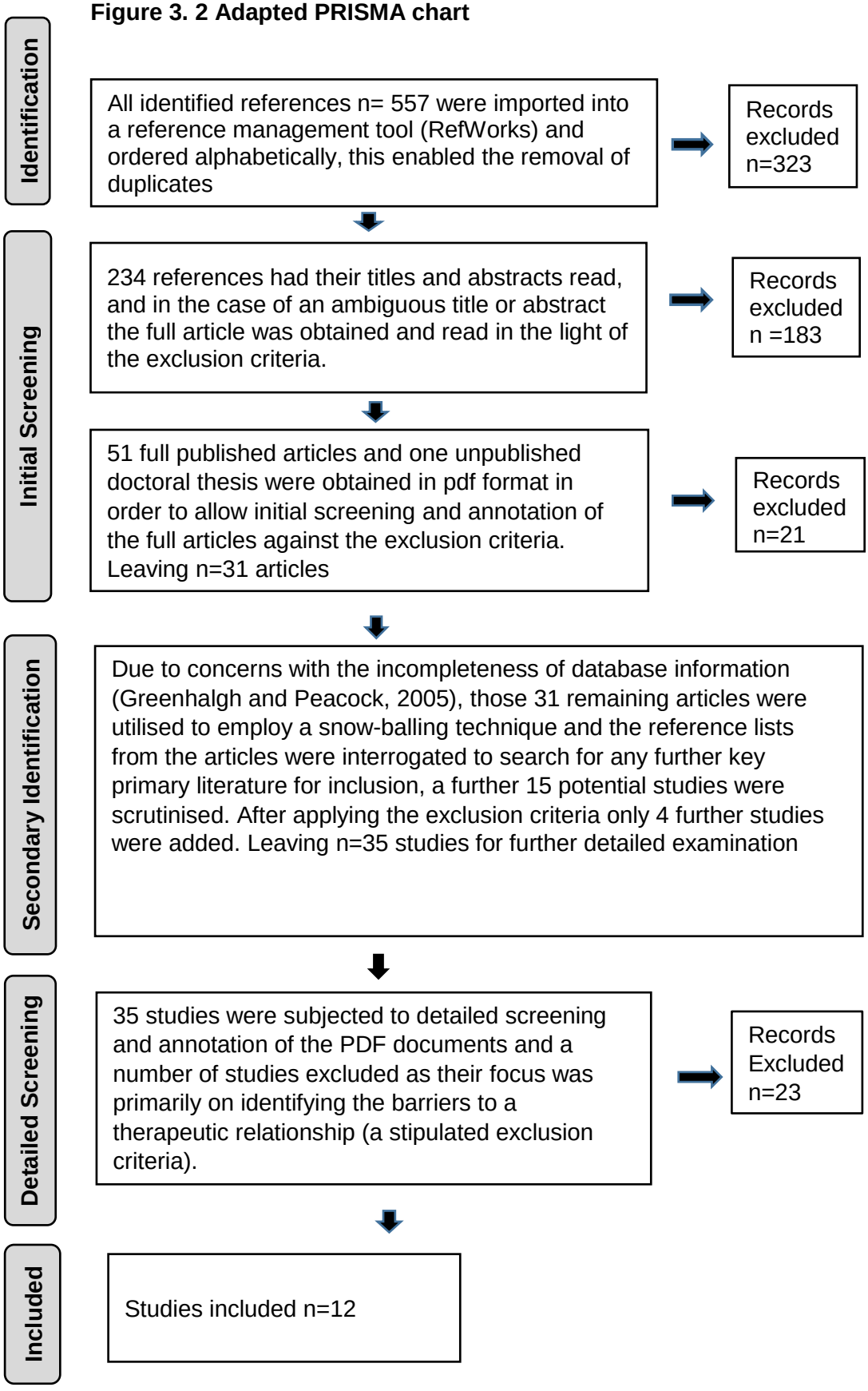
Sharfstein's (2009) observed, that some countries and healthcare systems may prove too culturally distant to offer useful insights into the practices of healthcare in other parts of the world. On the basis of that observation, a decision to filter the literature on the basis of which country they pertained too was taken. Sharfstein (2009) did go on to suggest that the acute inpatient settings of Europe, North America, Australia and New Zealand; had all followed similar health policy and care trajectories, so literature pertaining to the subject material from these countries and regions has been included, although literature from other parts of the world has been excluded on the basis of Sharfstein's (2009) concerns. Table 3.3 below summarises the exclusion criteria.

Table 3. 3 **Literature exclusion criteria**

Non-peer reviewed articles
Those not in English
Opinion based articles
Articles that detail insights based on non-acute psychiatric nursing views
Studies that solely sought to identify barriers to the therapeutic relationship
Articles published before 2000
Research outside of Europe, North America; Australia or New Zealand.

Moher et al. (2009) suggested that the value of a literature review depends not only on what was done, and what was found, but also upon the clarity of the reporting. In terms of that clarity of reporting; a key feature is the presentation of the process of how key literature was identified, and the associated numerics of that process (Liberati et al., 2009). Moher et al. (2009) identified four critical phases that should be reported to present those findings in a clear manner. Firstly, "identification"; this includes the number of references from the original data search plus the number of references that are identified through other sources. Secondly, "screening"; this is the number of references that remain after duplicates were removed. Thirdly, "eligibility"; the number of articles remaining after the eligibility (exclusion) criteria has been applied. Lastly, "the included": this is the number of studies that have ultimately been included for review. Moher et al. (2009) went on to note that the use of a standard flow chart to demonstrate these critical phases added greater clarity to the report; and went on to describe the "preferred reporting items for systematic reviews and meta-analyses chart (the PRISMA flow chart). Whilst the PRISMA flow chart format suggested by Moher et al. (2009) commences with the numbers of all included references; this literature review filtered the initial database results first, before then expanding the results again through a review of the filtered articles' reference lists. In respect of this, the PRISMA chart (Page et al., 2021), shown below has been adapted to show that process, of reduction, expansion and then reduction again, whilst still offering the numerics as suggested by Liberati et al. (2009) and Moher et al. (2009). See Figure 3.2 overleaf

Figure 3. 2 Adapted PRISMA chart



Of those 12 papers included for review nine were reports of original pieces of research, and three offered meta-synthesis. Reference to the authors of which are presented below within table 3.4.

Table 3. 4 Included papers within this literature review

Original Research Studies	
Berg and Hallberg., (2000)	Scanlon, (2006)
Bjorkdahl et al.,(2010)	Thibeault, (2016)
Chiovetti., (2008)	Cleary, (2003)
Gabrielson et al, (2016)	Gerace et al., (2018)
	Hem and Heggen, (2003)
Meta-synthesis	
Cleary et al., (2012b)	Delaney and Johnson, (2014)
	Dziopa and Ahern, (2009)

Sackett et al. (1997) suggested that the findings identified within reviews should be further organised within a hierarchy of evidence, according to the quality of the study. Sacket et al. (1997) presented from the perspective of the natural sciences, that meta-synthesis of randomised controlled trials offered the most robust evidence, working down from there through random controlled trials, qualitative enquiry and eventually to single case study research. Given the qualitative nature of the studies identified, and in particular the very small numbers of studies to date, coupled with the differences in those studies in terms of focus and method, it was not possible to apply a meaningful hierarchy of evidence from the perspective of the natural sciences. Never the less, all the studies identified were individually appraised with reference to the qualitative research critique chapters of instructional nursing research texts, in order to appraise their trustworthiness and robustness (Polit and Hungler, 1993; Treece and Treece, 1986). There is a danger that without such a review an illusion of fact is

created based on numbers as opposed to the quality of the information available (Siu, 2013). In order to aid such an examination and to extract the information from within those articles; Aveyard's, (2014) simplified adaptation of Woolians et al., (2009) framework (see Table 3.5 below) was utilised to support the construction of a working table in order to allow the researcher to systematically work through the identified literature, and record both notes on an appraisal of the research and also note the key findings and conclusions (see appendix 2 for a copy of the initial working data extraction table).

Table 3. 5 Critical framework Aveyard's (2014) adaption of Woolians et al., (2009)

Where	Where did this take place and where did the information come from
How	How did the speaker reach their conclusions
When	When was this written
What	What are the results and key Messages
Who	Who has written and said this
Why	Why have they conducted the research

Once the data had been extracted to the table, an analysis of that extracted data was then conducted in order to bring together and integrate the information into a synthesised account. Thomas and Harden (2008) described this process as a thematic synthesis. Such a synthesis has three stages, the line-by-line data extraction into a data extraction table, the development of descriptive themes and finally the generation of analytical themes. While the development of descriptive themes remains 'close' to the primary studies, the analytical themes offers interpretation beyond the primary studies and generates interpretive constructs (Braun and Clarke, 2006, Thomas and Harden, 2008). It is such synthesis of the data that is the defining

difference between a descriptive annotated bibliography and a literature review (Jesson et al., 2011).

3.3 Critical commentary of the literature included in this review

All of the original studies identified for inclusion in this review share similar methodological compromises; which was often necessitated by the pragmatic decisions that are often taken in qualitative research, in response to funding and time limitations, sample accessibility, and large data management issues (Polit and Hungler, 1993). The studies generally had small sample sizes, and used either convenience sampling or a purposeful sampling process, potentially increasing the likelihood that the views of particular individuals could be over-represented (Treece and Treece, 1986). Additionally, it appeared as though the researcher in most of the studies had prior working arrangements with, and were known to the participants, and whilst this has the potential to increase the likelihood that subtle and hidden phenomenon will be revealed (Mills, 2000), it equally holds the potential that any power imbalances may bias responses in favour of the 'correct' response (Couchman and Dawson, 1990). It should be noted that the researchers were mostly from local academic establishments, which may indeed have further influenced the responses, in terms of participants feeling compelled to offer the 'correct response'. Furthermore, consideration should be given to the purpose of the research in order to appraise the potential for the over representation of ideas and phenomenon that 'fit' the motivations of the researcher (Polit and Hungler, 1993). In respect of this it was observed that within the studies appraised here, there is universal reference to the perception of an existential threat to registered acute psychiatric nursing from a healthcare system that is focussed upon evidence based and outcome driven practice, there is, as a result of this, of the potential to over emphasise the importance of the relational skill sets, either intentionally or though unintentional sensitivity to those phenomena.

Such criticisms are common of qualitative design, and the advantages of qualitative research rest in the depth and breadth of the understanding generated, and its contribution to the wider

knowledge, does not rest in a single research narrative, but on the collation of the common themes that emerge from repeated studies across many different localities (Delaney and Johnson, 2014). It is noted that the current number of such studies remain small and the state of evidenced based knowledge on the phenomenon of interest can only be considered tentative at this point in time.

All studies included in this review, reported a systematic approach to their enquiry, with clear and understandable rationales for their sampling, method and the structuring of data. In terms of instruments the unstructured or very broad semi-structured interviews dominate the enquiry into how nurses articulate their understanding of their efforts to establish the therapeutic relationship, which is indeed useful in exploratory research as it seeks out the internalised views of the participants (Gibson, 1998). Whilst Hem and Heggen (2003) and Cleary (2003) report participatory observation also, it appears that this particular method was adopted to answer a much broader question of 'what nurses do' as opposed to establishing the nurses own perception of their relational endeavours.

Of the 12 studies included, three were meta-syntheses (Cleary et al., 2012b; Delaney and Johnson, 2014; Dziopa and Ahern, 2009). When closely scrutinised, two of those syntheses did not actually offer a specific review of the nursing relationship, and considered the much broader topic area, of what nurses do in acute inpatient wards (Cleary et al., 2012b; Delaney and Johnson, 2014). Despite this much broader focus, they did reveal that part of the work nurses do, is to form the nurse–patient relationship, and some discussion of relationship focused activity was included and thus allowed the extraction of data relating to this, for the purpose of this review of the literature. As these two meta-syntheses held such a broad focus; the articles identifying the relational elements of nurses' work, was drawn only from a handful of papers. An observation that suggests a degree of caution needs to be exercised in accepting the conclusions offered (Sandelowski et al., 1997).

Dziopa and Ahern's (2009) meta-synthesis did examine more specifically the literature, up until 2008, that made particular reference to the nurse-patient relationship in acute psychiatric nursing. However there was no distinction made of who provided that perspective, whether it be an acute psychiatric nurse, relative, patient or alternate professional groups, and so conclusions on the perspective of acute psychiatric nurses on their relational endeavours remains hidden amongst that of others. Additionally, there was an absence of a time frame to those studies included, and this raises questions over the relevance of the conclusions to a contemporary acute ward.

On further detailed examination of the 32 research studies that were included in Dziopa and Ahern's (2009) synthesis, the vast majority were from either patient surveys, or again were drawn from research into the nursing identification of barriers to the therapeutic relationship. Assumptions were made that by presenting the direct opposite to a barrier this would in turn indicate a relationship building endeavour. For example if the identified barrier to meaningful engagement was resolved; for example 'a lack of clinical supervision', then the assumption was made that 'engaging in clinical supervision' was one of the strategies nurses utilised in forming those relationships, the clinical experience of the researcher would suggest that such assumptions are certainly questionable. Dziopa and Ahern's (2009) meta-synthesis also offered an expanded inclusion criteria in terms of location, and included two studies conducted within the acute wards of the United Arab Emirates (Hawamdeh and Fakhry, 2014), and Iran (Pazargadi et al., 2015). It is questionable whether papers from such settings should be included, as they are culturally too distant to generalise the conclusions into the setting of a UK acute psychiatric ward (Salmond, 2012). Although, Pazargadi et al.'s (2015) opening assertion that the nature of the relationship between acute psychiatric nurses and patients is hidden from view, certainly resonated with the researcher.

Due to the concerns with the reported meta-synthesis, this review revisited and critically appraised the nine original research studies identified in this search (Berg and Hallberg, 2000; Bjorkdahl et al., 2010; Chiovetti, 2008; Cleary, 2003; Gabrielson et al., 2016; Gerace et al.,

2018; Hem and Heggen, 2003; Scanlon, 2006; Thibeault, 2016). As a result of that it is noted, that apart from Scanlon (2006) and Thibeault (2016) the research interest of most of those original studies was again concerned with the broader subject of 'what acute nurses do' or in understanding how the balance between security focused and therapeutic focused relationships are managed, and hence the findings presented here are done so tentatively with an understanding that conclusions are based upon a review of limited data.

3.4 Findings

Following Thomas and Harden (2008) process of thematic synthesis, the extracted data from the literature was examined and re-examined with a view to creating descriptive categories that remained close to the original data. It became apparent early in that process that the descriptive themes generated by Dziopa and Ahern (2009) from their own meta-synthesis of the research, potentially provided a comprehensive and inclusive mechanism by which the raw data from this review could also be represented, as such the extracted data was considered in the light of those descriptive categories (please see Appendix 3). Dziopa and Ahern (2009) had suggested nine categories; Summarised below in Figure 3.3 overleaf.

Figure 3. 3 Descriptive categories in the formation of the therapeutic relationship (Dziopa and Ahern, 2009)

The process of assigning the data from the included studies was undertaken and reviewed several times over a period of six weeks, and particular attention was placed on looking for data that would not fit with Dziopa and Ahern's (2009) categorisation in order to challenge a prima facie assumption of its apparent comprehensiveness. Whilst this process did lead to several changes to the category that data was assigned to; Dziopa and Ahern's (2009) categorisation remained an inclusive account of the findings of this literature review also.

Dziopa and Ahern's (2009) description of: skilfully conveying empathy and understanding was apparent within all the studies identified within the literature research, and Gerace et al., (2018) went as far as suggesting that establishing and conveying empathy in its own right offered a description of the establishment of the therapeutic relationship. Empathy was described as

understanding the patient's point of view (Delaney and Johnson, 2014; Scanlon, 2006) or putting yourself in the patient's shoes (Bjorkdahl et al., 2010) or as Cleary et al., (2012b) offered, imagining yourself in the patient's situation. The tenacity with which the endeavour to establish and convey empathy and understanding was also noted, referring to the practice, as holding a stubborn empathy (Hem and Heggen, 2003), or as Cleary et al. (2012b) noted, maintaining empathic responses when often under distress. Dziopa and Ahern (2009) concurred, and also highlighted a required stubbornness in achieving the objective of conveying empathic understanding within the acute psychiatric setting. The research reviewed in this literature search also highlighted the deployment of interpersonal skills, in achieving the objective of conveying an empathic understanding; such as active listening, reflecting, clarifying, questioning, and encouraging the ventilation of feelings and thoughts (Scanlon, 2006), presenting as calm and soothing (Cleary et al., 2012b), or as Dziopa and Ahern (2009) noted; the skilled use of interpersonal technique, that entailed the use of appropriate and sensitive eye contact, body posture, non-verbal responses and paying attention to cadence. Bjokdahl et al. (2010) observed this as a two-way process and recorded an observation that nurses were not only utilising such skills, but were equally assessing and interpreting the subtle non-verbal signals conveyed by the patient.

Dziopa and Ahern (2009) had described providing practical support as instrumental to the formation of the therapeutic relationship within acute inpatient settings. Delaney and Johnson (2014) simply described this as caring and connecting over small basic needs, or as Cleary (2003) observed, steps are taken to make a patient's stay in hospital as easy going as possible, or as Scanlon (2006) added, by providing both care and practical help when needed. Bjorkdahl et al. (2010) described conveying unconditional feelings of warmth, through the provision of basic human needs, such as food, drink, touch and physical comfort, with Cleary et al. (2012b) adding there is often a demonstration to the patient that nothing is too small to be of concern to the nurse. Dziopa and Ahern (2009) suggested that there is a knowing of when to do 'the small' things like making a drink or fetching extra pillows, and when to mother those that require

it, and knowing those that do not. Berg and Hallberg (2000) described the concept as supporting patients with activities of daily living; to potter about with, to sit with, to fetch for, and to make offers of extra comfort, such as offering blankets or assistance in running a bath. Cleary et al. (2012b), suggested such activity presented non-confrontational opportunities to make connections and build relationships.

Acknowledging and recognising individuality and in turn promoting that individuality was identified as a distinct intervention in the formation of the therapeutic relationship by Dziopa and Ahern (2009). Bjorkdahl et al. (2010) described this as seeking opportunity to provide an individually tailored response. Cleary (2003) suggested in order to deliver such an ambition the nurse was required to understand the patient's hopes, their likes and dislikes, preferences, personal circumstances and motivations. Dziopa and Ahern (2009) suggested it was necessary to see the individual person beyond the mental illness, to be mindful of stereotyping, and to support the patient to self -manage the illness in the context of their individual life.

The strategic placement of the nurse within the shared living space of a ward, was universally acknowledged in the reviewed research literature as a core strategy in the formation of the nurse-patient relationship. An observation often simply referred to as being there or being available (Berg and Hallberg, 2000; Bjorkdahl et al., 2010; Cleary, 2003; Cleary et al., 2012b; Delaney and Johnson, 2000; Dziopa and Ahern, 2009; Gerace et al. 2018; Hem and Heggen, 2003). Berg and Hallberg (2000), described this 'being there' as a waiting physical presence that had elements of the psychological, physical, existential, and social. Scanlon (2006) described this as being prepared to give the nursing minute when and where it was requested. Whilst simply being there suggests a passivity to the strategy, Delaney and Johnson (2014) observed the strategy to be more proactive, a seeking of opportunity, or as Gabrelsson et al. (2016) noted, there is a personal responsibility to find and present time. Thibeault (2016) described this as strategically creating encounters within the ward environment. Whilst reference is generally to the informality of such contacts, occasionally such encounters are

more formalised and described as “one-to-ones” or “talk-time,” and some registered nurses labelled such encounters as psychotherapy (Thibeault, 2016).

Being genuine or authentic in the nurse-patient encounter featured significantly within the accounts of the therapeutic relationship between nurse and patient (Chiovetti, 2008; Dziopa and Ahern, 2009). They went on to describe this as a naturalness that might reveal itself through the showing of genuine emotion, offering blunt feedback or straight talk when required, an openness and honesty within the exchanges. Others have characterised it by a presentation of friendliness over cold professionalism (Scanlon, 2006); a sharing of emotions and feelings (Hem and Heggen, 2003); the mutual disclosure of life experiences (Dziopa and Ahern, 2009); or the use of friendly humour (Scanlon, 2006). Gerace et al., (2018) simply described the concept as relating to a patient as a genuine compassionate fellow human being. There is a suggestion that such authenticity and genuineness is also boundaried, and of a need to demonstrate professionalism, and to know there is a fine line between the successful strategic use of friendliness and an expectation of professionalism from the patient (Dziopa and Ahern, 2009). Cleary, (2003) and Delaney and Johnson, (2014) purported that the authentic nurse – patient relationship had honesty and trust at its core. Gabrelsson et al., (2016) observed that to establish trust and honesty required nurses to tell the truth, and to take responsibility for the decisions made. Scanlon (2006) added the adoption and conveyance of a genuine non-judgemental attitude towards the patient played an important function in establishing the authenticity of the nurse –patient relationship.

Dziopa and Ahern (2009) identified the promotion of equality as a contributor to the establishment of the therapeutic relationship. Cleary (2003) described a need to help the patient to feel a sense of control in the care offered and provided; or as Berg and Hallberg (2000) suggested the establishment of a mutual collaboration in the task in hand. Dziopa and Ahern (2009) purported that an active strategy to empower and encourage patients to take control was necessary. To offer choices where they could be offered and to minimise times the nurse made decisions on behalf of the patient (Hem and Heggen, 2003). Chiovetti (2008)

suggested the goal to achieve full participation in all decisions needs to drive the engagement behaviour, or as Delaney and Johnson (2014) suggested the patients lead should be taken, wherever it can be. Dziopa and Ahern, (2009) stated to achieve equality, required adopting active strategies to manage the inherent power imbalances in the relationship, or as Cleary (2003) advised to actively take steps not to adopt a default authoritarian position. Thibeault (2016) observed that the process of therapeutic relationship required this shift towards collaborative working, or as Thibeault (2016) termed it; the establishment of common ground both in the care process and the objectives.

The demonstration of clear boundaries as a strategic endeavour in the formation of the relationship between nurse and patient was noted by Dziopa and Ahern, (2009). Scanlon (2006) suggested that firm boundaries, rules and limits created a feeling of trust that was linked to the establishment of a sense of safety and security, and fitted with a patient expectation that Berg and Hallberg (2000) identified; that at times a professional nurse should know best on how to support an individual's needs. Bjorkdahl et al., (2010) made a similar observation, noting, the therapeutic relationship is built on the mutual expectation, that at times the nurse will be the guardian of order and safety, or as Chiovetti (2008) observed, the nurse can be relied on by the patient to take a firm decision to keep them safe. Thibeault (2016) maintained that the maintenance of a boundary that related to safety and security often served to ground the patient, to bring them into the reality of the situation, and the relationship developed on a perception that someone was willing to take the responsibility to keep them safe, when it was necessary. For such relational opportunities to be realised, it was suggested that effort and attention was required to ensure the dual expectation of security and freedom was managed (Gerace et al. 2018). As Cleary (2003) summarised there is a need for negotiation and the adoption of a stance, or if it can be let go when the patient objects, then let it go. Gerace et al. (2018) argued boundaries should sway with the wind rather than be presented as a solid wall. Cleary (2003) went on to note a need to communicate that restrictive boundaries are a last resort. To present a calmness, and an opportunity for questions, education and explanations.

Cleary (2003) affirms that any such restrictive boundaries, need to be underpinned by a belief that any abuse and challenging behaviours that may result, are transient features of someone's distress, if the relationship is going to develop further or be maintained.

The relational opportunity afforded by the sensitive and skilled maintenance of the boundaries that relate to safety, security and treatment objectives, were not the only facilitative boundaries observed in the literature. Dziopa and Ahern (2009), made reference to the maintenance of a boundary, a limit, by which the nurse emotionally invests in the relationship; observing that the maintenance of such boundaries can allow a relationship to be formed, which otherwise would prove too emotionally challenging for the nurse as a lay person. Hem and Heggen (2003) referred to this as maintaining a therapeutic distance, allowing a connection to be made on a professional basis that would not be developed in any other circumstance. Gerace et al. (2018) described a need for the nurse to put on the emotional uniform, to consciously lock part of themselves out, in order to make a connection and to develop relationships with those that would ordinarily prove a challenge in a non-professional arena.

The demonstration of respect towards the patient from the nurse is reported to be a fundamental concept in the formation of the therapeutic relationship (Chiovetti, 2008; Cleary, 2003; Delaney and Johnson, 2014; Dziopa and Ahern, 2009; Gabrelsson et al., 2016; Scanlon, 2006). Scanlon, (2006) purported that this was demonstrated mostly through the application of good mannerly behaviour in each and every contact. Dziopa and Ahern (2009) suggested that it was the investment of time and interest, and conveyance of worthiness that created a sense of being respected within the patient.

The use of self-awareness was identified as a critical strategic component utilised by acute psychiatric nurses in their endeavour to form a therapeutic relationship with patients (Dziopa and Ahern, 2009). A practice that may be formalised into post event reflection exercises (Cleary et al., 2012b), or as Gabrelsson et al. (2016) observed involve critical daily discussions within the acute psychiatric nursing team. Thibeault (2016) described the reflective process as being

responsible for developing a conscious strategic approach to achieving a therapeutic connection. This self-reflective process was also described, as occurring simultaneously within actual nurse-patient interactions (Scanlon, 2006). Thibeault (2016) simply described this as thinking through responses whilst in a frontline situation. Scanlon (2006) refers to it as an intuitive responsiveness, that were rooted in past life and work experience, where nurses appraise, react and change interpersonal approaches whilst engaged with a patient in order to progress. Hem and Heggen (2003) identified this as an active regulation of oneself and one's reactions to achieve the correct therapeutic position, or as Thibeault (2016) noted a constant repositioning based on an awareness of the cause and effect of the nursing approach.

3.5 Analysis and synthesis

The most consistent theme from within the literature is that of a belief in the value of the therapeutic relationship; and the therapeutic use of self remains central to the practice of acute psychiatric nurses (Cleary et al., 2012b). Holding true to Peplau's (1952) and Barker's (2001) theoretical assertions (particularly within psychiatry) that nursing in itself can be defined as the therapeutic use of the relationship between nurse and patent. A relationship that remains rooted in core humanistic values of empathy, trust, genuineness and a non- judgmental approach (Bjorkdahl et al., 2010; Cleary et al., 2012b; Delaney and Johnson, 2014; Hem and Heggen, 2003; Scanlon, 2006).

The studies examined described nurses forming several types of therapeutic relationships rather than subscribing to a notion of a singular therapeutic relationship. Bjorkdahl et al (2010), described a continuum of therapeutic relationships that were specific to the acute psychiatric setting, ranging from the authoritarian and paternalistic; the 'bull dozer' through to the delicate and skilled engagement of the 'ballerina'. Hem and Heggen (2003) elaborated on this, describing relationships that are built and negotiated on the continuums' of the human to the professional, intimate to the distant, humanist to the biomedical technician. Others have described these relationships in role contexts, expert, collaborator, teacher, networker,

container and protector (Berg and Hallberg, 2000), or Dziopa and Ahern (2009) notion of equal partner, senior partner and protective partner. Such observations remain very much in touch with Peplau's (1952) theoretical assertions of the multiple therapeutic roles of nursing that she outlined within her theories of Interpersonal Nursing in the 1950's. Clarkson (1995) also offered a theoretical perspective that there are indeed five types of relationships within the therapeutic encounter: The working alliance; the transferential and counter transferential; parental; interpersonal; and transpersonal. Utilising Clarkson's (1995) categories of relationship, it was also possible to inclusively represent the data extracted from the studies within a theoretical frame. This in turn also suggested a potential theory with which the potential findings of this study could be referenced against. Please see table 3.6 overleaf for examples of extracted data ascribed to Clarkson's (1995) theoretical frame.

Table 3. 6 Example of the literature data represented within Clarkson's (1995) model of therapeutic relationships

Working Alliance	Agree goals and tasks (Scanlon, 2006) Conveying understanding from the patients perspective (Bjorkdahl et al., 2010) Clarify the patients viewpoint, empowerment activities, follow the patients lead (Delaney and Johnson, 2014) Collaborator, motivator, establish mutual confidence, encourage them in achievement of goals and practical tasks (Berg and Hallberg, 2000) Minimise position of authority, work in conjunction towards agreed goals, support self- control, identify hopes, opportunities for questions (Cleary, 2003) Coax towards own goals (Cleary et al., 2012b) Negotiate and provide choices (Gerace et al., 2018) Establish common ground (Thibeault, 2016) Create and co-create a new and shared perspective (Thibeault, 2016)
Transference / counter transference	Showing emotional involvement (Scanlon, 2006) Intensity of the situation sometimes felt and conveyed (Cleary et al., 2012) Connect emotionally (Berg and Hallberg, 2000) Convey emotional involvement (Hem and Heggen, 2003) Share and feel the emotions of the patient (Gerace et al., 2018) Engage in the distress (Thibeault, 2016)
Parental relationships	Trust based on the provision of safety and security, care and help, working hard to provide homeliness (Scanlon, 2006) Bulldozer, shield of control - guarantors of order and safety, taking decisions of what is needed (Bjorkdahl et al., 2010) Caring and connecting over small basic needs, alleviate suffering (Delaney and Johnson, 2014) Take care of practical issues, finances, housing, calm and soothe, (Cleary et al., 2012b) Expert – knowing what is best, meet practical tasks, tenderness, supporting activities of living eating and drinking, contain emotionally distraught situations, make it safe and secure around, tuck in, provide warm milky drinks, fetch blankets, being there to meet physical needs (Berg and Hallberg, 2000) To mother ((Hem and Heggen, 2003) To take control, handing back responsibility in increasing amounts Gerace et al., 2018) Present rules with credible rationales (Gabrelson et al., 2016) Present the professional front to manage own and patients anxiety (Thibeault, 2016)

Interpersonal Relationships	Friendliness as opposed to cold professional, include humour (Scanlon, 2006) Show an interest in patients as people, use humour (Cleary et al., 2012b) Being available to interact socially (Berg and Hallberg, 2000) Human, natural, friendly, self-disclosure, sharing experiences of life, sharing own vulnerabilities (Hem and Heggen, 2003) Honesty, being available, knowing each other's likes and dislikes and life circumstances (Cleary, 2003) Making sure you are in the vicinity to offer the chance to talk (Cleary et al., 2012b) To be human and feel for the patient (Gerace et al., 2018) Share interest and hobbies to live alongside (Gerace et al., 2018)
Transpersonal relationships	Intuitive Responses, connected (Scanlon, 2006) Intuitively tailor responses, being with physically, emotionally and spiritually (Bjorkdahl, 2010) Being there and seeking opportunity to be connected, (Delaney and Johnson, 2014) Just being there, using intuition, imagination, considering the experience they have and an understanding of that (Cleary et al., 2012b) Communicate understanding and search for meaning together (Berg and Hallberg, 2000) Sense of an authentic connection (Chiovitti, 2008) Support personal meaning (Hem and Heggen, 2003) Being there, creating a sense of calmness together (Cleary, 2003) A mutual understanding that goes beyond the role of nurse and patient (Gerace et al., 2018)

Whilst utilising an existing theoretical frame such as this, does allow the descriptive data from the reviewed studies to be collated and presented from a more theoretically connected perspective, any such representation requires a high level of suspicion of the evidence this represents. Not only because of the relatively small number of studies that have informed such attribution, but there are also severe limitations to using secondary data that is now being presented out of context (Polit and Hungler, 1993). Additionally, it should be noted that the lens through which the data has been analysed, has undoubtedly been shaped by the researcher's own insights into potential theoretical underpinnings. It should be noted that the researcher through consultation with his own reflective notes, acknowledges the potential influence of recent examination of existing theory and commentary on the subject matter as

part of the preparation for this research study, not least the influence of the writings of Clarkson (1995) and Heron (2001). Heideggerian philosophical thought noted the inevitably of such reflexivity within the investigation of a human phenomenon by a fellow human (Wilson, 2014). Mills (2000) added, that as long as that potential influence upon the lens is considered, acknowledged and made clear to the reader, such reflexivity with the data can enhance both the analysis and the understanding of the context of the phenomenon of interest. In order to challenge the potential for attribution bias towards such existing knowledge and theory (Polit and Hungler, 1993); an examination and re-examination of the extracted data, looking for data that did not fit with the theoretical categories was undertaken, despite this, the theoretical frame offered by both Clarkson (1995) did seem to offer an inclusive mechanism by which to consider the findings.

In addition to the multiplicity of the relationships formed, Thibeault (2016) noted the dynamic nature of the relational roles that were played out through an inpatient stay, describing a linear movement from a combative or confrontational relationship; characterised by jostling to establish rules and establish one's own perspective and understanding; through to an acceptance of each other's role, and finally establishing mutuality within the relationship. Both Bjorkdahl et al., (2010) and Hem and Heggen (2003) also described the relationship between acute psychiatric nurses and inpatients as moving along a continuum of relational states. Such observations are reminiscent of Peplau's (1952) theoretical assertions of the progressive nature of the relationships of nurses through an orientation, a working phase and finally a termination phase.

Thibeault (2016) acknowledged the similarities to Peplau's (1952) relational phases, but went on to argue that in a contemporary acute ward, those phases were better described as 'frontline action', 'establishing common ground' and finally 'the shift to the working relationship'. Thibeault (2016) asserted that such frontline action is characterised by looking for openings and places that give an opportunity to talk; orientation to the environment, roles, and the rules. A relationship characterised by the communication of personal perspectives and identity;

feelings of hostility and anxiety; rescue manoeuvres; letting somethings lie; looking for and communicating an understanding of what is going on, finding space and time to think. Whilst Thibeault (2016) then goes on to describe the two other phases of 'establishing common ground' and the 'shift to the working relationship', it is the relational endeavours of moving the relationship through the 'frontline' that is reported as the mainstay of the relational work conducted by acute psychiatric nurses. Thibeault (2016) went on to suggest that this is perhaps the unique relational contribution of acute inpatient psychiatric nurses to a shared team based therapeutic relationship with the patient, in a setting that spans both inpatient and community settings.

When considering the literature review data, in the light of Clarkson's (1995) theoretical perspectives of the multiplicity of relational types, and with reference to Peplau's (1952) notions of dynamism of such relations, there is an indication that future studies need to focus attention beyond an assumption that they are observing a singular relational phenomenon, and there is potentially also an equal range of diverse skills and relational endeavour to form those multiple relationship types.

Indeed it was observed from the data within the literature review that many of the relational endeavours that were observed appeared to be contradictory; such as providing expertise and knowing what is best (Cleary et al., 2012b) whilst at the same time agreeing goals and tasks (Scanlon, 2006); to show emotional involvement (Scanlon, 2006), and to share and feel the emotions of the patient (Gerace et al., 2018) whilst at the same time demonstrating professionalism and maintaining therapeutic distance (Hem and Heggen, 2003). Dziopa and Ahern (2009) within their meta-synthesis made similar observations of the apparent contradictory strategies utilised by acute psychiatric nurses in their endeavours to form therapeutic relationships. Such an observation of the multiple and contradictory relational endeavours appeared reflective of Heron's (2001) theoretical descriptions of six categories of interventional states; the prescriptive, the informative, the confronting, the cathartic, the catalytic, and the supportive, which fall into the two contradictory domains of the authoritative

and the facilitative. This observation of the potential similarities with the data from the literature review and Heron's (2001) theoretical positioning, prompted a further scrutiny of that data with reference to Heron's (2001) interventional states; again adopting a stance of trying to identify data that would disprove such an assumption. Despite several revisits of the findings with such a focus, it was indeed initially apparent that the therapeutic relational endeavours of acute psychiatric nurses could also be inclusively mapped to the theoretical perspective of Heron's (2001) six categories of intervention; with the data suggesting relational activity and endeavour across all components of that perspective. Table 3.7 overleaf, offers an example of data arranged within Heron's six categories of intervention.

Table 3. 7 Data arranged according to Heron's (2001) Six Category Intervention Analysis Model

Domain	Category	Example descriptors
Authoritative	**Prescriptive**	Utilise the science and psychological understanding and technique (Cleary et al., 2012b) Being expert and knowing what is best (Berg and Hallberg, 2000) Provide clearly defined goals that relate to health (Chiovitti, 2008) Set limits (Cleary et al., 2012b)
	Informative	Give information, applying and sharing psychological and biomedical understanding (Scanlon, 2006) Provide education (Delaney and Johnson, 2014) Present the rules with credible rationales (Gabrelson et al., 2016)
	Confronting	Regulate to achieve therapeutic position (Hem and Heggen, 2003) Shield of control; guarantors of order and safety (Bjorkdahl et al., 2010) Knowing when an issue needs to be forced (Cleary, 2003)
Facilitative	**Cathartic**	Engage and work with the distress (Thibeault, 2016) Feel, convey and work with the intensity of the situation (Cleary et al., 2012b) Show emotional involvement together (Scanlon, 2006) Work with emotions and vulnerabilities (Hem and Heggen, 2003)
	Catalytic	Agree goals and tasks (Scanlon, 2006) Motivator (Berg and Hallberg, 2000) Clarify the patients viewpoint, empowerment exercises (Delaney and Johnson, 2014) Coax towards their own goals (Cleary et al., 2012b)
	Supportive	Conveying understanding from the patients perspective (Bjorkdahl et al., 2010) Take care of practical issues (Cleary et al., 2012b Provide practical care, food, drink, comfort (Scanlon, 2006)

With reference back to the previous chapter, which considered interpersonal communication as a potential component of an emergent theoretical frame, the extracted data was also considered in terms of any connectivity to such a perspective. Although, apart from passing references to the need for skilled and appropriate use of eye contact, body posture, non-verbal communication and an appropriate cadence to the communication (Bjorkdahl et al., 2010; Cleary et al., 2012b; Dziopa and Ahern, 2009), the presentation of the data within the reviewed texts did not lend itself to any further analysis from this perspective, as they lacked the detail of what constituted skilled and appropriate strategies.

3.6 Conclusions

This literature review adopted a critical review strategy (Grant and Booth, 2009). This strategy, whilst retaining a focus on research literature, is described by Grant and Booth (2009) as being located towards the scoping end of the spectrum of literature search strategies, which has allowed the inclusion of research studies that would be excluded under more systematic searches on the basis of strict quality inclusion criteria, making it possible to identify the extent of the contemporary research literature in relation to the phenomenon of interest.

Having identified a number papers, they were firstly appraised for their fit with the literature review question: “what does contemporary research literature tell us, of how registered psychiatric nurses establish a therapeutic relationship within a psychiatric inpatient setting?” They were then reviewed in the light of an exclusion criteria that focused the search further in terms of: identifying contemporaneous research; those with a similar context to the intended research area; those that offered the nursing perspective; and those that related to the strategic endeavours of nurses as opposed to studies concerned with potential barriers to such efforts. As a result of the application of the exclusion criteria the number of research studies and meta-syntheses were very limited. Only nine original research studies and three offering a synthesis of the available research were identified. It was observed that of those 9 research studies, some of the practicalities of conducting qualitative research led to some inevitable and common

compromises relating to sample size and exposure to the inherent biases within an interactive human design (Treece and Treece, 1986). Additionally, critique also revealed the studies had often drawn on a wider perspective than that of acute psychiatric nurses, or the therapeutic relationship was only examined as part of the wider functions of acute psychiatric nurses, and in doing so lost the depth of detail. In terms of the meta-syntheses, two of them (Cleary et al., 2012b.; Delaney and Johnson, 2014) also lacked direct focus upon the relationship and the third (Dziopa and Ahern, 2009) drew upon such a broad range of perspective over time and contexts that direct application to the understandings of contemporary acute psychiatric nurses and their relationships has been limited. It can only be concluded that the aggregated findings and understandings presented in this search, can at best, only be said to be tentative understandings of the concepts and relational endeavours undertaken by acute psychiatric nurses to form a therapeutic relationship with patients. It is this critical observation that has been key in informing the decision to undertake the further exploratory research detailed later in this thesis.

The review presented that the existing nine descriptive categories offered by Dziopa and Ahern's (2009) meta-synthesis offered sufficient scope to be inclusive of the data extracted for the purpose of this review also, and presented the relational endeavours of acute psychiatric nurses as; skilfully conveying understanding and empathy; providing support; promoting individuality; being there and available; being genuine; promoting equality; demonstrating respect; demonstrating boundaries; and utilising self -awareness.

Further analysis of the findings questioned the notion of a singular type of therapeutic relationship presenting that the findings indicated a multiplicity of relational roles within the therapeutic nurse-patient relationship, and presented a view that Clarkson's (1995) theoretical assertions of five relational types: The working alliance; the transferential and the counter transferential; the parental; the interpersonal; and the transpersonal; offered an inclusive theoretical frame by which the relational behaviours of acute psychiatric nurses, identified within the findings, could be cautiously understood. Additionally, this review has observed from

the findings that there is a dynamic movement between such roles and is reflective of Peplau's (1952) assertions of the interpersonal and progressive process of the nurse-patient relationship.

Consideration of the relational endeavours revealed through this literature search, identified that those endeavours could often present as being broad and conflicting in nature, and was reminiscent of Herons (2001) six categories of intervention: presented within two overarching and conflicting domains of the authoritative and the facilitative. This review presented that the wide range and conflicting relational endeavour can be, with a high degree of caution, also be inclusively represented by those six categories and two domains.

Whilst verbal and non-verbal strategy was envisioned to be part of the strategic endeavours reported by nurses, there was insufficient detail within the literature reviewed to offer any clarity on this, beyond a confirmation that such strategy existed.

3.7 Research recommendations arising out of this review

As a consequence of the conclusions arising out of this literature review a set of research recommendations has been compiled, and is detailed in table 3.8 overleaf:

Table 3. 8 Research recommendations arising out of the literature review

There is a need for further exploratory research to uncover the insights held by contemporary acute psychiatric inpatient nurses in terms of their endeavours to form a therapeutic relationship with patients
There is a greater need for triangulation of research through comparing and contrasting acute psychiatric nursing research with research that considers the insights of patients, relatives, other professional groups.
There is a need to consider and account for the multiplicity of relational roles formed, and the progressive movement between them within any account of the relational endeavours of acute psychiatric nurses.
There is a need for greater theoretical framing and discussion of the findings of research studies, if the broad and often conflicting descriptive accounts of the relational endeavours of acute psychiatric nurses are to be understood
The relational labour of acute psychiatric nursing requires further exposure, and quantifying in terms of outcome for service users if it is to remain central to the practice and discourse of acute psychiatric nursing

In terms of this thesis and research endeavour, it is the first recommendation generated form this literature search; that in the light of a paucity of focused studies, there is a need for further exploratory research to be undertaken. Without such further studies the insights and concepts held by contemporary acute psychiatric inpatient nurses in terms of their endeavours to form a therapeutic relationship with patients remain poorly represented and understood. It is this particular theme that has set the direction of this research.

The following chapter identifies a research strategy by which those nursing insights into the formation of the therapeutic nurse- patient relationship within acute psychiatric wards can be investigated further.

Chapter 4

Methodology and Methods

4.1 Introduction

This thesis so far has argued that there is a lack of clarity in terms of how acute psychiatric nurses form a therapeutic relationship with patients, and therefore a tentative theoretical frame has been constructed from a review of existing theory. Furthermore, a systematic search of the literature demonstrated a paucity of contemporary research into the subject matter, and that the insights into the phenomenon remained essentially within the minds of the nurses themselves. It is suggested that there is a need for further exploratory research to give further voice to those insights, and in turn further an understanding of the phenomenon. This chapter details the methodological choices and methods undertaken by which those further insights have been sought.

Crotty (1998) described a linear process to identifying a research strategy; suggesting that a researcher moves from a consideration of both the ontological perspective and epistemological perspective, and bearing in mind both the research question and the theoretical frame; makes a considered choice of methodology. A choice is made which is informed by an appraisal of the philosophical congruence, strengths, weaknesses and intended focus of that methodology. This in turn is followed by a choice of methods that are congruent with that methodology and the epistemological and ontological roots as well as its likelihood to provide the data to answer the research question. Whilst the researcher cannot claim such a linear and organised thought process as described by Crotty (1998) it has served to offer a frame of reference both as a guide in the selection of a research strategy, but also as a structure to the construction of this chapter. Reassuringly; Gelling (2015) also noted that rarely is the research thought process linear, even if the process itself is presented as linear in its reporting.

This chapter will describe initially its ontological position, and makes a case for a relativist positioning of the research. This is naturally followed by the epistemological question of how that reality is to be understood and a methodology of phenomenology is presented which offers a congruent choice with the ontological underpinnings and focus of the research. In particular

reference is made to the use of an interpretive phenomenology. The chapter goes on to describe the convergent interviewing method as the mechanism by which data will be collected and analysed, presenting a description of the analytical strategy that is inherent in the method itself. The location of the research study, the population and the sampling strategy are discussed, which identifies the acute psychiatric wards within a single NHS organisation as the location, and the population as those registered psychiatric nursing staff within them. Sampling is described as a purposeful maximum variation strategy that continues until a convergence of ideas occurs.

The chapter also offers a description of the strategies that are utilised to manage some of the more operational and functional elements of the research, and includes reference to data capture instrumentation, recruitment, consent taking, data storage, quality control methods and the mitigation of bias. A pilot study was undertaken in preparation for this study and details of that are also offered within this chapter, as are the key learning points from that pilot study.

The Department of Health (2012) has suggested that questions of ethics should arise early within a researcher's thought processes. Those thoughts, in the case of this research, have been informed by reference to a number of ethical frameworks and codes that have been specifically developed to support research practice in health settings (Department of Health, 2012; Freegard, 2007; Nursing and Midwifery Council, 2008; Royal College of Nursing, 2011; Seedhouse, 1998; Seedhouse and Lovett, 1992). Reference to decisions around ethics is made throughout the chapter in relation to the various elements of the research process. Furthermore, for ease of reference a summary is presented at the end of this chapter that details the ethical approval processes sought for this study. The chapter concludes with a summary table of the key components of the research strategy.

4.2 Ontology

As suggested by Parahoo, (2014); Scotland, (2012); and Streubert and Carpenter (2011) beliefs of the nature of reality (ontology) and how we come to understand that reality (epistemology) were considered and have guided the selection of a methodology and subsequently methods that are congruent with that positioning.

There are frequently two ontological positions described: that of realism, with a belief in an objective reality, of universal truths, a solid reality so to speak (Wainwright, 1997); conversely relativism offers a position that suggests there is no such object reality, but only a temporal account of reality that is dependent on the context, perception and meaning that have been attributed to it (Streubert and Carpenter 2011). There has also been offered a middle ground between the two, one that suggests that there indeed maybe the object realities of realism, but such is the influence of social and cultural discourse, the understanding and presentation of those realities cannot be considered absolute (Bhaskar, 1979; 1989; Bhaskar and Hartwig, 2010), a position borne out of the critical theory offered by Habermas (Lafont, 2016). Indeed this thesis has already observed a notion of the critical realist stance earlier, noting how psychiatric nurses will seek to understand their more challenging relationships through the scientific insights of psychology, but then subjecting those insights to a process of 'nursification'.

Social science commentary offers a view that it is impossible to study humans from such a realist perspective (Mills, 2000) because their actions are highly complex and their behaviour is dependent upon habits, emotions, beliefs and rationales that are influenced and shaped through culture. As a result, their view and understanding of a reality, is in turn, highly contextual, and unique to a time, place and culture, therefore human reality cannot be seen as a fixed position (Holloway and Galvin, 2017). Such an argument, resonates with the researcher's own beliefs of the nature of human reality, and given that the research question for this study is essentially an exploration of the human (nurses') understandings of a

phenomenon; an ontological stance of relativism was taken with regards to this study, as it seeks to give voice to the lived experience of nurses.

Furthermore, given the observation that there is both a lack of clarity or a substantial body of existing knowledge of the phenomenon it would prove very difficult to generate a focus for scientific enquiry, without first conducting further exploratory research in order to isolate the concepts and hypotheses to be tested.

4.3 Methodology and epistemology

Having indicated an ontological positioning on the beliefs about the nature of reality; epistemological questions of then how that reality is to be understood are raised (Maxwell, 2013). A relativist position demands that whatever methodology and methods are chosen, it is requisite that there is a full and broad engagement with all the inter-related human influences that surround the phenomenon, in order to capture and present a contextual and temporary reality; as mutually constructed by the participants and researcher (Maxwell, 2013; Scotland, 2012).

As noted in the literature review and the underpinning theory chapters of this thesis, the concepts, influences and potential variables surrounding the 'how' of the nurse –patient relationship in acute psychiatric settings are not yet reliably fully understood or clear. This observation in turn would challenge the construction of a quantitative design; as what is to be measured or asked of respondents. Therefore a qualitative methodology was chosen; as qualitative design seeks explore and uncover concepts, to record the perceptions, understanding, history, social texts and the relationships that surround an account of reality (Charmaz, 2006; Holloway and Galvin, 2017; Maxwell, 2013; Parahoo, 2014).

Holloway and Wheeler (2010) and Grove (2017) identify three main research traditions of the qualitative approach, each with a differing governing ethos; ethnography, associated with the observation and rich description of culture and customs; grounded theory with a focus on

generating tentative theory and hypotheses; and phenomenological research and its primary concern with collating, and ultimately giving voice to the lived experience of participants in relation to a social phenomenon. Denzin and Lincoln, (2005); Parahoo, (2014); and Tappen (2016) advised it was important to choose one that has a central focus that is cognisant with the information being sought. In terms of this research question, the focus of the phenomenological approach in capturing the lived experience, as understood by the participants, is in direct keeping with the intention and interest of this research (Grove, 2017; Parahoo, 2014; Pringle et al., 2011), phenomenology is thus presented as the overarching methodology for this research.

Phenomenological enquiry in itself cannot be considered as a unified school of thought; and whilst there is universal agreement that understanding should be driven by the embodied experiential understanding of the participants, significant ontological and epistemological differences exist within the field (Finlay, 2009). There have been many changes of thought on the nature of phenomenological enquiry, informed by both philosophical and pragmatic commentary such as that of Merleau-Ponty, Ricoeur, Sartre, Levinas, Gadamer, Van-Manen and Giorgi (Smith, Flowers and Larkin, 2009); however, over time two main schools of thought have emerged; Husserl's descriptive phenomenology or Heidegger's interpretive (hermeneutic) phenomenology (Laverty 2003).

Husserl suggested that to 'know' the phenomena required a transcendental approach by the inquirer; to note and record all preconceptions, knowledge and beliefs, then to suspend them (bracketing), thus enabling the observer to then adopt an objective position, which in turn enables them to describe without influence or interpretation the 'essence' of a phenomena (McConnell-Henry, 2009). Notions of such an 'essence', suggest an underpinning belief in the existence of an object reality that is there to be uncovered (Laverty 2003). Heidegger and later Gadamer (McConnell-Henry, 2009) present an opposing argument to this belief, and suggested that such an essence did not exist, and that reality was temporal and contextualised, mutually constructed by the human participant and the inquirer; therefore bracketing was

impossible and notions of such were misleading. Both Heidegger and Gadamer argued, it was necessary to go beyond simply seeking a description of object reality, and to take note of the influences of both interpretation and prior knowledge in the construction of reality (McConnell-Henry, 2009; Smith, Flowers and Larkin, 2009). Thus, Heideggerian interpretative (hermeneutic) phenomenology argues that the goal of inquiry was to essentially elicit a mutually constructed and interpreted account of a phenomenon (McConnell-Henry, 2009). Smith, Flowers and Larkin (2009) argued that such an approach required the researcher to move between the emic and etic views. To empathetically interpret what it is like, from the point of view of the participants, to take their side so to speak and to try and faithfully give a cohesive voice to their understanding. Whilst at the same time also ask critical questions, such as 'what is the person saying here', is there a glimpse of something hidden being offered, or is something being inferred that the researcher suspects, based on their own experience or knowledge of the subject but the participants have not been able to give a direct voice to. Smith, Flowers and Larkin (2009) argued that allowing for aspects of interpretation in the inquiry, is likely to lead to a richer analysis and to do greater justice to the totality of the person. Such an approach is both in keeping with the ontological positioning of this research and offers a congruency with the researcher's beliefs about the nature of human reality. Additionally, it offers the opportunity for an honest and open account of the researchers embedded position within the research field, as often those undertaking professional doctorates will undoubtedly be, and as such of the impossibility of a bracketed view in such circumstances. Heideggerian interpretive phenomenology was thus selected as the methodology for this research.

4.4 Methods

Parahoo (2014) noted the inductive, holistic and interactional goals of qualitative research are best achieved through flexible, creative and penetrative methods. As suggested by Grove (2017), various methods were reviewed and appraised of their advantages and disadvantages

in terms of their likelihood to yield the information required whilst remaining congruent with the methodological focus, and ontological positioning of this research.

Both the research question and the selected methodology, suggested the need for a method that allows individuals to explore and express their views and perceptions in depth, to interact with the researcher and the data, to mutually clarify and interpret information, and through those discussions arrive at a mutually constructed perspective of the phenomenon (Laverty, 2003; McConnell-Henry, 2009). Whilst questionnaires and observation are significant and useful methods within qualitative inquiry, interviews and focus groups allow the greatest opportunity for interaction, clarification and the exploration of perceptions and potential hidden meanings (Holloway and Galvin, 2017). Both focus groups and interviews were appraised in more depth in order to inform the choice of method, or possibly methods.

Focus groups provide an inexpensive, pragmatic, flexible, stimulating, cumulative, and elaborative tool; and use group dynamics in assisting information recall and supporting the formation of ideas, and are indeed capable of producing rich data (Kreuger and Casey, 2015; Streubert and Carpenter, 2011). The interactive nature can offer the opportunity for discussion, clarification and the development of ideas; it allows the observation of non- verbal cues and inferences that guide new avenues of enquiry to expand the understanding of a phenomenon (Agar and McDonald, 1995; Gibbs, 1997; Kreuger and Casey, 2015). Although Kidd and Parshall (2000) suggested that prima facie notions of time and cost saving are illusionary; as the time to organise and record such groups along with the time necessary to detangle and analyse very messy data ameliorates such benefits.

Also, whilst the method seeks to exploit group dynamics to elicit information; those same group dynamics may prove problematic, and issues of coercion, conformance, censoring, conflict avoidance, or just plain fickleness can arise and require skilful and experienced negotiation, or at least an accounting for such difficulties within the analysis (Kidd and Parshall, 2000; Wibeck et al., 2007; Stevens, 1996). Such issues become particularly apparent where a hierarchical

structure based on position or experience exists, a position that certainly exists within a team of acute psychiatric nurses, and may be particularly the case with the researcher as a consultant nurse. This raised ethical concerns, in terms of the welfare of participants, when they are exposed to the pressures of such interpersonal dynamics whilst in the hands of a novel researcher, unfamiliar with the running and practice of focus groups (Smith, 1995).

Such hierarchical structures and group processes may also increase the likelihood of participants offering socially desirable, or the 'professionally' correct answer to questions (Kreuger and Casey, 2015). Furthermore, conscious of the novice status of the researcher in conducting a focus group, they also potentially offer a number of practical difficulties that require experienced management; difficulties such as the emergence of multiple threads; conversations within conversation, the emergence of complex group dynamics with multiple non-verbal inferences, which need to be understood and accounted for (Holloway and Galvin, 2017). The researcher also held some concerns that focus groups can present some technical difficulties in terms of creating an audible recording, and without such an accurate and clear recording it can be difficult to know who said what and when (Holloway and Galvin, 2017; Kreuger and Casey, 2015; Streubert and Carpenter, 2011).

A focus group undertaken by a researcher with a good understanding and experience in working with group dynamics and facilitation, and with access to the technical skills to manage the data capture, could have indeed offered a useful method to answer the research question (Kreuger and Casey, 2015); such pre-requisites would have proved a challenge to the experience and ability of the novice researcher conducting this study. This in turn may have compromised the adequacy of the data collection and such a failure to capture accurately and meaningfully the participant views, not only compromises the research conclusions, but may also raise further ethical concerns with regards to the false or inadequate representation of participants (Tappen, 2016). Thus, this method was not chosen, despite its face value as a potential method to answer the research question.

An in depth consideration of interview strategies was undertaken to identify an approach to interviewing that could offer the best chance of eliciting the breadth of the information required. Interviews maybe conducted in person, or remotely over the telephone or video link (Holloway and Galvin, 2017). The more remote techniques certainly offered an advantage of using time and people resources efficiently. At the time the method was being considered for this study, there was a concern with the researchers and the participant's potential awkwardness and unfamiliarity with remote technology, which sat alongside a concern with the reliability of the existing technology; which in turn would negatively impact on the ability to either collect data directly, or lead to a failure in the establish of a rapport, or the ability to pick up on any subtle nuances and cues (Mussellwhite et al., 2007). Initially the research strategy was to conduct face to face interviews, and this remained the position and desired strategy through the early months of the COVID-19 pandemic when there was significant restrictions on face to face contacts. As a result, the commencement of data collection was initially deferred until face to face interviews could be undertaken. Despite this initial decision, the advancement and reliability of video linked communication technology moved very quickly over the first few months of the COVID-19 pandemic, as did both the familiarity and confidence in the use of the technology, as it became part of the daily routine of communication. Early concerns with the use of such technology became moot and an amendment to the research protocol was made to move to video linked interviewing and the protocol was resubmitted for ethical approval, and subsequently approval was granted through the various ethical bodies detailed later in this chapter.

The fundamental skill set of conducting an interview to elicit information and understanding through the establishment of a rapport, trust, and the subsequent use of open ended, summarising and clarifying questions, are very familiar to the researcher through the daily practice of being a psychiatric nurse. In practice such interviews are undertaken as a means to understand patients' emotions, perceptions and understandings of health and ill health (Tappen, 2016; Holloway and Galvin, 2017). Tappen (2016) thus suggested that interviews,

where appropriate to the research question, presented a useful and accessible strategy for the novice nurse researcher.

Interviews can be conceptualised on a structure continuum that ranges from completely unstructured through to highly structured (Gubrium, 2012; Gubrium and Holstein, 2002). Highly structured interviews are particularly useful, where precise data about a well-defined subject or phenomena is required, and has the advantage that data is both manageable in terms of the amount generated and the subsequent analysis (Polit and Hungler, 1993). In direct contrast unstructured interviews are useful in exploring phenomena where little is known, and offers the opportunity to explore and clarify the participants' view- points in depth. They capture the participants' own words, and allow an opportunity to explore meaning and inferences, non-verbal cues and contradictions, they also allow the participant to direct the discussion and clarify interpretations (Holloway and Galvin, 2017; Parahoo, 2014). Given the paucity of information in relation to the research question it was inevitable that the interview, at least initially, required an unstructured format. Holloway and Galvin (2017) observed, it is not uncommon that the highly motivated novel nurse researcher will, after launching into a series of unstructured interviews, will then be faced with an overwhelming data set to potentially transcribe, manage and analyse, which will often lead to a failure to complete the research project. Therefore an interviewing style that offers an opportunity for unstructured conversation but offers a mechanism for moving towards increasing structure and a planned approach to data management and analysis from the onset was sought.

Dick (2017) developed and described an approach, which he entitled the 'convergent interviewing method'. It has its roots in market research, but is increasingly finding a place in social and healthcare research (Logan et al., 2013). Bohle et al. (2009); Dick (2007, 2017); Dreidger (2008); and Rao and Perry (2007), have described convergent interviewing as an in-depth interview method that is characterised by a structured process that moves the researcher from an unstructured approach towards increasing levels of structure as the data starts to converge towards an understanding of the phenomenon. Analysis follows each interview, and

that analysis in turn informs the next interview, with increasingly focused questions as the research hones in on the key characteristics of the phenomenon being investigated. Dick (2017) described convergent interviewing as a twin process of the interviews and the process of data analysis, cyclic and data driven. Thus, data collection and analysis alternates in a tight circle. A position arguably reflective of the hermeneutic cycle of understanding, cognisant with Heideggerian phenomenology.

Reige and Nair (2004) offered an opinion that after supervising forty post-graduate researchers they concluded the method offered the novice researcher an uncomplicated and rigorous method that meets the goals of exploratory research, providing robust auditable data and analysis. Williams and Lewis (2005); Rao and Perry (2003); and Jepsen and Rodwell (2008) concur with this assessment of the technique. Whilst their conclusions have largely been drawn from experiences of the method in market research, Bohle et al. (2009), Moloney et al. (2016), Rodwell et al. (2009) Logan et al. (2013), Driedger et al. (2006), and Van-Biljon et al. (2017) have applied the method within healthcare environments and have presented similar conclusions of its application and usefulness. Thus, convergent interviewing was selected as a method that was both congruent with the ontological beliefs, epistemological stance and the methodological choice, whilst also offering a means by which the research question could be answered and data managed.

4.5 Analytical strategy

Analysis is an integral part of this interview method, and is undertaken in between each interview (Dick, 2017). Initial interviews are unstructured and introduce the subject material in the format of very broad open-ended question. After each interview, the interview recording is listened too and interview notes scrutinised (Dick, 2017): Interviews are compared with interviews and as the process progresses; comparison is undertaken with the emergent themes (Rao and Perry, 2003). Novel ideas, contentious issues, agreements, disagreements, ambiguities and loose ends are noted on analysis sheets and future probe questions developed

(see appendix 4). Probe questions seek to tie up loose ends, seek exceptions to agreements and explanations for disagreement. Analysis sheets are thus progressive in their recording, and ideas and quotes that illustrate the key points are then carried forward with each interview for further investigation. Probe questions ensure that the insights at the end of such a process have survived multiple attempts to disprove them and seek alternatives (Dick, 2017). The convergent interviewing method with its cyclical analysis is detailed below in Table 4.1, additionally Table 4.2 offers an example of types of probe questions.

Table 4. 1 Convergent interviewing adapted from Dick (2007, 2017)

Interview format

Interview commences from an open-ended format and the degree of structure thereafter is added through probe questions to deepen the understanding of the phenomena

Clarify and summarize the interview with the participant with time to spare

Check completeness with participants (ask if anything important has been missed)

Analytical framework

Following each interview compare interview with previous interviews and emergent themes

Identify novel ideas	Identify similarities	Identify differences
Identify ambiguities	Identify contentious issues	Identify ideas that require clarity

Develop probe questions that seek exceptions to similarities

Develop probe questions that seek to explain differences

Develop probe questions that explore unclear avenues of thought

Table 4. 2 Example Probe Questions (adapted from Logan et al., 2013)
Can you give me an example of this?
Can you elaborate a little?
What exactly did you mean by?
Is that all? Is there anything we have missed out?
How does that compare with a view?
What are the pros and cons of that situation?
How did / do you feel about that?
Why do you think this is the case?
What would have to change in order to?
How was…. Different to?
What sort of impact do you think?
What criteria do you use?
How do you decide / determine / conclude?
What is the connection between… and….?
How might your assumptions about…. Have influenced..?

4.6 Data capture

Within the study both audio recording and flip charts penned by the researcher, were utilised. The recordings offered a mechanism to access the data as it was presented, complete with verbal nuance and inflection, allowing for deeper reflection and appraisal than can occur within the interview (Gubrium, 2012; Polit and Hungler, 1993). Additionally utilising digital recording devices allowed secure data storage within the format of password protected files upon an encrypted computer. The additional use of flip charts, mutually constructed with the participant, offered a visual representation of the spoken words, capturing major headings and thoughts, they also offered a medium to check meaning and explore connections and contradictions and to summarise thoughts with the participant. They also provided an opportunity for the participant to visually appraise if any data has been missed, or misconstrued (Patton, 1990). Flip chart notes were digitally photographed and again securely stored digitally for later reference, with the original being confidentially destroyed. The use of the flip chart did present some technical challenge in presenting camera angles that enabled the participant to see both the researcher and the flip chart, however following several practice runs with family members it was indeed possible to achieve.

The requirement for transcription as part of the data collection process has been argued as unnecessary and impractical with the convergent interviewing approach, as initial analysis takes place immediately after each interview and is revisited again before the next interview, whilst the insights and clarifying questions remain fresh in the mind of the investigator; with each interview informing the next (Dick, 2017). Dick (2017) observed that the realities of acquiring a high-quality transcript, with potentially the cost of enlisting skilled support was not only likely to result in a loss of the timeliness of the next interview, but also there was a very real potential that the process of transcription may deter the researcher from conducting sufficient interviews to complete the research, or to answer the research question thoroughly. In light of Dick's (2017) reported experience and cautions of both the practicalities and the

limited usefulness of transcription with the convergent interview method, the researcher did not utilise transcription for this study.

4.7 Research location

Following a review of the debates presented for the various merits and practicalities of insider and outsider research (Dwyer and Buckle, 2009; Holloway and Wheeler, 2010), a decision to adopt an insider position utilising the researcher's organisation was taken.

The insider position was adopted as it allowed for a greater depth and understanding, as the researcher remained close to local cultural understanding, the subtle language cues and inferences that are often utilised in detailed cultural exchange (Dwyer and Buckle, 2009; Holloway and Wheeler, 2010). Additionally, as the researcher is a trusted and credible clinician within the organisation, there seemed as Mullings, (1999) and Streubert and Carpenter (2011) observed, to be less restraint from participants in offering sensitive data. Furthermore, as Holloway and Wheeler (2010) had suggested, the insider researcher position was felt to have offered the advantage of securing an audience in the first instant, due to a familiarity with the researcher. Additionally, as Holloway and Wheeler (2010) went on to note, such local knowledge also helped to inform initial decisions of whom was likely to hold and communicate the information being sought.

Utilising the insider position, as Mullings (1999) had reported; also offered greater efficiency in terms of an existing awareness of the governance and support systems within the organisation and the people within them. In addition, this familiarity with the research environment allowed a degree of ease with the mechanisms by which scheduling interview times with participants could be undertaken.

Such localised, in-house research is arguably highly contextualised, but the strength of such an approach is the depth of the knowledge generated, and it is the addition of such knowledge to the understandings generated by multiple qualitative studies and the synthesis of those

studies that builds a more generalizable account (Cleary et al., 2012b). Additionally, pragmatism and efficiency has had to be a key consideration of this research project, as it is with many qualitative studies, to account for the limited funds and time that are often available for such studies (Couchman and Dawson, 1990; Holloway and Galvin, 2017).

4.8 Population

This study relates to a single site NHS psychiatric hospital, with four acute wards offering a total of 64 beds, serving an inner-city area and a surrounding rural area. The central area is characterised by a past of, but now largely redundant, heavy industries that related to steel, coal and the manufacturing industries; the rural component is characterised by larger lowland estate farming to the south and smaller isolated hill farming communities to the north.

Given that there is always a potential danger of overgeneralizing conclusions from such a localised qualitative study (Tappen, 2016), the population is tightly defined below, in order to be clear to the reader of whom the insights and knowledge are intended to represent. The population was identified simply as all the registered psychiatric nurses who are currently working within the acute inpatient wards of a single NHS organisation. It is anticipated though, that given the similarities of acute psychiatric wards across the United Kingdom, the findings and discussion are envisaged to hold significant meaning to the much wider population of acute psychiatric nursing.

4.9 Sampling strategy and size

In the convergent interviewing method, Dick (2007, 2017) suggested that it is the disagreement between participants that drives the data and analysis; the greater the diversity, the greater the likelihood of disagreement, which ultimately leads to a richer and deeper understanding of the phenomena. In keeping with such a desire for that richer and deeper understanding a purposeful sample was utilised in order to ensure a wide diversity of views were captured. Such sampling was described simply by Palinkas et al., (2013) as a maximum variation sample. The

purpose being as Patton (2002) had suggested was to gather and understand the breadth of views, opinions and the differences surrounding the phenomena, rather than achieve representation. Palinkas et al. (2015) had observed that such a purposive strategy was common in qualitative studies and was a pragmatic and justified means of ensuring the depth and enriched data ambitions of qualitative inquiry were realised, minimising the chance that marginalised views were not lost in the process of a random selection process. Both Mason (2002) and Robinson (2014) concurred and added that as long as the sampling strategy and its purpose were made clear to the reader in a bid for trustworthiness, such purposive sampling often enabled the depth of understanding to be portrayed adding credibility.

The study adopted Rao and Perry's (2007) suggested approach for achieving such a sample; this initially focused on the recruitment of the local leadership into the research process, and then coupling their knowledge with that of the researchers to identify individuals that are most likely to be able to offer a perspective on the phenomena. A divergent sample then continued to be built by asking subsequent interviewees whom may offer a difference of opinion, or are seen to have a different relational style or maybe offer a different perspective by virtue of a differing demographic; such as a different age, experience level, sex or race.

The notion of data saturation drives sample size rather than any pre-set number within qualitative research (Morse, 1994). Data saturation has been described as 'information redundancy' or the point at which no new themes or codes 'emerge' from data (Clarke and Braun, 2021). However Clarke and Braun (2021) went on to contest whether this was ever the case in interpretive research as each hermeneutic interpretation of the data resulted in new understandings, and as such the decision that nothing new was being offered was indeed a subjective decision limited by the researchers scope of vision. However as Morse (1994) observed the researcher must at some point make a decision to stop data collection and more often that was at a point where it was apparent, that more interviews at that time, would not yield anything new. Clarke and Braun (2021) described several attempts to operationalize data saturation and provide concrete guidance on how many interviews would be enough to achieve

some degree of data saturation. Morse's (1994, 2000), often cited position, that in terms of phenomenological interview at least 6 interviews are necessary; and Cresswell (1998) suggestion of a normal range between 5-25; with Mason's (2010) review of phenomenological studies finding that 68% did actually fall within this range.

In this research, seventeen participants were interviewed, although with reflection no new ideas or opinions were being offered after 10-12 interviews. However it was the caution of a novice researcher, making a decision that saturation had occurred, that led to several more interviews being undertaken, to confirm that decision.

4.10 Recruitment

The host organisation offered the opportunity to use a secure and encrypted e mail account that is available and widely used by all staff (including the researcher) for both work purposes and professional dialogue, that e mail account is supplied with a global address list, available to all employees. This e mail function is routinely utilised to inform staff of training opportunities, meetings and to deliver other material that may be of either professional or corporate interest. Targeted group e mail is routinely used where the subject material is of interest only to specific staff within the organisation.

The researcher utilised this system to send an ethically approved pre-worded group e mail (see appendix 5), to potential participants inviting them to attend a 20-minute research presentation via video link about the research project. A single pre worded reminder e mail (see appendix 6), also subjected to the ethics procedures, were sent 14 days after the first date. Both e mails made it clear that attendance for the presentation was voluntary and without consequence should an individual not wish to attend. The e mail also detailed, that should an individual not wish to attend, it was not a requirement to decline the invite. To help inform the decision to accept the invite or otherwise, the participant information leaflet was also attached (appendix 7). This use of group e mail; limiting reminders to a single occasion; removing the need to reply; and explicitly stating the voluntary nature of attendance; were direct strategies to reduce any

sense of coercion that may stem from a more personalised approach by the principal investigator. After potential participants received the 20-minute presentation, if they then offered an initial indication of a desire to engage with the research, their name and contact was noted then they were left without contact for 7 days to afford them an opportunity to digest and discuss the information with peers. Following this, a pre-worded e mail (see appendix 8) was then sent by the principal investigator to invite those that expressed an interest, to an interview. If an individual directly declined further involvement this was accepted without questioning. Where there was no response within 7 days, a further and final pre-worded e mail reminder (see appendix 9) was sent inviting the potential participant to arrange an interview. Again, both the interview invite and reminder were subject to the ethical review process, to ensure the wording offered both the clarity of what was been asked and to review any unintended coercive language.

Each e mail also contained the information leaflet, and informed that following the second e mail, a 'no response', will be accepted as an individual declining to be part of the research and that the researcher will not make any further enquiry.

A divergent sample then continued to be built by approaching subsequent tranches of potential participants in the same manner, and so on until no new data is emerging; and saturation had occurred.

4.11 Consent

Verbal consent to be part of the research was sought utilising a pre –written consent form (see appendix 10) and was again formally checked within the pre-amble before the interview, where the information sheet was also discussed again. Consent was also separately sought for the use of anonymised quotes within the final report (see appendix 11), this was requested as utilising the words of participants to convey their lived experience adds to the quality of phenomenological reporting (Willgens et al., 2016). Consent forms were dated and signed by

the researcher as they were taken. Both the forms and the consent process were also subjected to ethical review procedures.

4.12 Data storage security

All data (apart from consent forms) is stored digitally within an encrypted server, within a password protected account that has been created specifically for the storage of the research data, and is only accessible by the researcher and their lead supervisor. All data was assigned an alphanumeric code and stored in a separate password protected file to the password protected file that contains the information identifying individuals with their alphanumeric codes. Flip charts were immediately digitally photographed on completion of the interview, and the original confidentially shredded at that point. Digital recordings and the digital images of flip charts were uploaded from the digital devices within 24 hours and the data on the devices was then permanently deleted from those devices. Up until that point recorded information was kept on the person of the researcher, or stored within a lockable cabinet identified specifically for the storage of the research data, within a locked room.

Consent forms are stored within a lockable cabinet identified specifically for the storage of the research data, within a locked room. Consent forms are accessible to the researcher, and the lead supervisor within the school of medicine.

4.13 Participant welfare

The interview method can present some inherent concerns in relation to the welfare of the participants, unless steps are taken to consider and manage any discomfort or even unintended coerciveness that can be born out of the interpersonal nature of the interview method (Gubrium, 2012; Gubrium and Holstein, 2002; Holloway and Galvin, 2017).

The researcher had not held any direct managerial responsibilities within the acute psychiatric wards or the wider Trust for over ten years, but as a consultant nurse he is a senior clinician, and arguably that in itself could have led to a level of discomfort for the participant discussing

their own practice. Although, such reflection and clinical supervision is a requirement of continuing professional practice (Nursing and Midwifery Council, 2019), and the process and any level of discomfort was within the realms of the individuals' usual experience. Additionally, the researcher has considerable experience (over 30 years) of providing such reflective practice interviews with junior staff, and holds both the practical and interpersonal skills to recognise and resolve such discomfort. This may have included a sensitive termination of the interview if this had been required. Additionally, it was made clear in the interview pre-amble that the participant also had the right to terminate the interview at any stage.

The lack of immediate managerial responsibility did ameliorate some concern that the participants would feel any managerial expectation coercion to take part in the study. However, the senior clinician role of the researcher still held some potential to exert some unintended coercive influence in an individual's decision to take part; and so it was made clear to the participants that they had the right to decline involvement in the research in the first instance, and to withdraw from the process at any point. The right and limitations to withdraw was clearly stated in the information sheet and restated in the process of consent seeking, additionally the information sheet and the consent form also clearly stated and reiterated the freedom without sanction to refuse to take part. This was also reiterated within the pre-amble and consent seeking at the commencement of the interview process. Furthermore, the remoteness of the recruitment process in terms of utilising e mail was particularly designed in order to allow participants to opt out, without having to make a direct refusal to the researcher.

Whilst the study was not seen to be of a sensitive nature, as it sought to uncover the positive endeavours of nursing staff in forming a therapeutic relationship, the acute psychiatric environment and staff experience of it may have led to exposure to traumatic events (Bonner et al. 2002; Howard and Holmshaw, 2010) and the opportunity of an interpersonal interview with a senior clinical colleague may have led to the unintended disclosure and distress reaction to such events, again whilst the research interviewer held key clinical skills and experience to support an individual immediately with such distress, external resources were also taken to

identify further ongoing emotional support should an individual wish to take up that option. Similarly, the interpersonal nature and interaction of an interview may have led to the disclosure of practices that contravened professional and organisational standards (Polit and Hungler, 1993), thus all participants were informed beforehand through the information leaflet and the pre-amble that in such circumstances, such incidents would be forwarded through the appropriate reporting channels. Despite anticipating and planning for such difficulties, they did not arise within the research interviews undertaken for this study.

4.14 Quality control

Polit and Hungler (1993) suggested that all research should consider and in turn be appraised of its quality. Chiovetti and Piran (2003) suggested that the quality of qualitative research should be judged, not by the criteria afforded to quantitative design, but by the rigour with which the study is designed and conducted, its congruence with ontological and epistemological positioning and whether research strategy decisions, processes and conclusions follow a logical trail in relation to that. Charmaz (2006) and Maxwell (2013) suggested within relativist influenced work; the impacts and issues of reflexivity should be made clear. Ultimately the research should demonstrate credibility, auditability and fittingness (Beck, 1993). This research undertook a number of steps to both demonstrate and account for such concepts of rigour (Cheung and Hocking 2004, Chiovetti and Piran 2003, Greene et al. 2007) (Please see Table 4.3)

Table 4. 3 Methods utilized to increase rigour (Informed by Cheung and Hocking 2004, Chiovetti and Piran 2003, Greene et al., 2007)

Credibility

- The participant responses have guided the inquiry process
- Constructs and concepts have been checked with participants
- Reference to the participants' own words has been used in the presentation of the findings
- The research has considered existing theoretical frames, research and literary opinion drawing on a systematic literature search and within analyses and discussion
- Attention to ontological and epistemological consistency has been given

Auditability

- Personal views and insights have been articulated throughout the process from methodological decisions through to the data collection process and analysis. These have been recorded in a personal journal kept throughout the research
- A critical autobiographical reflective account of the personal professional and political that have led to the research question has been presented
- The decision-making process throughout the study is recorded.
- An explicit account of the data analysis process is offered
- Liberal reference to raw data (reflecting ethical considerations of security and anonymity) is made through the report of the research

Fittingness (transferability)

- The scope of the research is delineated in terms of the setting, the wider population, the nature of the sample and the sampling process
- Limitations with regards to the conclusions of the research is offered
- A presentation of how those conclusions pertain to existing literature both theoretical and existing research understanding is offered within a discussion section of the final research report

4.15 Mitigation of potential bias and potential difficulties

Researcher bias is a mechanism by which the researcher's own beliefs, values and expectations of the research creates subconscious blind spots to some aspects of the data offered, or drives the researcher to pick up on certain threads over others, or influences decisions on what information is to be emphasized and explored, and ultimately what the data is saying (Polit and Hungler, 1993; Tappen, 2016). This poses a risk that any final account is either incomplete or a skewed account of the phenomenon (Holloway and Wheeler, 2010). There is a greater risk of this in single researcher, interview based, studies, as was indeed the case with this investigation, as the researcher is both the sole instrument of data collection and the data analysist (Chenail, 2011).

Mitigating such researcher bias is a major concern of qualitative research (Polit and Hungler, 1993). Enlisting third parties in data analysis, may aid and mitigate against such researcher bias (Holloway and Wheeler, 2010). However the time to find a reliable and credible second or third data analysist, that was willing to familiarise themselves with the research and then to work to the time schedules necessary to match the deadlines, that are inevitably embedded within university award based research, presented a concern. Due to that concern, a pragmatic decision to keep the progress of the research within the researcher's own hands as much as possible was taken. Additionally the nature of the method used; that is interview followed by an immediate immersion and analysis of the data over the subsequent few days, and then the development of probe questions before the next interview following in relatively quick succession (Dick, 2017), would have further challenged the ability to achieve further analysist involvement. Thus alternate methods of mitigating researcher bias were considered.

The use of qualitative data analysis software also presented an option to mitigate against researcher bias (Banner and Albarran, 2009, Cypress, 2019). However St John and Johnson, (2000) warned that researcher's should seriously consider their own computer literacy and attain sufficient knowledge of the package to consider its fit and congruency

with the research methodology, methods and aims, or whether the time required to gain these skills and knowledge is indeed available within the research time frame, otherwise more problems may arise through the use of software than it may offer to solve. Whilst acknowledging the benefits of such software, St John and Johnson's (2000) warning certainly struck a chord with the researchers current lack of both knowledge and literacy, and in particular the lack of available time within the research time frame to acquire such a level of understanding. Therefore with reference to nursing research texts (Couchman and Dawson, 1990; Holloway and Wheeler, 2010; Newell and Burnard, 2011; Parahoo, 2014; Polit and Hungler, 1993; Tappen 2016), other mechanisms were considered to mitigate against such bias.

A research diary that records critical insights and reflections as they occur throughout the research process was kept and reference to it prompted the seeking of alternate perspectives to those first presented throughout. Furthermore the researcher engaged in an autobiographical reflective exercise prior to the research in order to identify motivations and personal attunements, which could be checked against assumptions and decisions made. Additionally the interview process, analysis and later discussion constantly returned to the experience and words of the participants to confirm and check interpretations. The use of the participants own words and quotes is utilised in this report to openly demonstrate the link to any interpretations made.

In addition to researcher bias there are a number of other potential biases and inherent difficulties that have been considered below. Therefore with reference to the learning from the pilot study (Fieldhouse, 2018), and with reference to a number of nursing research instructional texts (Couchman and Dawson, 1990; Holloway and Wheeler, 2010; Newell and Burnard, 2011; Parahoo, 2014; Polit and Hungler, 1993; Tappen 2016) these have been considered along with the mitigation and these have been tabulated overleaf for ease of reference (please see table 4.4)

Table 4. 4 Mitigation of bias: With reference to Couchman and Dawson, (1990); Hollowa and Wheeler, (2010); Newell and Burnard, (2011); Parahoo, (2014); Polit and Hungler, (1993); Tappen, (2016)

Potential Bias /difficulty	Mitigation / safeguard
The potential for an interview to be fatiguing was experienced within the pilot study. This has the potential to introduce fatigue bias, either on part of the researcher or the participant. As a result, answers may not be fully offered or fully explored and thus limit the scope of the data	Interview scheduling was mindful of working shift patterns, time of day and work load. Additionally sufficient time between interviews was planned. With no longer than 1 hour been allocated for each interview
It is possible in open ended questions that the participant may go off at a tangent or miss the point of the interview.	Opening questions were preceded with a pre-amble about the context of the research and the focus of interest. Additionally, the pilot study allowed the development and fine tuning of an opening question that was both easily and mutually understood, and focused the participant in terms of generating data that could be enriched utilizing inquisitive interview skills.
The convergent process does run the risk that convergence is reached too quickly and saturation is assumed too early.	Within each interview a clarifying summary using the participants words was offered with approximately 15 minutes to go, to allow for any further clarification and the opportunity to pose an open question of 'is there anything missed or important that has not been mentioned'. Thus, re-opening an opportunity for further breadth and unopened avenues
The engrained experience of clinical or supervisory interview by the researcher as opposed to that of research interview may lead to a loss of the neutrality of the researcher within an interview unless consciously managed.	The experience of the pilot study found that an explanatory, pre-amble about the adoption of interview neutrality helped both the researcher and participant to manage the neutrality expected of the research interviewer.
It is possible that participants will respond with what they perceive to be the right answer, (social desirability bias). Utilizing descriptors from professional texts and training.	When a participant responded with simple terms or unquantified remarks, such as; I establish trust or empathy, the interview allowed a gentle exploration of the concept offered by the participant with encouragement to offer examples based upon their lived experience

There is potentially a concern that themes and subsequent questions maybe attributable to individual participants in a sequential interview process that builds on previous interviews, thus breaching confidentiality	In order to avoid any potential for the attribution of opinions to particular participants by other participants; the early interviews, only presented probe questions that related to broad emergent themes.
In such a small population demographic detail had the potential to identify participants if findings were correlated with a demographic profile	The reporting of demographics will only be utilised to demonstrate the variants within the maximum variable sample and will not be utilised to indicate a correlation to a point of view

4.16 Pilot study

In order to test the method within a healthcare setting and in terms of appraising its usefulness and appropriateness to the research question, a pilot study was undertaken (Fieldhouse, 2018). A pilot study proposal that matched the research strategy of the main study, albeit utilising student psychiatric nurses in their final year of training rather than the target population for the main study, was presented to the University's ethics committee, and approval secured. Thereafter, six, third year psychiatric nursing students were recruited to the study. Whilst the students were not seen as representative of the experience and insights offered by registered acute psychiatric nurses, they were seen to hold a level of experience, based on their student placements within the acute psychiatric ward, to offer a robust test of the research strategy. Additionally, the recruitment of students from the university, rather than the main study site, also presented an opportunity to test the research strategy without contamination of the research site and also significantly reduced any ethical concern of the potential burden of the same subjects being approached to take part in both the pilot and the main study.

The experience of the pilot study, suggested a greater need to raise awareness of the study before attempting recruitment was necessary, and there was a need for some style changes in terms of opening the interview and closing the interview. Additionally, the pilot study experience suggested some better placement of data catchment devices and room

requirements. Although ultimately these latter learning points proved moot, given the move to video linked interviews. In particular, the pilot offered valuable experience in adapting the skills of clinical interview to that of the more neutral research interview. The pilot study also confirmed that there was also likely to be sufficient interest in the research study to generate a sufficient sample, as recruitment to the pilot was easily achieved.

Aside from the pragmatic learning opportunities, the key finding of the pilot study was that the research strategy was suitable and practical for the purpose of answering the research question, and was congruent throughout in terms of ontology, epistemology, methodology, method and analysis.

Indeed, the experience of the process of analysis involving, the digital image, visible in front of the researcher whilst listening to the interview recording, with analysis sheet in hand offered particular confidence and encouragement that the intended analytical strategy would offer a mechanism for the organisation of potentially complex and divergent data.

4.17 Ethics

Research proposals were submitted to a Keele University research progression panel to secure a view on the merit of the research question and the fittingness of the proposed research strategy in answering that question; and permission to progress was granted. The research proposals were then submitted to Keele University's ethics committee utilising the university's ethical approval process, and approval secured (see appendix 12). The research proposals and papers, utilising the integrated research application system (IRAS) were then submitted to Keele University's research governance department and sponsors approval was granted (see appendix 13). The IRAS form along with sponsor approval letter was then submitted to the health research authority and approval was granted (see appendix 14).

The host organisations pre-requisite research training requirements were met through the e learning training 'good clinical practice (GCP training) and the IRAS form and research

papers were submitted to the host organisations Research and Development Department for review. Once satisfied the host organisation offered acceptance of the study and confirmed capacity and capability (see appendix 15).

All research papers along with the health research authority approval letter were then resubmitted to Keele University's research governance department for further review to attain the necessary sponsor's green light to commence recruitment. The difficulties in completing face to face interviews due to the Covid-19 pandemic necessitated an amendment to change the face to face interview indicated in the protocol to video linked interviews that then required Keele University's research governance department review and approval before the green light to commence recruitment to the study was issued (appendix 16).

4.18 Conclusion

In order to answer the research question both a methodology, method and the mechanisms by which that method have been applied have been presented in this chapter, alongside a description of the rationale for those choices. The ethical approval process for those decisions has also been described. A summary of the research strategy is again presented below to offer further clarity. Please see table 4.5 overleaf;

Table 4. 5 Summary of key components of the research strategy

Ontological Position	Relativism
Epistemology	Inductive methods / socially constructed
Philosophical Perspective	Post Modern / Constructivism / Temporary reality
Methodology	Interpretive Phenomenology
Method	Convergent Interviewing
Population	Qualified psychiatric nurses working within the acute psychiatric wards of a single NHS organisation
Sample	Maximum variation
Status of Researcher	Insider
Data Analysis	Inherent within the Convergent technique; Involves inter-interview analysis seeking the identification of recurrent or novel themes and the development of probe questions that explore differences and seek exceptions to agreements within subsequent interviews. Commencing from a broad and open perspective and increasingly moving to a position where convergence occurs or an explanation for disagreements is reached. Findings are then considered with reference to existing texts and insights
Data Collection Apparatus	Digital audio recordings and Flip charts (digitally photographed) all stored securely in digital format

Chapter 5

Results

5.1 Introduction

The focus of this chapter is to provide an account of the insights that participants have offered in how they, as registered nurses, form a therapeutic relationship with patients within an acute psychiatric ward. Sandelowski (1998) stressed the need for an account of the research findings that was congruent with the research methodology, with a focus on presenting an answer to the research question. Van Manen (2006) concurred, and wrote of the need to represent phenomenological inquiry through the adoption of a congruent qualitative writing strategy. In keeping with the phenomenological methodology of this study and its focus on giving voice to the lived experience of the participants, the writing strategy, as Giorgi (1997) suggested, will present a sense of the whole story through the use of a palpable narrative, or as Todres and Galvin (2008) advised the writing should leave the reader with an account that offers an emotional recognition of the truth (a homecoming), one that is meaningful, familiar and authentic.

In keeping with the interpretive nature of this study the presentation of the results as Smythe and Spence (2020) advised, will not simply present the spoken words but interpret and embody the meaning behind those words. Likewise van Manen (2006) offered that whilst the writing still requires the passive illustration and perceptions of the phenomenon through the words of participants, they also needed to be brought to life and given meaning by the words of others.

This results chapter sets out to present not only the words of the participants, but also to offer a degree of interpretation of their meaning, in order to brings to life the lived experience of the participants: to present to the reader an accessible account of the narrative as it unfolded into the view of the researcher. In order to make it clear to the reader the genesis of the narrative, as suggested by Smythe and Spence (2020), the words of the participants are highlighted in italics throughout the text, whilst the researcher's interpretations of the meaning are not. In acknowledgement of Tordres and Galvin's (2008) guidance to not present the reader with incomprehensible sentences, where every single utterance, vocal filler and hesitation marker

are slavishly scribed into text; for the purpose of clarity and readability, unless such hesitation or vocal fillers aid the portrayal of meaning, they have been edited out.

Six major themes emerged from the narrative: Making connections and relating to each other; the utilisation of a value base; appraising the situation and manoeuvring; utilising and managing boundaries; managing the challenges and pressures of acute psychiatric work; and working as a team. Three of those major themes could be divided into sub themes. The theme "making connections and relating to each other" could be sub themed into: initiating contact; acknowledging and validating the distress; getting to know each other; and making the most of your personal style. Whereas the theme "appraising the situation and manoeuvring" could be sub themed to include: reflection in action; and utilising clinical supervision. Finally, the theme "Utilising and managing boundaries" was sub themed with; stating the care agenda; and stating and managing the boundaries. For ease of reference this is tabulated below. (See table 5.1 overleaf). To further aid clarity for the reader as Sandelowski (1998) and Wolcott's (1990) advised, the narrative text is subdivided into sections and sub sections that follows the themes and subthemes that emerged from the research.

Table 5. 1 Summary of major and sub themes that relate to how participants described forming a therapeutic relationship	
Major Themes	Sub Themes
Making connections and relating to each other	Initiating contact Acknowledging and validating the distress Getting to know each other Making the most of your personal style
Utilisation of a value base	
Appraising the situation and manoeuvering	Reflecting in action Utilising clinical supervision
Using and working with boundaries	Stating the care agenda Stating and managing the boundaries
Managing the challenges and pressures of acute psychiatric work	
Work as a team	

In terms of this chapter's structure, it initially offers the reader some contextual information in terms of the demographic detail from whom the data has been collated, and also a brief demographic description of the setting, in order to offer context. The chapter then goes on to present the data subdivided into the major and sub-themes identified. Additionally, the report records a notable incidental finding that relate to the perceived purposes of the therapeutic relationship between acute inpatient psychiatric nurses and the patients within those units. Finally, the chapter concludes with a summary account of the major findings of this study.

5.2 Contextual demographics

The catchment area for the acute psychiatric units included in this study covered a population of just under 500,000, with just under half living within an inner-city conurbation (Office for National Statistics, 2019); an area that has been economically, culturally and socially defined by the large scale closure of the manufacturing and mining industries, which were once the basis of both the community and working life in the area until the mid-1980's (Hannavy, 2016.; Rice, 2010). Since then the area has suffered with high levels of poverty and social deprivation and the associated poor physical and mental health (Ministry of Housing, Communities & Local Government, 2019). The other half of the population of the local area is typically split between a socially isolated, low level income farming community to the north and a wealthier farming community to the south, with east and west offering a mixed picture of both demographics (Office for National Statistics, 2019).

The data was collected by the researcher via video linked interview, over a period of three months in 2020, from the registered psychiatric nurses working within the acute psychiatric wards of a single NHS hospital site; the sole provider of acute psychiatric care in the North Staffordshire area. That provision consists of one male ward, one female ward, one mixed ward and one mixed psychiatric intensive care ward, in total there were 65 beds at the time of the study. The acute psychiatric inpatient care offer, is also supported by an acute psychiatric home treatment team, who provide acute psychiatric care within patients' homes.

17 video interviews were conducted. Interviews ended as data saturation was reached, and once any assumptions or themes had either been confirmed or refuted, and any apparent differences of opinion understood. The purposeful maximum variant sample (Palinkas et al., 2013) utilised in this study was built using the recommendations of participants; who identified other individuals who were likely to offer a difference of opinion or may hold a differing perspective based on a different demographic. Whilst it is not possible to tabulate the notion of a difference of opinion, it is possible to offer an overview of the demographic to the reader, as

an aid to understanding the context of the study. This data is presented below. Please see Figure 5.1

Figure 5. 1 Demographic detail of the participants

Age	Numbers	Percentage of sample (to nearest whole number)
20/25	4	23%
26/30	3	18%
31/35	2	12%
36/40	1	6%
41/45	2	12%
46/50	0	0%
51/55	5	29%
Ethnicity	Numbers	Percentage of sample
British (White)	14	82%
Non-British (White)	2	12%
British (BAME)	1	6%
Sex	Numbers	Percentage of sample
Male	2	12%
Female	15	88%
Years of Acute Psychiatric inpatient experience	Numbers	Percentage of sample
1/5	8	47%
6/10	5	29%
11/15	2	12%
16/20		0%
21+	2	12%
Total number of participants	17	

5.3 Theme 1: Making a connection and relating to one another

5.3.1 Sub theme: Initiating contact

The relationship forming activity of the participants was reported to start immediately *"…right from the start as they walk through the door"* or *"…as soon as I come on shift"* and even before the patient arrives on the ward; *"I try and find out as much as I can before some-one comes onto the ward, you start to formulate a picture of how they're going to be, you are looking for stuff that you both will relate to, looking for what they might need, so you have something to offer them".*

First impressions are carefully managed; *"I introduce myself, first names, that first impression of you as friendly and at ease is important".* Indeed the conveyance of friendliness through a *"…warm smile…"* or a *"…greeting and offering your first name with a relaxed warm smile"* was often noted as the initiating action in terms of the nurse-patient relationship.

Within that initial contact there is a focus on making the patient feel at ease and familiar with the new surroundings; *"You are trying to make them feel at ease, showing them around, welcoming…", "…orientating them to the ward, and the staff", "…asking them if they need anything", "…something to make them comfortable, a drink or a sandwich if they missed lunch".* Nurses reported being attuned to what it must be like to initially walk into an acute admission ward, and in particular the threat that is likely to be felt by a patient; altering body posture to put the patient at ease adopting *"…a non-threatening stance, open, like more side on, open hands"* and *"…making sure that you are lower than the patient"* or *"you are the one that sits on the uncomfortable foot stool, whilst the patient has the seat".* Also, with reference to making the patient feel at ease, the importance of taking the initiative for the first encounter was noted; *"It is you at this stage that is taking the initiative to speak and engage, to fill the voids and the pressure of silence"*.

Several participants noted that sharing the lived space of the ward environment in its own right presented an opportunity for nurses to utilise their relationship building skills, for example

participants offered *"The cramped space of a ward causes problems, but it also helps, you cannot exactly avoid each other";* or as another offered *"The ward can be cramped at times, but you can use this to your advantage, so you can position yourself so as to maximise contact and an opportunity to engage".* This notion of strategic placement of the nurse to maximise contact was seen as a very deliberate act; *"Place yourself somewhere approachable, just be around so someone can catch hold of you; leaving the door open to an office, like as an open invite"; "you have got to just leave your space, the office, and your chair and just be around people"* ; "*Just being out there* {on the ward as opposed to in the office} *it gives you an opportunity for a bit of banter, ice-breakers that make it easier later to dig into more in depth things".* Another individual added an observation of the impact upon the relationship from just being able to share a space: *"…like at the weekend, I had loads of time to just go and approach patients where they were, like in their space out on the ward, and just offer time to talk, I would say that quality time, built the relationship, faster and stronger than the two weeks of 9-5".*

The same individual went on to qualify that such opportunities to just be around in the lived in space of the ward were not always available, and it was then necessary to utilise some of the more formal tasks of nursing within the ward to engage: *"When you can't get quality time, you have to make do with the times you are undertaking a formal task to engage, like meds rounds, risk assessments, doing a KGV or Becks assessment, or like dinnertime is a good time, you make time"* . Or as a fellow participant noted *"Time is busy for qualified staff, it now tends to be focussed around opportunities that fit round tasks like med rounds, ward rounds, reviews";* or as several others noted that spending time undertaking the formal processes associated with extra observation equally offered an opportunity for engagement; *"just make sure you spend some time doing the obs (observations), you are then around and in a good position to strike up a conversation".*

5.3.2 Sub theme: Acknowledging and validating the distress

A strategy which was repeated often by participants and was typified by responses such as, *"It could be me in their circumstance, rape, suicide and devastation, they need to know that this could happen to anyone, including you*" or more simply put *"…you acknowledge distress, affirm feelings and share understanding that this could happen to anyone. Let them know you have heard";* or *"you need to communicate you have understood their distress and how an individual has arrived at this point**".*** Or couched in terms of a personal validation; *"Validate the service uses experience and situation, and communicate an understanding that you can appreciate their difficulties, like almost letting them know you get it"; "people need to know you are interested in their story and you recognise their distress".*

5.3.3 Sub theme: Getting to know each other

Participants offered a perspective that it was useful to find some common, non-health related interests, if the formation of a therapeutic relationship was to be both initiated and strengthened. "*You need to share basic interests, like tv, music, just basic shared interests some generally relatable stuff, let them see the person behind the uniform"; "I think it important to share a little bit of your life, tell them about some of the basic things you are interested in and done",* others described developing opening lines to encourage such dialogue, ***"****I've found just asking simple questions like are you a dog or a cat person, gets it all going".*

Additionally participants made reference to using getting to know you boards (introduced through the SAFEWARDS initiative (Bowers, 2014), a board which offers photographs and names of staff with some of their basic interests detailed, *"…patients see those boards, and read them, then they might just bring something up in conversation that then helps you to relate to each other".* Despite the purposefulness to the strategy, participants noted it is the naturalness with which the conversation is presented that drives this as an effective strategy; *"…like you present it like a chat, just be chatty, like you would in meeting any new person".*

Caution was also noted, in terms of ensuring the conversation wasn't centred around the nurse; *"You wouldn't tell them your life story, all your problems, you keep it safe"; "It's about sharing the minimum that engages and gets things going, it's not about you"* {the nurse}. *"You just need to be careful about not presenting your life as wonderful, and talking about all your wonderful holidays and things like that, when the person in front of you is really struggling"*

5.3.4 Sub theme: Making the most of your personal style

Participants spoke of using their natural relational strategies; *"You just use all the social skills and social style you have, there is something about being yourself, natural self"; "It's like a natural thing to talk and know what to say, it's an instinct thing"* or as one individual put it *"We all use our own style, same hymn sheet different singing voices, a range of styles, some humorous, some irreverent some more formal";* or simply put *"Everyone has their own style, you use your personality and play to your strengths".*

Participants identified that the utility of the personal style developed through reflection and more refined versions of their *"…natural self…"* were utilised, perhaps the most succinctly put; *"I was chatty before I was a nurse, I learnt how chatty can help, I did it better"* or *"You learn more about your own way, life experience, job experiences, you watch others succeed and fail*, *and you are looking at your own style and how that is working*". This conscious development of the natural self in order to develop the utility of their personal style was particularly emphasised by participants as a significant part of their professional development, in becoming effective in forming relationships. In terms of those relationship building endeavours, such conscious use and development of a personal style, subsequently required the submission of that skill to a sub conscious level, a level that belies a personal mastery, as one participant observed, *"…It is about consciously extending your natural skills and strategy, but if you think about it too much it becomes unnatural and you fail, it has to be mastered",* or as a fellow participant explained *"Much of what you do is just natural, but it just has a purpose and you think about what you are doing, but then this needs to then become the new natural"* or *"You*

just get to a stage where you don't even realise or think about your style, it's just what you do". The importance of this presentation of this *"…natural self…"* in terms of its relational forming function was succinctly summed up; *"…people respond to people, not a fake technique".*

5.4 Utilisation of a value base

There was liberal reference to the value base of nursing practice, and in terms of translating that into a relationship building strategy participants were actively touching base with those values to assist in their endeavours to form relationships; "…*stick close to your motivation to nurse, never forget that"*; or simply *"Hold onto you values, you have to remember you are there for a purpose"* or*, "…I remind myself what I'm doing really matters"*

Additionally participants suggested there was a utility in communicating their value base in their efforts to build the relationship; "*It helps to tell them, or show you care"* ; "*You need to show them you have respect, you treat people with dignity"; "you need to be there for someone, to be altruistic in your intention and communicating that to them"; "People need to know that they are not being judged by you, and that you are honest, truthful and want to help them"; "showing a bit of compassion and care goes a long way".*

Whilst participants for the most part spoke in terms of communicating their own values, they equally spoke of presenting a set of professional nursing values to the patient, particularly in situations or circumstances that challenged their personal value base. A phenomenon typified by the response "…*I'm not like this at home, it is a mind -set that you go into, it's like I put the uniform on, I have a job to do, I am a nurse and I have a professional role to play",* or as a colleague contemplated *"I am like two people, at work non-judgemental, and at home strongly opinionated and vocal"* , or "*yes it's like I am two people, one the nurse and then me at home".* Although, participants were quick to quantify such statements; "…*it is not like it's an act though, it is genuine"* or as another offered *"I am genuinely like two people, I am an authentic nurse, you have really got to want to care for somebody, its real"; or "The genuineness and authenticity*

comes in your desire to nurse and to want to help somebody". "I suppose it's like being genuine to the hat you are wearing".

Whilst participants more often spoke of a value base in broad terms, they also emphasised particular values that seemed to have the greatest utility for them in terms of relationship forming. For ease of reference these have been tabulated below (See Table 5.2 below).

Table 5. 2 Key values emphasised by participants

Value	Examples
Empathy	*"Empathy you have got to have it, and you have got to show it".* *"Patients need to know that you've got it, to know you can see things from their perspective".* *"You need to let people know that you can appreciate or understand how they have become ill, as quite often if I had experienced what they have then I would be in their shoes"*
Equality	*"There is always a power imbalance, they are ill and coming into a scary environment, a bit of informality, a joke, something a little about yourself, ordinary language, that's not too professional helps to tip the scales"* *"Never come across as better or in a higher status than the patient, show them you are not the big I am, if you want someone to work with you"* *"Allow the patient to see the other person behind the uniform"* *"I poke fun at myself, to challenge any perception that somehow I'm different or better"* *"I joke about my inadequacies; I suppose this helps to paint a picture that just because I am nurse, I am no better than anyone else".*

Non-judgemental	*"You just don't offer judgements"* *"You don't judge people by their actions or history, or the hostile words and insults they may make, you stay professional and non-judgemental, people need to feel accepted* *"So even when someone is challenging, covered in swastikas, spouting white power and supremacy, you just have to switch off from that, you have to see they are human first and not their morals and ideologies, people are very sensitive to being judged, they need to understand you are not judging them".* *"You just have to tell people, you are not there to judge, you have to settle that early on".*
Altruism	*"You have to remember that when it comes to helping it's all one way"* *"You and the patient have got to realise it is about them and not you".* *"You offer bits of your life and feelings, but it is always kept on safe ground, you don't want the patient to feel burdened by anything of yours".* *"You have to be sure that you keep your own troubles, or your good life, to yourself when you are talking to colleagues, like when you are on obs (observations), and you're outside a room, patients might not seek you out or open up if they think you have your own troubles".*
Shared humanity, genuine and authentic	"*You offer yourself as a fellow human being"* *"Be genuine about wanting to care"; "Be open, honest and truthful". "You have genuine emotional reactions and showing a bit of that helps, even though I know I'm supposed to be more empathetic than sympathetic".* *"Sometimes it really helps if you are really clear that it affects us too, it's like you have to remind people we are not monster nursing robots, we are human like them, and this helps"* *"Like you can't be having a therapeutic conversation about their problems all the time, you need to take a break and just chat, like ordinary people"* *"On a ward, we are all people together in the same space and you just relate as human beings, acute nurses can do that, it isn't intense like with your psychologist or care co-ordinator who visit with a purpose, its more relaxed we can chat, it makes it easier for people who are quite ill to build a relationship with you".*

Care and compassion	"*Offer a shower, a drink, something of comfort, its powerful if you can, people can see you are busy, and so really appreciate you taking the time for this"* *"You just let them know you are bothered about them, by just attending and supporting them with everyday things"* *"This is really important, offer drinks on admission, make toast if they have missed a meal; like go the extra mile. For example we had the evening drinks trolley but then I made a round of milky drinks for everyone, or like letting someone use the office phone when you are busy. It all shows you care, its massive really in helping to build that connection, relationship".* *"Just be nice to someone, being nice certainly never harmed the relationship"* *"You offer reassuring words, compliments maybe, show an interest in their comfort by simply asking"* *"When you are passing in the corridor, or you come on shift, just take a bit of time to ask how someone is doing"* *"You don't have as much time as you used to, but doing something nice for someone, like helping to make a bed or with their laundry, anything practical"* *"On this ward I find I have a little more time, because we have less patients, so we can find time to make a drink, or perhaps do an activity together, that can help a lot".* *"Time is always tight,* like we are really busy on this ward, but you have to make time and prioritise that if you are going to show you care" "*You have to show them you are willing to stop what you are doing and go and help out with something, I always say patients first, paperwork second even if that can get me into trouble"*

5.5 Appraising the situation and manoeuvering

5.5.1 Sub theme: Reflecting in action

Participants spoke of a process of active reflection, a continual and fast paced process of appraisal, manoeuvre and subsequent re-appraisal of their relational strategy whilst in action. A process typified by the responses: *"…you are judging impact, reaction and making adjustments constantly"; "I will always be looking at the patients' reactions, to make sure I get it right, like the timing, you need to gauge the pace and response",* or very simply, *"You have to observe what is working and what is not and amend your approach".*

Such appraisal allowed the approach to be adjusted in order to manoeuvre towards a much more personalised engagement strategy, for example *"You need to assess the rules for an individual, like is it okay to talk in a certain way, to be direct, indirect, to use humour or not, to address formally or informally, it's all individual".* Equally staff spoke of the appraisal and manoeuvring associated with the hostility that they face at times; *"You are constantly monitoring responses, verbal and non-verbal, monitoring demeanour, adjusting and flexing and knowing when to just back off",* and again *"…you have to flex, you need to apologise, adjust or get out and fetch someone else". "Apologise for miscommunication, always take the blame* {responsibility} *if it's gone wrong and work to try and clarify the situation",* or "*Apologise, be honest, own any mistakes, state it was not your intention, discuss and negotiate a next time".*

5.5.2 Sub theme: Utilising professional knowledge to appraise and manoeuvre

Appraisal and manoeuvring was not just a case of trial and error, but was also based on professional understanding and an interpretation of the impacts of illness and past experiences; *"You have to make adjustments based on a professional understanding of how someone with fear, paranoia, trauma or bi-polar might see things,"* or, *"Of course symptoms are a big thing, you have to know how it affects people, like catatonic, anger, scared, or off their heads on substances, you have to adjust your approach knowing how they might see*

things". Participants spoke of taking into consideration psychiatric history as informing the adjustments they take in their approach, as typified by one participants response; *"You need to know something of their history, particularly if it involves trauma, this allows you to make sensitive adjustments to your approach.*

As well as drawing on diagnostic understanding, it would seem that the participants also drew on their professionally acquired knowledge of psychotherapeutic technique and approach, to appraise their success or otherwise: *"I have got an understanding of formal therapies through my training and sometimes when things are not going so well, you need to take some time out for supervision and you can then use the knowledge of those approaches to formulate an idea of what is going on, and then take a different tactic next time";* or as a fellow participant concurred, *" I have had training in CBT* (cognitive behavioural therapy) *and SF* (solution focussed) *work, and it helps you to understand what might be going on if it's going pear shaped, and perhaps might give you a clue where to go next, like some way, a technique to get it back on track*". Whilst the use of such knowledge was universally seen as a reflective tool, the utilisation of such a structured manoeuvre was certainly not, and the opposing view is summarised in the following words, *"yeah you use training, but not necessarily the techniques taught, but as a way to look at your own style and recognise the bits that relate to your style and why they might work"*

5.5.2 Sub theme: Utilising clinical supervision.

In addition to reflection in action, participants were also keen to express the use of more formalised clinical supervision. It should be noted that there is the potential here for the influence of some significant local context in terms of this response. The acute wards in the study are all served by a psychologist who has established supervisory structures in each of those wards. Hence some of the more formal language and direct attribution to psychology may be representative of such a local phenomenon in the experiences of the participants, for example; *"It's important to try and understand relational difficulties and fractures through a*

psychological formulation on the state of the relationship" or *"you need to share your understandings of what is going on, reflect together, and make use of the psychology sessions".*

Notwithstanding the need for caution over the particularly strong influence of the local context in this instance, participants did also more generally emphasise the need for formal supervision as an integral part of their relationship building strategy; *"I think supervision is very important, I use supervision, like I really do, you can appraise your approach, review situations that didn't go so well or went well, it can confirm or challenge your approach";* or as a fellow participant observed of supervision *"To be getting it right 95% of the time you have to hold a mirror up to yourself, and take the time to reflect on what you learn in training, it helps you to become aware of, if I do this then this will happen, and that's why".*

5.6 Using and working with boundaries

5.6.1 Sub theme: Stating the care agenda

In terms of laying the foundations of the relationship at an early stage, there was a particular emphasis on the need within acute inpatient care to stress the care agenda with patients; *"State early on that you are there to care for them and then show it"* and *"I tell people on admission that we are here to help and care"*. Typically participants offered views such as "*I introduce myself and what I do, but very much in terms of I'm telling them I'm there to provide care and help"* or *"I'm here to care and help you, you need to make that point clear".* Such a stress on stating the purpose of care was offered in the context of providing re-assurance, and a mechanism of orientation to the intention of the nurse. Equally it would seem that stating the purpose of care goes beyond the intention to inform and orientate, it functions as a mechanism to diffuse the perceived threat of conflict that patients detained against their will under the Mental Health Act (1983) or those with altered perceptions of reality may feel, an emphasis succinctly captured in one participants words; *"Stress what you are there to do, for example; I'm not here to fight with you or to make your life harsh, I'm here to help and care"*

5.6.2 Sub theme: Stating and managing the boundaries

Within the inpatient setting, participants spoke of the boundaries that arise out of ward rules, patient safety plans and procedures, and the application of mental health act (1983) restrictions. Participants spoke of the need to actively and consciously communicate and manage such boundaries if the therapeutic relationship is to develop. Such boundaries were described as having utility in their own right in terms of aiding the development of the therapeutic relationship. Summarised by one participant as *"Boundaries and rules are really important in recovery and people do need to understand these if the relationship is to be built on mutual understanding without any hidden agendas or surprises",* or as a colleague noted "*Setting the boundaries is really important if you are going to get on, people that are really ill need to feel safe, they need to know where they stand".*

Participants spoke of the need to approach boundaries with a direct and straightforward approach *"…you have to be really clear, open, and up front about the reality of the situation*" or similarly *"you need to be straight, honest and firm, explain the boundaries and why they exist and be consistent in the message".* Another participant typified a belief that such honesty and directness *"…builds a stronger and lasting therapeutic relationship, there's a respect that you were the one to take a decision in their interest, even if it meant you would get grief for it at the time".* This notion of the possibilities of a stronger relationship through the ownership of a decision was emphasised in the response that *"…you need to be able to take a tough decision in the patients' interest, be straight up about it, hold responsibility for that decision, do not blame the doctor or a colleague, this builds a mutual respect that you will do what is right for them, as they recover your relationship is better for it".* Interestingly participants did not necessarily have to agree with a decision to take such ownership and saw that their own therapeutic relationships benefited from being consistent with the messages of other colleagues; *"It is important that everyone sings from the same hymn sheet, you might not necessarily agree totally with the hymn sheet, but if an approach is decided as a team then you stick with it, it*

helps to set up clear expectations and you are not the source of confusing messages for the patient".

Aside from environmental and situational boundaries, participants also spoke of the need to establish and communicate personal boundaries if the relationship was to develop therapeutically; *"…boundaries are part of starting to get back to normal, there's always rules. All relationships have their rules".* A participant offered an example of such; *"For whatever reason, if they think it is ok to be abusive or call you names and stuff, at these times if you are going to get on, you have to be really clear in stating limits, expectations and each other's responsibilities to each other",* or *"…say the response over steps the mark, and say it's like flirtatious or something, then you have to be direct and let people know that's not your intent and the response is inappropriate";* and summed up by one participant *"You do have to point out the impact they are having in terms of the relationships with you and other patients, you need to be honest with them, without honesty and understanding you don't have a starting point".*

A striking feature in terms of the communication of both the personal boundaries as well as the environmental and situational boundaries was the purported need for a direct and forthright approach, a belief typified in this response; *"…you need to be truthful, direct, you need to ground someone in terms of what is acceptable if you are going to form any relationship".* Participants were quick to emphasise that such forthrightness does not equate to a *"…harsh approach…",* typified by simple statements such as *"I am not one to be stating boundaries in like a rigid harsh way"; "…avoid the hands on the hips and wagging the finger stuff"* or *"You always get much further if the message is delivered with sugar rather than spice".* As a strategy in relation to this; participants identified that they would *"…allow some flexibility when the opportunity arose"; "…leave space to negotiate";* or *"You need to make sure there is room for negotiation and flexibility".* Additionally allowing the patient a voice to be heard and acknowledged was suggested *"When someone disagrees, you need to listen and acknowledge their point of view, and sometimes that may mean trying to agree to disagree"* or *"You have*

just got to stay open to suggestions from the patient, they may have a different interpretation than you, they need to know you understand their perspective". Furthermore, participants frequently noted that whilst directness was important it was *"…always necessary to explain the reasons for boundaries and to state the caring purpose behind them".*

5.7 Managing challenges and pressures of acute psychiatric work

Acute admission wards were spoken of by the participants as environments that were hostile, emotionally demanding and busy, which in turn presented challenges to their relationship building endeavours. The context was summarised by one participant as "*If I haven't been verbally abused in a day, I have to check I've actually been in work, you need pluck, courage and resilience to get through a run of shifts",* or as one other participant noted *"It is just so busy on here, patients constantly asking something of you, and because of their frustration or illness they can just be so rude, your brain fries".* Participants suggested a need to recognise this and to suppress reactions and manage the response to challenges and the situation if the therapeutic relationship is to endure; for example, one participant suggested *"You have to take insults with a pinch of salt, you have to take it in your stride, remind yourself it is not often a personal attack, don't react stay calm";* or *"you have to take a direct strategy of not taking things too personally or to heart, you need to remain professional".* This strategy of managing the emotional reaction was not only in response to the personal *"…insults, and hostility…"* , but also extended into the emotional challenge of a very busy ward environment; *"It's important that the patient sees you as calm, stable in control; you might be paddling like mad under the surface but you need to look like a swan on the top, the patient needs to see you managing, a calm nurse that is not all stressed out";* or *"You need to manage your anxiety and come across as confident in what you are doing, patients need confidence in you, if they're going to trust you".* Equally participants spoke of hiding their own frustration from patients in order to ensure the focus remains upon the patient: *"Sometimes it can be very frustrating, you are putting a lot of effort in and getting nowhere, or you might be getting frustrated with the team and the*

decisions, but you have to manage that and keep it out of the conversations with the patient" or as one participant noted *"…hold on to your frustration, either with the patient or other staff".*

It was suggested that such a strategy not only served to maintain the *"…professional…"* response, but equally it was seen as a mechanism for building the relationship; *"…don't react, you stay safe, but don't react to stuff that's directed at you, you need to react with compassionate language and actions, this all helps in the long run with getting someone on board";* or "*The fact that you engaged with it and didn't take it personally shows an acceptance and somehow that can make the relationship stronger, violent incidents and confrontation can be like that too".*

Part of the strategy involved internalised dialogue or personal strategy that enabled the helping or professional face to be presented to the patient. As one participant's typified response noted *"You need to think past what is in front of you, like be open to criticism and see what is behind it, even when it might not be put to you very constructively or politely, if you know what I mean"* or *"Sometimes you just have to tell yourself and accept, that you are a sounding board for a lot of frustration and anger"* Or more simply put still *"You have to tell yourself this is illness or frustration that is presenting, it's not about you personally".* In addition to exercising such internalised cognitive strategy participants recalled behavioural endeavours to meet the *"…need to look after yourself mentally and physically":* noting the need to be *"…robust and tough in yourself"* or *"…resilient…"* As one participant noted; *"Work life balance is massive in acute, make sure you take some time to do stuff for yourself outside of work".* Additionally some participants referred to an in work strategy; *"You have to recognise when your brain starts to fry, you have to find some time out, the office space with colleagues, shutting yourself away with some paperwork, or engaging in trench humour with colleagues, you have got to find a way to let off steam and appreciate how absurd acute wards can be"* or *"You need to use the team, the banter, the humour, it's all a chance for some informal supervision, you have to look after yourself"*

One individual reflected and summarised the responses in relation to this particular phenomenon with reference to a theoretical perspective and simply suggested; *"It's all emotional labour and emotional intelligence really"*

5.8 Work as a team

One of the most surprising findings from the interviews, which was unanimously referred to by participants was the primacy and efforts afforded to the formation of a "…*collective therapeutic relationship"* between the patient and the rest of the psychiatric care team sometimes taking a primacy over the individual relationship. This was very simply summarised by one participant as, *"The team relationship is what matters most".* Others expanded on the rationale for this *"The team relationship is more important than an individual, a split team approach or individual approaches that create a strong relationship with one and a negative one with someone else, in the end is just not therapeutic".* Furthermore those efforts extended beyond the immediacy of the acute inpatient team, and as an example one participant offered *"We try and set up the relationships for others and others services, in terms of building trust in services and of the hope of recovery"* Or as a fellow participant noted *"You have to remember you are only there for a small part of the time, both because of your shifts but also as people are only in acute wards for such a short time, you have to think broader, like in how you are setting up the next services relationship, you have to think about how you speak of them and of the promises you might make or the expectations you raise".*

In a similar manner to the one to one relationship a degree of intuition or internalised mastery of working the team to form a collective relationship were described when asked how, and was typified by the response: *"I don't know, you just seem to know what works for the team, you know your colleagues, you know how they are likely to react, you have to play to the strengths, you kind of know who most likely get the best response in what situation and what day"* ; or *"You always have an idea who is around on the day, their style , you do not really think about it".* It was clear that this was not the whole picture and participants revealed a degree of

planning, communication and reflection across the team, and in particular where there were difficulties in establishing a therapeutic relationship; *"Sometimes, when for one reason or another, the relationship with the team just is not happening, or where there is splitting of the team, we will sit down and discuss it, sometimes this is in clinical supervision, you try and get an understanding of what might be happening psychologically for someone or are there things going on with their illness that explains things, so you can change your approach"* . Then based upon such understanding active plans were made and communicated amongst the team; *"You have to agree on a plan, where you will decide as a team the approach towards someone".* The aim of such planning was to *"…be consistent across the team with the approach, inconsistency or a multitude of personal styles can be very confusing for very ill or disturbed people".* Such was the emphasis on ensuring the planned team approach was implemented, that a proportion of the participants, usually those in more senior posts reflected that part of their relationship endeavours included the active management of both the team and individuals in respect of the relationship, and was typified in the response *"In my role, I have a responsibility to intervene, where a member of staff is taking a different approach to the plan, or where someone for one reason or another has a poor attitude or approach to someone, sometimes it is about supervision, sometimes it's about actively managing them"*

In essence the team based relationship and strategy identified by participants was summarised in the words of one participant; *"You have to remember that you are engaging as a team, speaking as a team, it needs to be consistent; sometimes in difficult cases there will be a support plan, and we agree how we're going to interact and the nature of that interaction, you will be consistent, advocating for the relationship of others, building confidence in a relationship with services, including those beyond acute care"*

5.9 Incidental finding of note

It became clear that when participants spoke of appraising how the relationship was progressing, they were measuring that progress against a variety of outcomes. There was universal agreement of the value of the therapeutic relationship to their practice; "…*well it's massive"; "It is what we do as nurses", "…nothing works without that relationship"; "…it brings it home how important it is, if you think of what would be lost if robots did the job".* But there was no clear agreement of what those measures of progress were, and their words belied a multitude of perspectives of what the purpose of the therapeutic relationship actually was. For example when considering whether their relationship was having impact they noted: *"You see how things are going, it is going well when you see incidents are down, the person is engaging more"; "…you might see better scores on the DASA, less challenges"* (DASA; dynamic appraisal of situational aggression inventory, a violence prediction scale (Chu, Daffern, and Ogloff; 2013). *"…concordance with medication goes up"; "They might open up more to you and we understand more how we can help"; " They might be engaging in more activity with you and start to work with you on a recovery plan"; "I know if it's working because people open up more, you discuss their illness or problems, it helps because you both get a better idea of what then needs to be done*"; *" …you see people expressing their opinion more, engaging in recovery plans, more insight"; "…they trust me, they start to engage with everything and everybody more, their relationships improve with everyone" ; "It starts to show in their interactions with others"; "They might be opening up about their thoughts and feelings and start to think differently about things"; "You see them engaging with you more and they then start to make sense of what has been happening to them and in their lives" .* Seemingly the purpose of the therapeutic relationship is seen to be multifaceted but universally accepted as to be of benefit.

5.10 Conclusions

The insights offered by the participant registered nurses into how they form a therapeutic relationship within an acute psychiatric ward, reveal the use of a social ability derived from the development of both a personal and professionally informed set of social interaction skills. A skill set that includes an ability to initiate contact in a friendly, non-threatening way; but one that adapts an approach to account for the often difficult circumstances and distress that surround an admission to an acute psychiatric ward; circumstances such as the patients experiences of symptoms, power imbalances and of a personal displacement or disorientation. Indeed, a sensitivity to and an express acknowledgement and validation of such distress was emphasised as a substantial part of the initial strategy to build a relationship. Part of those early processes also involve developing a shared understanding of each other and establishing a sense of connection, and participants reveal an active strategy of searching for common interests and hobbies as a key mechanism by which they look to build that sense of interpersonal connectivity.

Going forward, participants highlighted the role that an altruistic value base played within their relationship forming endeavours. It was highlighted how remaining in touch with an altruistic, non-judgemental value base served as a reflective reset mechanism when relationship building was proving challenging, which in turn then enabled the continuation of the relational efforts of the nurses. In addition, to the reflective use of a value base, it was also revealed that a direct verbal and non-verbal communication, of the altruistic, caring and compassionate intentions of the nurses was also utilised as a strategy in its own right in forming the nurse –patient relationship.

It was indicated that the strategic endeavours of the nurses were as much an internal activity as it was an observable behaviour. Nurses revealed that there was a constant internal appraisal of the response of the patient to their words and behaviours, matched by a process of constant adjustment as they sought to find an interactional style that maximised the likelihood of

engagement and sense of connection. That reflective endeavour was noted to become increasingly externalised and formalised in parallel with increasing complexity and relational challenge, up to a point where nurses were describing formal clinical supervision and the use of psychological insights to reflect on their relational endeavour.

Participants described the rules, restrictions and boundaries that were in place within an acute psychiatric ward, borne out of the requirement to implement risk treatment strategies and to deliver treatment under the provisions of the Mental Health Act (1983), or of a need to reinforce the boundaries of the nurse-patient or patient-patient relationship within a communal living space. In terms of the therapeutic relationship they described a need to carefully manage such situations. Participants noted the importance of stating the caring intent along with the rationales for any difficult decisions, of a need to take ownership and be really consistent clear and honest about any actions to be taken or restrictions to be enforced. Participants described such times as a very active period of relational endeavour, in terms of both reflecting and manoeuvring, but also within the application of the amalgamated personal and professional social skill set described earlier, but with an added emphasis on listening, negotiating and apologising if necessary. Furthermore, the nurses revealed that the successful negotiation of such difficult times, provided an opportunity that enabled the deepening of the relational bond between themselves and patient.

The participants described the emotional and physical toll of their efforts, and revealed that in order to form a meaningful relationship with patients, they needed to be conscious of the pressures within an acute psychiatric ward and to actively manage them or at least keep their own work-related pressures from the view of the patient if the relationship was to progress.

Participants suggested that the relationship building endeavour was a team effort on occasions, particularly where the clinical picture or personality of an individual, presented considerable challenge to relationship forming attempts. At such times a more formulated, psychologically informed approach to building the relationship was described, which required

nurses to adopt, and modify their personalised styles of engagement for the greater benefit of establishing a therapeutic relationship with the team or wider service team. It was observed that an incidental finding of this study was that the therapeutic value of a meaningful relationship between nurse and patient was universally accepted by participants. Although, it was noted that there seemed to be a diverse account of what those therapeutic outcomes were. Whilst this chapter has focused upon presenting the results as close to the data as it was revealed to the researcher, there is further need to interpret that data and offer discussion in the light of existing theory and research, and the next chapter will consider this.

Chapter 6

Discussion

6.1 Introduction

The previous chapter offered an account of how acute psychiatric nurses view their therapeutic relationship building endeavours through their own words and narratives; an account that as a result remained very close to the raw data. It presents as Tilley (1995) described, an accessible and useful untheorized account of the 'common sense' responses of nurses, or as Thibeault (2016) had noted, offers an account that readers can easily appraise their own experience against. However, as Rodgers (2011) had observed to simply present the account in such a manner runs the risk of the study being seen to be of an idiosyncratic nature; possibly of interest in its own right, but adds little to the body of knowledge. Hence this discussion chapter seeks to extend that account in the light of existing literature, commentary and with reference to the literature review and theoretical frame presented in earlier chapters. Each of the major themes generated from the results are revisited, and in turn are considered in the light of extended commentary and theoretical positions, noting any observations, insights and implications. This chapter, then offers a further revolution of the hermeneutic circle, through a revisit of the initial proposed theoretical frame in the light of the insights of this study. As a result an amended theoretical frame is presented as a summary of that revisit.

Finally this discussion chapter offers a consideration of the limitations of this study and offers some recommendations to mitigate against such limitations in future research of the phenomenon.

6.2 Making a connection and relating to one another: discussion

The first major theme identified in trying to understand how acute psychiatric nurses form a therapeutic relationship, was a sense of making connections and relating to one another. To this end a great deal of emphasis was placed on the importance of an initial friendly approach to the patient. This is described as a deliberate relationship building encounter, characterised by the nurse taking the initiative to engage the patient. An initiation process that mirrored Thibeault's (2016) observation, of how acute psychiatric nurses actively sought out opportunity to engage on a personal level. Participants described this need to convey friendliness and acceptance, with a strategy of matching language style and vocabulary, the use of a gentle and easy tone, and non-verbal skills such as smiles, open posture to convey warmth and acceptance, or making considerate practical gestures, such as tea and toast making. This was couched in terms of the use of an ordinary, everyday social skill set, a skill set that nurses described as their normal, everyday approach to new people. Geanellos (2005) and Gardner (2010), argued that such friendliness has often been overlooked as a coincidental finding in research, although as this study revealed, the act of friendliness and the ability to convey that friendliness, is a strategic endeavour in its own right, particularly as an initiation strategy to building a therapeutic relationship. More specifically to the acute psychiatric inpatient setting both Scanlon (2006) and Gerace et al. (2018) had also observed the functional role of such friendliness in terms of establishing a therapeutic relationship. Or as Hem and Heggen (2003) also described of the initial approach within the acute inpatient psychiatric setting; is one that is characterised by the human, the natural, and the friendly. In such an endeavour participants placed an emphasis on strategies of engagement drawn from the social environment, describing such things as the use of humour, just being chatty, showing an interest in the person and their lives and what they have to say, alongside practiced and adaptive non-verbal communication of appropriate eye contact, open body postures, and listening carefully.

Participant's descriptions of just being normal, and every day seem to indicate, as Chambers (2005) had observed, that the nurses often down- played such skills, however it is clear from

this study that the use of such so called normal social skills, offer an important strategic component to the acute inpatient psychiatric nurse's endeavour to build a therapeutic relationship. Bjorkdahl et al. (2010), Hem and Heggen (2003) and Scanlon (2006) in their own studies in the acute psychiatric field had also made reference to what appeared to be the intuitive and subconscious social responses of acute psychiatric nurses, as they sought to build a relationship. Freshwater and Stickley (2004) observed the therapeutic value of such normal social interaction, noting that whilst such simple human contact may easily be taken for granted, it may in a moment, be both profound and healing.

Whilst there was general reference to employing a range of social communication skills in the formation of the therapeutic relationship, a particular emphasis of participants, was of exploring shared interests, getting to know each other and making a sense of connection through those shared interests. This strategy involved an active search for shared interests, of trying to establish some commonality based on those interests, often small and tangential, whether that be sports, hobbies, television programmes, music or even a preference for a cat or a dog. A phenomena that very much concurs with earlier studies examining the relationship forming endeavours of inpatient staff (Cleary et al., 2012b; Gerace et al. 2018; Thibeualt, 2016). Certainly Bowers (2005) in his seminal work on the reduction of conflict within acute psychiatric wards had identified the therapeutic value that an understanding of each other's interests held. To this end participants also spoke of supplementing this natural social endeavour with a more formal strategy through the use of "getting to know us" boards and files, based on Bower's (2014) safe-wards initiative.

Furthermore, staff spoke of a purposefulness in creating opportunity for social interaction to occur. This was described as just being out there (on the ward), either through the day to day activities of a shared work and living space, or ensuring that they were seen to be available through the positioning of themselves within the environment, a phenomena widely reported within the literature search, and often also simply referred to as "being there" (Andes and

Shattell, 2006; Berg and Hallberg, 2000; Bjorkdahl et al., 2010; Cleary, 2003; Cleary et al., 2012b; Delaney and Johnson, 2014; Delaney, Shattell and Johnson, 2017; Thibeault, 2016).

Participants did speak of the time and task pressures of a modern acute ward, and then out of necessity, as Cleary et al. (2012b) had also observed, to maximise the opportunity presented through the tasks of ward routine; such as the assessment interview, drug rounds, meal times, assisting someone with a daily activity, or the simple process of fetching someone to see the doctor. Such insights of how registered acute psychiatric nurses utilise routine tasks to interact on a social level as part of their relationship building labour, may be particularly pertinent to consider within any skill mix review, otherwise the opportunities for such interaction may lessen as some tasks are considered to be the labour of unregistered healthcare staff. Ironically, this is based on a belief that this will in turn, free more time for registered nurses to interact therapeutically (Munro and Baker, 2007).

Whilst participants described an ordinariness to their social approach of making a connection and relating to one another, they equally spoke of taking into consideration a professional understanding of the healthcare circumstances in which that encounter took place. In particular participants described being aware of the inherent and overt power imbalances that surround an admission to an inpatient acute psychiatric ward (Cleary, 2003). Then with that specific understanding in mind, they compensated for that phenomenon and actively sought to dub down the power status of nursing, through strategies such as matching language style, self-depreciating humour, or presenting themselves in a relaxed, open manner and adopting a position in the room, such as a low chair or an uncomfortable stool to undermine any sense of status. Equally nurses spoke of the adjustments they made to their so called natural and ordinary social engagement strategy based on their professional understanding of psychiatric symptoms, such as paranoia, voice hearing, or the slowed cognition of severe depression.

A particular strategy suggested by the nurses in those initial stages was to communicate an acknowledgement and a validation of the distress that an individual may feel. Participants identified very much with the humanist perspective (Maslow, 1999; Rogers, 1965) of the

centrality of such an empathic response in establishing a relational bond. An observation that Cleary et al (2012b) had observed as a communication of a sense of “for the grace of God”, a phrase also used by participants in this study; a phrase to communicate an understanding that they themselves may experience similar difficulties if exposed to similar circumstances. This conveyance of an empathic response (and at times sympathetic response) within the opening exchanges, certainly has some support within nursing texts and is seen as a critical component of establishing the interpersonal relationship between nurse and patient (Moreno Poyato and Nogueira, 2021; Peplau 1997)

Whilst a relational bond built through social endeavour and friendliness were key components in the establishment of a therapeutic relationship, participants clearly indicated that there was an invisible limit to the depth of such a relationship. Participants indicated that it required conscious effort and strategy to manage that limit, such as being conscious not to share too much personal information, or to allow the focus to drift from the patient’s agenda, or at times, verbally reminding patients of the professional and temporary nature of their relationship. A similar observation was recorded within Gardner’s (2010) exploration of friendliness, noting a threshold where friendliness would be considered to overstep into unprofessionalism, a threshold that needed to be monitored and positions actively adjusted to account for it. As Griffith (2013) recorded the relationship is required to exclusively focus upon the needs of the patient if it is to be of therapeutic value, let alone meet professional standards (Nursing and Midwifery Council, 2015). Participants reported toggling between the friendly and the social whilst managing a professional distance, a phenomenon observed by Barker et al. (1999) who offered a typology of the ways nurses relate to patients; relating as me, relating as the professional nurse and relating as the pseudo or engineered version of me.

Much of the initial approach described here resonates with Barker’s (2001) and Watson’s (1979) descriptions of nursing’s relational work; as the skilled application of this so called ordinary. As Benner’s (1984) would have argued the skilled practice appears to have been committed to a subconscious level, so as to be considered normal and every day. Participants

did offer some credence to such a notion offering an insight that those so called innate “natural” skills had actually developed through a personal process of testing and reflection of what worked for them in their nursing practice and what did not, this was reported to be at both a subconscious and conscious level. The use of such reflection and personal development as part of the strategic endeavour to form a relationship is discussed later in this chapter.

The identification of a friendly social strategy suggests a striving to create an interpersonal social relationship between nurse and patient; an observation that very much resonates with Rogerian notions of the intrinsic therapeutic value of such relational bonds (Rogers, 1965). A position that lends further credence to Cutcliffe et al.’s (2015) assertion that the founding theoretical belief that inform the therapeutic relationships of acute psychiatric nursing are indeed Rogerian notions of the inherent value of a strong relational bond. Likewise, Clarkson’s (1995) classification of the five types of therapeutic relationships included this interpersonal social relationship as a distinct form of helpful relationship, a relationship distinct from the more contemporary view of the therapeutic relationship as purely that of a working alliance, a therapeutic relationship that is defined by the presence of both task and goal agreement (Bordin, 1979).

Chambers (2005) also noted the importance of the friendly interpersonal and social relationships in nursing, but saw it more as an essential foundation for the therapeutic relationships of nursing, and that alone it could not wholly account for the concept of the therapeutic relationship in nursing. Similarly, Peplau’s (1952) theoretical account described these early encounters as an orientation phase, where nurses and patients get to know each other, and construct and understanding of each other’s preferences, objectives and style, before moving towards a working phase.

The observation of a major theme in the raw data that relates to “making a connection”. A concept that is enacted through the deliberate and early engagement of the nurse with the patient, utilising an inherent friendly social skill set, that is then modified and adjusted to reflect professional insights into the nature and impacts of illness, power, personal boundaries and

altruism, is also reflected in contemporary literature and commentary; thus lending further credence to the interpretation of the original data.

Such observations of the use of the inherent social skills, often referred by nurses themselves as the natural self within this study, highlights Waugh et al. (2014) assertion of a pre-requisite requirement to recruit nurses with an existing degree of social ability, which in turn will be fine-tuned and shaped through both professional education and clinical practice.

6.3 Utilisation of values: discussion

Unsurprisingly in a profession that has put a great deal of emphasis and given voice to the possession of personal and professional values, (Rassin, 2008), the nurses in this study made reference to a value base. A value base that listed core concepts of empathy, equality, non-judgemental, altruism, shared humanity, genuine, authentic, care and compassion. Interestingly, as with the descriptions of a social skills, that value base was both drawn from a personally held perspective and equally from professional practice literature (Nursing and Midwifery Council, 2010a, 2010b).

In respect of answering the research question, of how nurses form a relationship within acute psychiatric settings, it was the participants' descriptions of the utility of those values that drew the focus of this study. The reporting of the utility of values in the formation of the nurse patient relationship within acute psychiatric environments was certainly not unique to this study, and concurred with other studies in this field of practice (Bjorkdahl et al., 2010; Cleary et al., 2012b; Delaney and Johnson, 2014; Hem and Heggen, 2003; Scanlon, 2006).

In terms of that utility, the participants spoke of an internal strategy of consciously reminding themselves of their personal and professional values; a mechanism by which to retain a focus on developing a therapeutic relationship, within what at times can be a challenging and hostile environment (Cutcliffe et al., 2015). A strategy reminiscent of Verpeet et al. (2003) descriptions of the need to make a connection between the nursing endeavour /task and the values of

person and the profession if the nurse –patient relationship is to be seen as therapeutic and transcend the obvious barriers; a phenomenon that as Raissin (2008) had observed to be particularly needed within the work of psychiatric nursing.

This strategy of consciously touching base with personal and then professional values was reported to directly relate to the level of challenge being faced, and the greater the challenge the more important this reflective strategy became to the nurse. Additionally, the greater the challenge the greater was the shift to a conscious connection with a prescribed professionally held value base (Nursing and Midwifery Council, 2010a). Delaney, Shattell, and Johnson, (2017) had equally observed that such internal dialogue was an important strategic component of the nurse patient relationship; one often overlooked in research into nurse patient relationships. It would appear that such dialogue, as Barker et al. (1999) had observed offers an opportunity for the patient to interact with a pseudo or engineered version of the nurse, where the nurse as themselves may otherwise struggle. Of the values required of the professional nurse (Nursing and Midwifery Council, 2010b), participants particularly identified with the issuing of self-reminders of their altruistic and non-judgemental intent; which were key concepts of the therapeutic relationships of acute psychiatric nurses reported throughout the texts included in the literature search (Berg and Hallberg., 2000; Bjorkdahl et al., 2010; Chiovetti., 2008; Cleary, 2003; Gabrielsson et al, 2016; Gerace et al., 2018; Hem and Heggen, 2003; Scanlon, 2006; Thibeault, 2016).

Such an observation of a move to the pseudo / engineered version of self (Barker et al., 1999) by the nurse, did raise the need to clarify what at first appeared to be conflict with reports of the need for genuineness, honesty and truthfulness. With regards to this, the participants were quick to note that when working as a nurse, there was a move from the personal to the embodiment of the professional persona, which interestingly is listed as one of the professional competences of nursing (Nursing and Midwifery Council, 2010b). Participants described this embodiment as something that required conscious strategy at first, but one which became increasingly subconscious with experience, akin to Benner's (1984) descriptions of a novice to

expert progression. A strategy that then enabled them to transcend what may have been normal barriers to a relational endeavour. Watson (1979) described this within her description of the caritas of nursing, identifying a need for nurses to transcend personal biases and beliefs about the nature of humanity in order to be effective.

The notion of the personally possessed value set supports arguments of a need for recruitment practices based on such prerequisite altruistic value bases (Groothuizen, Callwood and Gallagher, 2018; Miller, 2015; Patterson et al. 2016); although the description of the utility of a professional value base (particularly in challenging circumstances) would suggest that values can also be taught and embodied, as Fahrenwald et al. (2005) had asserted. An observation that prompts an ongoing need for debate, research and appraisals of the recruitment and educational practices of acute psychiatric nurses.

Reynolds (2005) in conceptual analysis of the value empathy, went on to assert that possession alone was insufficient to account for the whole concept and he went on to describe a cognitive behavioural element where values, such as empathy, need to be both communicated and enacted. An observation equally reported in Egan's (2002) accounts of the skilled helper. A position that the participant accounts of the utilisation attested too, revealing that it is the communication and enactment of the value base that offers the strategic component of their endeavour to forming a therapeutic relationship. Participants described; verbal strategies of just simply telling someone; for example, in statements that convey the message such as I am here to care for you, I am being straight with you, and this is how it is, I am not here to judge etc. Or alternatively demonstrating those values in the day to day of ward life through such things as compassionate actions, offering time, going the extra mile to do something for someone or in just the keeping of promises to do something. An observation equally made in the research to date on the subject matter (Cleary et al, 2012b)

Equally patients expect nurses to hold such values and to offer them dignity and respect (Chambers et al., 2017; Delaney; Shattell and Johnson, 2017; Kontio et al., 2014, McAndrew et al. 2014) and perhaps it is then unsurprising that the communication of such a value set,

through words and actions has such a direct impact upon the establishment of the nurse-patient relationship.

The communication of values as a strategy in forming the therapeutic relationship is certainly not a new concept, as previously noted, Egan (2002) described such within his descriptions of the actions of the skilled helper, or in Rogers (1965) insistence of the importance of communicating empathy, trustworthiness and genuineness if a relational bond is to be formed. Such insights would suggest that it is not enough within nurse education or the development of psychiatric nurses to simply enculture or teach the value base of nursing, but to also focus upon how they are then to be communicated to the patient, as Reynolds (2005) had suggested.

6.4 Appraising the situation and manoeuvering: discussion

The dynamic nature of the therapeutic relationship was emphasised by participants, one which was described as requiring reflecting and adapting in action; a process that occurred as a real time event, which quickly twisted, turned, flexed and adapted to the individual needs and responses of the patient as they happened; as Hagerty and Patusky (2003) observed it is an iterative and dynamic process. Participants' spoke of an internalised dialogue that allowed an appraisal of the situation in front of them, an appraisal that enabled the constant modifying of their approach, which included at times undertaking rescue moves such as offering apologies or restating intent, where an approach or style prove to be sub optimal or even unacceptable to the patient. It is indeed this pace and dynamism, the back and forth of the getting to know each other, that led Hagerty and Patusky (2003) to question the lack of finesse to Peplau's (1952) description of a steady linear movement of the relationship working through orientation to alliance to termination. Thibeault (2016) in her own analysis of the relational processes within a contemporary acute ward, also had observed both the pace and the toing and froing of the relational status, and whilst recognising Peplau's (1952) description of this as an orientating process, Thibeault (2016) described these rapid manoeuvres within a frame of reference of a conflict resolution. Thibeault (2016) described this as a struggle towards establishing some

common ground; a process characterised by a jostling where each party sought to assert their position and establish the rules of engagement; a process of move and counter move. Thibeault (2016) utilised a conflict metaphor to describe this reflection and adaption, describing it as frontline action. Parse (1997) in describing the activity of nurses in establishing the therapeutic relationship described this as a continuous rhythmical process between nurse and patient moving toward possibilities, although it should be noted that Parse (1997) was offering a generalise view of nursing activity in this instance. A process that reflects the existence, as Erskine (1998) would have described, of an interpersonal and emotional attunement of the nurse with the patient's psyche.

Such descriptors suggest a conscious and almost formal process of: a tentative approach, followed by appraisal of its effect, leading to a modified or radically different approach. Participants indicated that for most of the time this was a very much in the moment, a real time reflection that was more of an intuitive sub conscious reflex and reactionary process. As Billay et al. (2007) observed, it appeared as though nurses were tapping into a rich source of intuitive knowledge. Whether that was nursing knowledge or personal knowledge was unclear from participants. Perhaps it is as Cadman and Brewer (2001) had observed greater relational success was apparent in those with the pre-requisite skills of self- awareness, the awareness of others and adaptability. Although, equally Benner's (1984) assertion that such intuitive and reflex action is the demonstration of professional expertise and knowledge that has been submitted to the subconscious level could be applied. Schon (1992) was to describe such activity and introduce the phrase of reflection in action into the discourse of expertise.

Whilst this notion of a live and active process of appraisal and modification held some prominence in the descriptions offered by participants, it would be an insufficient reflection of the data to simply suggest these alone enabled nurses to build their relationships with patients. Certainly Moyle (2003) had observed that nurses within an acute ward did not naturally find it easy to engage with patients. Participants concurred with such a view and alongside the personal reflection they also spoke of drawing upon professional knowledge of mental illness,

its symptoms and how those symptoms may impact upon the interpretation of the nursing approach by the patient. Furthermore, the participants also spoke of drawing not only on this psychiatric understanding of illness to inform and adjust their approach, but also reported the utilisation of an eclectic mix of psychological and psychotherapeutic understandings of mental distress. Participants spoke of their more formal reflections being informed by a range of psychological theories, such as cognitive behavioural theory (Beck, 1976); dialectical behavioural theory (Lynch et al 2007); solution focussed brief therapy theory (De Shazer et al. 1986); and trauma informed theory (Muskett, 2014).

Whilst participants reported making reference to an eclectic mix of psychological, psychotherapy and medical theory within their more formal reflective practices, this in turn did not manifest itself in terms of any particular psychological style of interaction. It was as Howard and Mishue (2020) observed that such reflective clinical supervision was being utilised to allow in-patient psychiatric nurses to simply see past the messy face value of relational challenges. The strategy of using clinical supervision in this way was described as a mechanism by which to depersonalise any challenge to them, which in turn allowed a continuation of their efforts to form a relational bond, quite often in the face of personally challenging circumstances and an absence of an alliance.

In essence it would seem that a two-fold strategy of reflection was utilised within the context of supporting the formation of the therapeutic relationship in acute, both the traditional notion of clinical supervision of reflecting on action (Fowler, 2020; Mann, Gordon and MacLeod, 2020) but equally the more intuitive practices of reflecting in action (Schon, 1992; Welsh and Lyons, 2001); an observation that suggests the need for time and understanding of how both can be established and developed with the context and cultural environment of an acute psychiatric ward (Cleary, Horsfall and Happell, 2010).

6.5 Using and working with boundaries: discussion

The acute admission ward is a busy clinical area; a place of rules and restrictions associated with safety and risk management, and at times enforced treatment regimens (McAndrew et al. 2014). Also the lived-in space of an acute psychiatric ward, is a shared social environment with the requirement for social rules, and the maintenance of personal and professional boundaries (Cutcliffe et al., 2015). Within an acute admission wards there are many boundary points which have the potential for nurse-patient conflict (Bowers, 2005). It is this inherent nature of an acute inpatient environment, which is often presented as a barrier to the therapeutic relationship (Cutcliffe et al., 2015). Therefore, it was indeed surprising that participants in this study identified the use of such boundaries and challenges in connection with the building of a therapeutic relationship.

Participants saw and spoke of the opportunity that the environment of an acute ward held, they described the intensity of the situation and the confined social environment of a ward; a situation that left little choice but for both parties to interact, and to then seek agreements, or at least mutual understanding. A position where the two parties were pushed together, and where interaction was then initially focused on a jostling for position, a mutual striving to be understood and to be heard, and to ultimately reach a position of acceptance of each other's stance; a labour towards a mutual truce. A position very reminiscent of Thibeault's (2016) descriptions of the frontline action that characterises the initial stages of the therapeutic relationship with an acute psychiatric ward.

Participants spoke of this frontline action as a joint experience with patients and one which in itself often had the impact of deepening the relational bond. A deepening bond born out of the difficulties experienced together, a notion of being together at the most difficult of times. Certainly Wright (2015) had also observed a similar phenomenon within an inpatient eating disorder unit.

To reach such a position of mutual acceptance, participants described the necessary relational labour if a safe navigation of the inherent relational risks are to be avoided. To this end participants spoke of assertive negotiation strategies of creating space for concessions, discussions, exploring interpretations and making known lines that would not be crossed. They spoke of a need to be really clear to communicate the care and security intention and purpose of any restrictions, to use direct and an unambiguous language that matched the language style of the patient. Also, as with all strategic efforts; the need for a constant monitoring and manoeuvring of their approach to engage the patient; participants spoke of employing relational rescue moves, such as changing tack, offering reassurance of the care purpose, or offering an apology for distress caused. Furthermore, nurses spoke of the need to own the message, and to present any decision as one in which they were in agreement with, in order to convey truthfulness and honesty about the situation.

Whist non- verbal communication was noted as an aspect of all nursing endeavours, which included attention to tone and cadence, participants laboured the point when it came to the communication of rules and boundaries. Participants spoke of the need to present a calm confident exterior, even if the actual emotional experience of the nurse was one of anxiety. The use of the metaphor of a being like a swan, calm and serene on the surface whilst paddling like mad against the current underneath was used by several participants. Or an alternate metaphor of avoiding being like a stern school teacher with hands on hips, wagging a finger, and enforcing the rules. Nurses also spoke again of the importance of self-sustaining strategies, such as humour with colleagues, taking time out and making sure that they made the most of rest and recuperation time.

This notion of reaching a position through relational labour of truce and mutual understanding as Thibeault (2016) suggested, or the position Peplau's (1952) would have described as orientated, do still seem to fall short of Bordin's (1979) descriptors of the therapeutic relationship of an alliance based on task and goal agreement. Although, it could be argued that as Hem and Heggen (2003) and Stenhouse (2013) noted; patient's expected nurses to take

steps to keep them safe. With Bjorkdahl et al. (2010) asserting that nurses were seen and expected by patients to be the guardians of security and safety within an acute psychiatric inpatient unit. Perhaps then there is some form of tacit task and goal agreement than at first seems. Although this argument would still seem a little thin in terms of describing an alliance.

The focus and need for alliance, through task and goal agreement, dominates contemporary psychotherapy definitions of the therapeutic relationship, and the phrase therapeutic alliance has become interchangeable with the term therapeutic relationship (Mc Andrew et al. 2014). However it was not always so (Elvins and Green, 2008; Horvath, 2000); earlier psychotherapy concern was more focused on the depth of the relational bond, as a measure of the therapeutic relationship (Elvins and Green, 2008). Bordin (1979) also identified the intrinsic therapeutic value of a strong sense of relational bond as a key component of the therapeutic relationship, a concept built on the humanist principles of the intrinsic value of a sense feeling personally connected (Maslow, 1999; Rogers, 1965). A position that lends some credence to Clarkson's (1995) identification of a therapeutic trans-personal relationship as a distinct relationship from that of an alliance based relationship. Perhaps then the endeavours and experiences of acute psychiatric nurses should be considered within the frame of how they construct and maintain a strong relational bond, as opposed to an alliance. A distinction that recognises Cutcliffe et al. (2015) observation of the prominence of the humanist perspective of the therapeutic benefit of relational connectedness (Rogers, 1965) as a persistent underpinning theory of acute psychiatric nursing practice. Wright (2015) lent some support to such an argument; observing the considerable therapeutic progress made by patients in an eating disorder unit where the relationship was built upon bond in the absence of goal and task agreement. This certainly would help to explain why the inherent barriers to alliance within acute psychiatry has not necessarily resulted in as a negative impact on the relationship as is reported in some literature (Cutcliffe et al., 2015; McAndrew et al., 2014)

Certainly the insights offered by participants, that there is even relationship building opportunity, if skilfully managed, in being the one to take a hard and possibly restrictive decision

in the interests of safety, does indeed question whether goal and task agreement are defining concepts of the therapeutic relationships within acute psychiatric nursing, as much as they are within the psychotherapy encounter (Bordin, 1979). That is not to say that such concepts are not desired or featured within the nurse-patient relationships within acute inpatient psychiatric settings, but that such insights appear to challenge an assumption that they are essential defining characteristics of the therapeutic relationship. Interestingly it is observed that such an assumption underpins much of contemporary research into the state of the relationship between nurse and patient in acute psychiatric inpatient settings, with the frequent revelation that the relationship is difficult if not impossible in the face of the inherent barriers to goal and task agreement. Such a discourse, is only enhanced with the implementation of measurement tools, that measure the state of the relationship based upon the level of task and goal agreement. A practice that Wright (2021) observed was a common feature in the measurement of therapeutic relationships in nursing. This adoption of measurement tools that do not accurately focus upon the labour of acute psychiatric nurses should be of significant concern, if as McAndrew et al., (2014) reported; nurses needed to objectively demonstrate their achievements in a business orientated healthcare system if their labour is to be recognised. In the light of the insights offered by participants here, it would seem far more appropriate to utilise measurement tools that identify the state of the relational bond between nurse and patient. It would appear that it is the forming and maintenance of such a bond despite the difficulties that is the defining characteristic of the therapeutic relationships and is indeed the focus of the nursing labour within acute psychiatry.

6.6 Working with and managing the pressures of acute psychiatric work; discussion

It was interesting to note that participants highlighted the need to work and manage the pressures that arose within the highly charged environment of an acute psychiatric ward as a strategic endeavour in the formation of the relationship. An assertion, which was based upon

a premise that an obviously stressed nurse was unlikely to be engaged by patients or be unable to exercise the necessary skills to engage patients. Participant's spoke of a mental toughness, of seeing behind insults, seeking and reflecting on explanations to challenge, and of a need to present themselves as non-reactionary and in control of their emotions and in turn of the need to be conscious of attending to their own welfare both within and without of work. An observation that does seem to be under-reported in the studies included within the literature review, although Cleary et al (2012b) did touch upon a need to take time out from the situation in order to take stock.

There is certainly a resonance with Goleman's (1998) descriptions of emotional intelligence and in turn the utilisation of it in the successful formation of interpersonal relationships. An observation re-presented by Majer, Salovey and Cruso (2004) as the exercise, of self-control, self -care and an awareness of oneself within the bigger picture. Indeed Van Dusseldorp, Meijel and Dertisen (2011) reported higher levels of measured emotional intelligence within psychiatric nurses than that of the general population. Although, they do not go on to say whether that is in their nature or is indeed the product of their environment or training. Furthermore, there does also seem to be a dearth of literary descriptions that supports a notion that the self-sustaining or mental toughening strategies of acute psychiatric nurses is a reflection of the utilisation of an emotional intelligence (Guy, 2019; McQueen, 2004; Powel, Mabry, and Mixer, 2014; Van Dusseldorp, Meijel and Dertisen, 2011).

It would seem that emotional intelligence and its utilisation is a core component of how acute psychiatric nurses form the therapeutic relationship. This suggests that there are either implications for a pre-requisite skill of emotional intelligence prior to recruitment, as suggested by Cadman and Brewer (2001), who noted the considerable length of time it takes to develop, or as others have argued for the need for development and bolstering opportunities as suggested by Fitzpatrick (2016). An observation that prompts a nature / nurture debate that is beyond the focus, and certainly the word limit of this study, which has merely sought to identify the strategies used by acute psychiatric nurses. Although there is certainly an indication of the

need for such debate and further investigation in this field, within the context of the relational elements of acute psychiatric nursing.

6.7 Work as a team: discussion

One of the most surprising findings of this research into the strategic endeavours of nurses in terms of forming an interpersonal therapeutic relationships, was the revelation that some of those strategic endeavours were more focused on establishing a therapeutic relationship as an acute inpatient team, or in some cases as part of the wider psychiatric care team than they were on the one to one interpersonal relationship. To some extent this formation of the relationship with the team, was seen as more of a primary task than the interpersonal relationship with any individual nurse. Thibeault (2016) touched on this in an examination of the relational elements of acute psychiatric nursing, going as far as to suggest this vicarious relationship building on behalf of the wider psychiatric team, was perhaps the unique contribution of a modern day acute psychiatric service to the therapeutic relationship.

Participants made particular reference to the team approach when recalling more challenging relationships or situations, as a mechanism for achieving a nurse-patient relationship where individual attempts were failing due to patient difficulties in working with or misinterpreting the different personal relational styles offered by individual nurses. To this end participants spoke of the need for robust communication systems within the team and a focus upon a more formulated understanding of the relationship and in turn a more formulated and agreed strategy of communication and engagement. Participants spoke of the need for consistency between members and how this then required a sacrifice of some personal style and strategy, and some curtailment of the intuitive response.

Fairbrother et al. (2010) had noted that literature pertaining to the relational endeavours between nursing teams and patients appeared scarce within psychiatric settings, whether that be within an acute psychiatric ward or otherwise. This is despite Fairbrother et al's (2010) observing that team nursing as a structural model of care delivery had been around in nursing

since the 1950's, and in in psychiatry since the 1960's (Wyatt and Hannah, 1964). Deacon and Cleary (2013) did note some resurgence of interest in more recent years, but very much on a focus on the solutions that team nursing may offer to efficiency and task management demands, rather than its contribution to the interpersonal relationship. This surprising finding from the research has been difficult to appraise against existing literature, but it will undoubtedly require some further consideration, particularly given if Thibeault's (2016) tentative suggestion that the unique contribution of acute psychiatric nurses was the initial relation building they did on behalf of the wider psychiatric team, gathers further evidence and voice.

6.8 Revisiting the theoretical frame.

Through the process of analysis, the recording the results, and through the process of the construction of this discussion chapter, a further revolution of the hermeneutic process has been undertaken, however it would be incomplete, without a revisit of the original proposed theoretical frame.

For ease of reference the original theoretical frame is re-presented overleaf in table 6.1.

Table 6. 1 Original proposed theoretical frame of the therapeutic relationships of acute psychiatric nurses

Ontology	The nature of the relationship is characterised by dynamic movements between positions of authority based on universal understandings of illness and equally a facilitative endeavour to explore and construct meanings of illness and recovery, resulting in an ontological pluralism surrounding the relationship	
Epistemology	Bio-psychological insights are subjected to a process of "nursification", resulting in a socially constructed nursing account of the relationship. Reflective of hermeneutic and critical realist commentary	
Defining characteristic	There is a presence of a relational bond between nurse and patient	
Purpose and Orientation	Restoration of psychiatric or psychological health (Peplau, 1952) The construction of new narrative of the meaning of illness and recovery alongside spiritual growth (Barker, 2001)	
Relational Roles	Nurses enact a number of differing roles (Peplau, 1952) characterised by five relational types: The working alliance, the transferential/counter-transferential, the reparative/ developmentally needed and the interpersonal/ transpersonal (Clarkson, 1995)	
How	Nurses utilise verbal and non-verbal interpersonal skills to establish therapeutic relationships	
	Verbal	**Non-Verbal**
	Verbal Paraverbal	Kinesics Proxemics Haptics
Interventional Strategy (Heron 2001)	**Authoritative**	**Facilitative**
	Prescriptive Informative Confrontative	Cathartic Catalytic Supportive

The findings did hold some support for an argument of ontological pluralism, participants did speak of a professional way of 'being' with patients that reflected relational truths purported by psychological, bio-medical perspectives and professional notions of right and wrong; however they equally spoke of the notion of an individually styled relationship built on Rogerian notions of a therapeutic bond that held an intrinsic trans-personal value, which helped an individual to construct new meaning, understandings and insights (Rogers, 1965).

The epistemological stance of critical realism, was certainly reflected through the findings; nursing staff reported the usefulness of scientific understandings to inform what was happening in their relationships and why individuals present in the way that they do. Although, such understandings would not then directly result in any particular scientifically informed psychotherapeutic strategy. Neither were participants wedded to any particular scientific perspective, they described being informed by an eclectic range of psychological perspectives, as well as medical understandings of illness. Participants indicated that such scientific commentary was simply additional fuel and material, with which to appraise and modify their own nursing approach. This did seem to approximate towards a critical realist perspective; referred to as 'nursification' (Mortimer-Jones and Fetherston, 2018) within the original theoretical frame. Although, it can only be considered an approximation, as there did not seem to be any objective critique of the realist position, it was just utilised as a base from which to socially construct meaning from, there was no sense of a primacy of a realist perspective.

In terms of the purpose of the therapeutic relationships in acute psychiatric nursing, the initial theoretical frame argued that there was a multitude of theoretical perspective, as to the purpose of the therapeutic relationship in nursing, suggesting a purpose that ranged from the construction and creation of personal meaning as suggested by Barker, (2001) amongst others (Parse, 1997; Travelbee, 1971; Watson, 1979), through to Peplau's (1952) who purported the purpose was to facilitate a return to a defined position of health, whether that be psychological or physical. The findings could not offer any further clarity on this, indeed the incidental finding of the study reinforced the requirement for an eclectic theoretical stance on the purpose of the

therapeutic relationship, if it is to accommodate the views offered by the participants. The incidental finding from this study suggested that participants accepted and noted the beneficent nature of their relationships with patients but offered a broad account of what it was useful for.

Peplau's (1952) interpersonal relations model suggested a progressive nature to the therapeutic relationship, moving from an orientation phase, to an alliance and eventually termination. Whilst the findings certainly identified with a strong sense of relational orientation between nurse and patient within the acute psychiatric inpatient setting; the pace, level of need and the throughput of patients within an acute ward, challenged the notion of a linear progression to a next phase beyond orientation. An observation equally made in Forchuk (1994) review of the model and one acknowledged by Peplau (1997) herself when revisiting the model in the context of a contemporary short stay modern acute wards.

Participants indicated that as Thibeault (2016) observed, that in a modern-day acute ward, for the most part, the therapeutic progression seemed to be from an orientation phase through to a position of mutual acceptance, rather than a progression to a full working alliance. As Thibeault (2016) had observed this was often the point of discharge with care then continuing in the community setting. Indeed Thibeault (2016) went on to postulate that this negotiation of the orientation phase was a role acute psychiatric nurses performed on behalf of the wider psychiatric service, a view that certainly resonated with some of the reports from participants with regards to strategically adjusting and modifying personal relational strategy so as to support the wider relational efforts of the psychiatric team. Thibeault (2016) proposed that the relational strategies of acute nurses, referred to by Peplau (1952) as orientation would be better described as a process of frontline action, where there was a jostling for position, the seeking of understanding, the identification of common ground and the seeking of opportunities to engage, resulting in an acceptance and understanding of each other's position. An account that certainly resonated with the reports of looking for ways to make contact and to build a connection, the expression of caring intent, that also sat alongside the communication of boundaries or restrictions..

Through the process of this research and being faced with a dearth of data, which appeared confirmatory of Bjorkdahl et al. (2010) observation that the relational interactions of acute psychiatric nurses was similar to observing both a bulldozer and a ballerina at work at the same time. Of being facilitative and at the same time being the guardians of security and order (Hem and Hegen, 2003). Or as Peplau (1952) had witnessed the employment of multiple roles; such as teacher, mother, and counsellor amongst others. Similarly, Clarkson (1995) suggestions of five different types of therapeutic relationship, were all borne out by the descriptions offered by participants, and certainly indicated the existence of a multiplicity of relational types. For example, the sub theme of making connections and getting to know each other was certainly in keeping with descriptions of the interpersonal relationship. Or the use of clear and explained boundaries resonated with the reparative or developmentally needed relationship. The sharing of values and purpose was a strategic attempt to help form a greater alliance. Or mentions of being emotionally connected, sympathetic, and human with the transferential/ counter transferential relationship. Accounting for all five therapeutic relational types described by Clarkson (1995).

Irrelevant of the type of the relationship formed, participants described strategy and effort that suggested an overriding Rogerian concerns with the formation and retention of the therapeutic bond, that transpersonal sense of connectedness and of being understood, of mutual trust and genuineness between two people (Rogers, 1965), and as Cutcliffe et al. (2015) observed that belief in the intrinsic value of such a relationship is prevalent throughout acute psychiatric nursing, and suggests it is the dominant theoretical underpinning to the nurse-patient relationship. Perhaps it would be simpler and more accurate to frame the therapeutic relationships of acute psychiatric nurses within such a defining context, rather than artificially dissecting it into therapeutic relational types as observed by Clarkson (1995). Interestingly this existence of relational bond was originally widely seen as the defining characteristic of the therapeutic relationship (Bordin, 1979, Rogers, 1965), but one that has been overshadowed in recent times by the focus and subsequent publishing prominence of the therapeutic alliance

(goal and task agreement) within psychotherapy research (Elvins and Green, 2008; Wright, 2021). It is perhaps appropriate that acute psychiatric nursing states a position that the therapeutic relationship within acute psychiatric care is defined on the basis of an existence of a relational bond as opposed to being drawn into psychotherapy definitions and the current research focus upon alliance. Such a stance is not to say that alliance is not sought or desirable, but that perhaps the establishment of a therapeutic relationship through that sense of relational bond is more in keeping with the realities and practices of acute psychiatric nurses.

An amendment to the original theoretical frame is suggested, to remove Clarkson's (1995) descriptions of five types of relationship, and to simplify the frame, by identifying the defining characteristic of therapeutic relational bonding as an overarching theoretical tenet of the acute psychiatric nurse-patient relationship, irrespective of what type of relationship they form. With reflection, whilst participants were asked about their therapeutic relationships, their responses would have equally answered the question; of how they formed and maintained a therapeutic bond, perhaps suggesting that for acute psychiatric nurses therapeutic relationship and relational bond are one and the same, as it would seem that in modern psychotherapy research, that therapeutic relationship and alliance are synonymous (Elvins and Green, 2008; Wright, 2021). As Chambers (2005) had observed many professions lay claim to a therapeutic relationship but it is important to consider the different contexts. Such a distinction between psychotherapy and nursing notions of what constitutes a therapeutic relationship does indicate that future research and commentary on the nature and state of the therapeutic relationships in acute inpatient psychiatry would need to consider these differences carefully. As Wright (2021) noted, that how nurses articulate what the therapeutic relationship is now will have an impact on future generations of psychiatric nurses.

In terms of the 'how' of the therapeutic relationships of acute psychiatric nurses, a retrospective view of the proposed theoretical frame in the light of the data, now appears to have been naive. To have framed the 'how' of the therapeutic relationship simply within Heron's (2001) six categories of intervention, with reference to accompanying verbal and non-verbal skills, had

not heeded Chambers (2005) warning; that it was not enough to simply consider the therapeutic relationship as something that can be established through simply taking on the instructed communication skills. Whilst it would have been easy to transcribe a number of the strategies described within the results chapter against each of Heron's (2001) six categories of intervention, and to record the non-verbal communication from the data that supported each one; to do so, would potentially misrepresent some of the complexity indicated by participants, and equally by doing so it would only to serve to dissect further a phenomena, which participants had indicated was complex and featured a number of interconnected concepts. Whilst there remains an indication for a theoretical frame that includes reference to communication strategy, as indeed various communication skills were recalled (although not in detail), the use of Heron's interventional model, with its focus on the type of interventions nurses undertake, now seems inappropriate as it detracts from the complex and changing interplay between strategy, time, situation and person. Indeed, it would appear that no single theoretical frame is wholly representative of the phenomenon, and there is a strong indication from this research and those identified in the literature search that there is a gap in theory in terms of how acute psychiatric nurses form a therapeutic relationship despite the challenges of their work. It would seem that the state of knowledge of the phenomenon remains at a concept generation stage. In order to more accurately reflect that, Heron (2001) categorisation has been replaced in the proposed theoretical frame with some broad themes drawn from this research, with some reference to the related theories as discussed below.

It became clear from the data, as Delaney et al. (2017) had observed much of the how of the therapeutic relationship rests with what goes on within the nurse as it does externally with their interactions. Participants had spoken of reflection, and of reactionary dynamic manoeuvring as a major theme of their endeavours. It suggests that a key strategic endeavour is to select the right strategic approach at the right time for the right person. It indicated participant's attunement to the patient and of their needs at that specific time. Erskine (1998) had described this attunement as the sum effect of a number parts such as; empathy, mindfulness,

immediacy, active listening, presence, self-awareness, experience and knowledge, and cognitive understanding, concepts that ran throughout the data offered by participants. Erskine (1998) argued that such concepts combined to enable a changing and emotional sensing of the needs of another and in turn the possibility of reacting to and matching the needs of that individual. Again, as Erskine (1998) acknowledged, a concept closely linked with Rogerian notions of the therapeutic value of relational bonding, through the sense of being understood, connected and responded to (Rogers, 1965).

Erskine (1998) also noted the importance of attunement to one-self in the therapeutic encounter. An attunement that was evident from participant's reports of self-awareness, monitoring the impact of personal information offered, the need to engage in self-sustaining strategies and an ability to objectify /professionalise any challenges to the relationship. Descriptions that also align with descriptions of emotional intelligence and of its application in practice (Goleman, 1998). To offer a theoretical frame that better represents the findings of this research, also requires reference to both Erskine (1998) and Goleman's (1998) writings of attunement and emotional intelligence respectfully. Please see table 6.2 overleaf.

Table 6. 2 Amended proposed theoretical frame of the therapeutic relationships of acute psychiatric nurses

Ontology	The nature of the relationship is characterised by dynamic movements between positions of authority based on universal understandings of illness and equally and a facilitative endeavour to explore and construct meanings of illness and recovery. Such multiple objectives result in an ontological pluralism
Epistemology	Bio-psychological insights are subjected to a process of "nursification", that approximates to a critical realist position
Defining Characteristic	There is a presence of a relational bond between nurse and patient (Rogers 1965) irrespective of goal and task agreement
Purpose and Orientation	Restoration of psychiatric or psychological health (Peplau, 1952) The construction of new narrative of the meaning of illness and recovery alongside spiritual growth (Barker, 2001)
How	Nurses utilise verbal and non-verbal interpersonal skills to establish therapeutic relationships

Verbal	**Non-Verbal**
Verbal Paraverbal	Kinesics Proxemics Haptics

Make connections and relate to each other • Initiate contact • Acknowledge and validate the distress • Get to know each other • Make the most of your personal style
Reflect upon and communicate a value base
Appraise the situation and manoeuvre (attunement Erskine, 1998) • Reflect in action (Schon, 1992) • Utilise clinical supervision
Use and work with boundaries • State the care agenda • State and manage the boundaries
Manage the challenges and pressures of acute psychiatric work (utilisation of emotional Intelligence, Goleman, 1998)
Work as a team

6.9 The limitations of this study

As with all studies (Polit and Hungler, 1993), this study has limitations; limitations that are inherent in the choice of research methodology and method; of the need to make compromises of scale due to finite resources; and not least from the decisions made by a novel researcher without the gift of hindsight. Within this limitations subsection, those limitations that relate to researcher bias; sampling strategy; the chosen method; and an assumption that underpinned the research; will be discussed in turn and recommendations made for future research to mitigate against such limitations going forward.

Within qualitative research, Mills (2000) drew attention to the subject of reflexivity; and in particular the influence of the researcher's lens and positioning within the interactional and interpretive processes of research, and then in turn the influence that this exerts upon the account of the research findings. Heidegger (King, 2001) noted that such influences were particularly at play within phenomenological research, suggesting the impossibility of absolutely bracketing one's own view, so as not to influence the narrative given or interpretation offered. Heidegger (King, 2001) argued that phenomenological narratives, should be considered more as a mutually constructed account, between participant and enquirer, offering a temporal, contextualised insight of the phenomenon at a fixed point in time, rather than an objective truth of the matter. Both Mills (2000) and Heidegger (King, 2001) argued that it is such reflexivity mutual construction and insightful interpretation that offers richer, deeper and nuanced interpretations and accounts of the phenomenon to be presented. Tappen, (2016) went on to state it is the synthesis of a multitude of such enriched studies that ultimately will reveal a more generalizable account of the phenomenon. Never the less, despite arguments that advocate the advantages of the embedded researcher and of the usefulness of reflexivity with the data, and the research process, such studies remain open to the critique and influences of researcher bias (Polit and Hungler, 1993).

This study presented and undertook control measures to address elements of such researcher bias: the undertaking of an autobiographical reflection by the author, the use of a reflective

diary throughout the research process; presenting and remaining close to the original words of the participants; and a constant revisiting of the raw data to check interpretations. However with hindsight, and with the learning offered from the completion of a first research endeavour, more could have been done to balance the influence of researcher bias. Whilst the researcher held concerns of the impacts on time scales and the flow of the research method if a third party was to be used in the analytical process, the utilisation of such a third party in the review of the data and the interpretations would have allowed an independent perspective to be offered, and an opportunity for the researcher to check interpretation, thus helping to mitigate the impacts of researcher bias and concerns thereafter (Cresswell, 2008; Sargeant, 2012). Likewise the use of qualitative data analysis software also introduces an element of objectivity to the process, and thus helps to increase both rigour and trustworthiness (Banner and Albarran, 2009; Cypress, 2019; St. John and Johnson, 2020). Although as St. John and Johnson (2020) went on to note the use of such software requires a degree of understanding into the nature and use of such software systems to enable the researcher to choose the most appropriate package and to achieve the maximum benefit. Therefore recommendations for future research endeavours would include both third party involvement in the data analysis, and to address any learning need to enable the choice and use of qualitative data analysist software. Without such measures it remains necessary to synthesis this report, not only with the limited research that is completed which is required of all qualitative research, but also with the personal experience of the reader; to make a sense check of what is being offered here.

The purposeful maximum variance sampling strategy utilised in this study relied upon participants identifying individuals who they felt would offer a different perspective to their own, or those that presented with a differing demographic. Whilst this offers an opportunity to capture the breadth of the phenomenon, it does not necessarily offer a consensus view of the phenomenon that can be easily generalized. Furthermore those that have not been willing to be interviewed, or those who have a demographic lacking in the local sample, may have a corresponding characteristic that offered a very different relational style to those that were

interviewed and subsequently presented in this research. Furthermore this study has limited itself to a focus upon the nursing staff's own view; their own perception and understanding of their relationship forming strategies, as a result, only one half of the two parties in the nurse – patient relationship have had their account recorded; as such the study can only claim to present a partial understanding of the phenomenon. As such the strategic endeavours uncovered in this study would require further triangulation with other studies that adopted a larger and more randomised sampling strategy, and one which also incorporates a broader perspective than that just of the nurses themselves.

The method used for this study was, the "convergent interview" (Dick 2017), it is a relatively novel research method in a healthcare setting, it has emerged from the market research arena, where the objectives are to quickly gain a consensus upon the subject of investigation. Analysis is integral to the data collection process and takes place after each interview, with agreements, disagreements and novel ideas noted, and probe questions generated, with each interview building on the last, until an understanding is reached. As a result, the staples of healthcare based interview research, such as transcription, and to an extent a separate analysis of each transcription has not been utilised, or as Dick (2017) suggested, it was not warranted. This did offer a number of pragmatic advantages, particularly in terms of significantly increasing the number of interviews possible that can be conducted within a limited time resource, as well as pulling the analysis into a live and in situ process, whilst context and details are fresh in the mind. However in presenting the findings, it became apparent that the lack of a transcription with an ongoing working analysis format which is taken forward with each interview; coupled with an inexperienced researcher without the foresight to attach pseudonyms to the quotes being taken forward, it became impossible to comply with a post research discovery of the customary healthcare practice of reporting quotes alongside a pseudonym and the auditability that transcriptions offer. Whilst this does not change the results, it does limit the auditability of the research somewhat. A consideration that had been overlooked by the novice researcher, most likely because of the lack of reference to audibility within the original descriptions of the

method by (Dick, 2017); an observation which is perhaps due to its origins within market research as opposed to healthcare research. Going forward any phenomenological enquiry that utilises the fast paced convergent interviewing method, would benefit from a more robust process of being able to retain an attribution of the statements recorded through the live and developing analysis format and to consider how transcriptions (or a sample of transcriptions) may be achieved without compromising the method, if it is to avoid the limitations to auditability that this study now presents with. The rapid advancement of technology that supports the video based meeting/interview since the COVID pandemic would also now allow the automated transcription of interviews. Whilst the accuracy and suitability of such technology would require further testing, this may allow an opportunity for timely transcription and in turn the greater auditability of the research and also potentially provide a further mechanism whereby third party involvement in this fast paced method could be enhanced.

Further inherent difficulties within the method, relate to the single data collection strategy of the interview, and of course what is said is done, may in reality differ greatly from what is actually done. Therefore it will be necessary to triangulate the finding of this study, with more observational based study to offer confirmation that what is said is done, represents the reality of the verbal report. Additionally this study by design, was an exploratory study of a very broad phenomenon, and as with all such research, many broad concepts are generated, this in turn often limits the detail with which individual concepts can be described (Mills, 2000), and in the case of this research each theme generated, warrants further investigation or conceptual analysis in their own right.

Within the study there is an underpinning assumption of positive endeavour towards the establishment of a relationship; it is assumed that nurses are forming relationships despite the difficulties, and nurses were asked how they managed to do this. This style of assumed competence and the subsequent solution orientated questioning or interview, is a familiar psychotherapeutic technique to uncover strengths, resources and abilities, and to drive greater attention to positive action and narrative (De Shazer, 1994). Whilst the reflective research diary

offers a cautionary note by the researcher to himself, of a personal attunement to that approach, and to guard against unduly over emphasising the positive responses of participants, the tendency towards optimism that the approach drives needs to be considered in any critical appraisal of the work, and the narratives offered need triangulation with alternate investigative methods to ensure they are not merely presenting an idealised account of how nurses believe they are forming a therapeutic relationship .

6.10 Conclusions

The major themes identified within the results chapter have been considered in the light of the existing literature identified alongside contemporary commentary. It is noted that the major themes presented in this study, remain largely consistent with the observations of contemporary investigators and wider commentary upon the phenomenon. The discussion in this chapter has affirmed the major themes identified from this study are not likely to be idiosyncratic. The notion of the therapeutic relationship as potentially a team related phenomenon within a contemporary acute ward, requires further affirmation and consideration. Additionally, the notion of actively managing and working with the pressures of an acute ward as part of the strategic endeavour to form a relationship does also appear to be under represented in the literature. Given the dearth of literature that identifies the challenges and pressures within acute psychiatric wards, it would seem logical that to form relationships in such an environment, the active management of those challenges would need to be part of the relational strategy.

This chapter has also revisited the theoretical underpinnings and presented a critical and analytical argument that the therapeutic relationships of acute psychiatric nurses are more accurately defined by the presence of a relational bond than they are the tripartite arrangement observed in the psychotherapy therapeutic relationship of relational bond coupled with both goal alignment and task agreement (Bordin, 1979). Furthermore, it is suggested that a theoretical understanding of how acute psychiatric nurses form a relationship remains

underdeveloped and knowledge remains at a concept/ construct identification stage, of which this study contributes to.

This chapter has also identified the limited nature of this exploratory study, and therefore suggests that findings should be accepted as a tentative account of how acute psychiatric nurses understand how they form the therapeutic relationship. Suggesting the need for further appraisal and synthesis across a much wider context than the localised nature of this study.

Having presented an interpretation and discussion of the results of the study in this chapter; this thesis will conclude in the next with both the conclusions and recommendations that have arisen out of the research.

Chapter 7

Conclusions and Recommendations

7.1 Introduction

The conclusions arising from this exploratory study are many, they have arisen from each aspect of conducting this study. Conclusions can be drawn from the review of the theoretical underpinnings, the literature search and from the experience of using a relatively novel (to healthcare) research method, and crucially the conclusion to the research question itself, of what insights do acute psychiatric nurses hold into the formation of the therapeutic nurse patient relationship within acute psychiatric wards.

This chapter presents those conclusions within subheadings that relates to each aspect. They are presented within the order of the research process for ease of reading, although in reality the cyclical nature of reflection and analysis does not necessarily mean that the conclusions offered were arrived at within such a neatly timed sequence.

Finally, this chapter will present the recommendations that have arisen out of those conclusions.

7.2 Conclusions of a theoretical perspective

The assertion that the therapeutic relationship is central to nursing practice, including the practice of acute psychiatric nursing (Cutcliffe et al. 2015) does seem to be borne out by this research.

Attempts to construct a theoretical frame from which to view the therapeutic relationships proved complex and to a degree elusive, an observation of a constantly shifting ontological position; an ontological plurality was noted. Texts offered both realist and relativist perspective. There was descriptions of the relationship based upon the scientific truths uncovered through psychology, and simultaneous commentary that references the social and narrative constructed nature of the relationships. It was argued that nurses came to understand their relationships through an equally diverse epistemological stance and would equally offer a psychology informed account of their relationships as they would a socially constructed

account. A position that seemed to be reflected within the participant's responses, as they described socially constructed skill sets and intuitive responses, but equally taking actions based upon understanding their relationships endeavour through the scientific truths of psychology and psychotherapy.

Rogers (1965) description of relational bond alone was presented as a potential defining theoretical tenet of the therapeutic relationship of acute psychiatric nurses, as opposed to a tripartite arrangement of relational bond, goal alignment and task agreement that defines the therapeutic relationship of psychotherapy (Bordin, 1979). Indeed, it was evident from the research that whilst goal and task agreement was sought and desirable, they were not defining of therapeutic benefit in the relationship between patients and acute psychiatric nurses, an observation most evident as they worked to maintain the relational bond despite the difficulties and challenges that arise out of the treatment and safety aspects of their work. As Cutcliffe et al. (2015) asserted the most persistent theoretical underpinning of acute psychiatric nurses' relational endeavours is a belief in Rogers (1965) assertion of the intrinsic therapeutic value. Of the relational bond itself. An assertion that suggests observation of the therapeutic relationships in acute psychiatric nursing should be made from a stance of viewing or measuring relational bond as opposed to the tri-partite definitions of psychotherapy, which include goal and task agreement (Bordin, 1979).

Various nursing theorists were considered and it was observed whilst there appeared to be universal agreement on the therapeutic value of the nurse-patient relationship, each text offered a differing emphasis on what the therapeutic outcome of that relationship was. Therapeutic claims appeared to be very much dependent upon the writers understanding and philosophical perspectives of what constituted health and wellness. Interestingly an incidental observation from this study also recorded that there was indeed a diverse perspective of outcomes; participants volunteered outcomes that ranged from greater concordance with medication and risk plans; a lessening of conflict or confrontation; or more internalised outcomes for the patient, such as feelings of validation or the construction of personal meaning;

or the gaining of insight and understanding. The relationship between the nurse-patient whilst universally seen as therapeutic, there seems little agreement on what that therapeutic outcome is. As a result, it does seem pertinent to consider more than a single model of nursing if the purpose of the relationship is to be theoretically presented.

Further theoretical review went on to propose that the therapeutic relationships of nursing within acute psychiatric wards were not a single entity, but that acute psychiatric nursing reflected a collage of therapeutic relational types to fulfil a broad scope of therapeutic objectives, encompassing all of Clarkson's (1995) five categories of relationship. Whilst this is certainly a possibility, participants did not reveal any conscious distinction between types of relationship, but more that they saw them as a single type defined and underpinned by the notion of the more abstract concept of relational bond previously noted. As a result it was observed that Clarkson's (1995) five categories of relationship offered little to this research as a theoretical frame.

Likewise, Heron's (2001) six category intervention model was presented as a potential theoretical frame by which the relational activities of acute psychiatric nurses could be viewed and presented. Although in this study the process of data analysis, revealed that in terms of attempting to understand those behaviours, this did not offer a natural framework by which the relational actions reported in this study, could be understood or analysed. Much of the relationship forming endeavour reported would have held some representation across a number of the interventional types described by Heron (2001).

In the absence of identifying any particular theory that directly related to 'how' the relationship between nurse and patient is formed in acute psychiatry; Communication theory was considered and a loose frame based on aspects of verbal and non-verbal communication was presented. However the broad explorative nature of this study did not lead to participants discussing a level of detail that would have enabled a meaningful reference to such a frame. With hindsight this would have required a much narrower focus, and future research may wish to examine whether the individual themes or concepts that relate to the phenomenon of the

therapeutic relationship are indeed related to more distinct aspects of verbal and non-verbal communication.

Indeed, it became clear through the process of this study that the how of the therapeutic relationship, within the context of acute psychiatric nursing, requires much more theoretical development, and on reflection it would appear that the state of theory with regards to this particular phenomenon is very much at the construct/ concept generation stage. Of which this study and the handful of other contemporary studies into the phenomenon have contributed.

Based on the experience of this research, there does seem to be an indication that Erskine's (1998) notion of attunement, Goleman's (1998) descriptions of the utilisation of emotional intelligence, and clinical supervision theory along with Shon's (1992) notion of reflection in action all offer potential frames by which aspects of the 'how' can be framed.

7.3 Conclusions borne out of the literature review

In addition to an iterative review of the theory this study also conducted a comprehensive review of the research literature to further seek any accounts of how the nurse-patient relationship in an acute psychiatric ward is formed. That literature review uncovered only a handful of contemporary studies that included a consideration of the positive relational endeavour of nurses within acute wards (Berg and Hallberg, (2000); Bjorkdahl et al., (2010); Chiovetti, (2008); Cleary, (2003); Gabrielson et al., (2016); Gerace et al., (2018); Hem and Heggen, (2003); Scanlon, (2006); Thibeault, (2016); The bulk of the research effort appears to have been to identify the barriers to the establishment of a therapeutic relationship based on the premise of the essentiality of alliance. Of the few studies that attempted to explore the relational success despite the challenges; they were largely unfunded, single researcher, often single site, exploratory and qualitative in nature. All were small scale projects and highly contextualised, mostly due to the pragmatic decisions that needed to be taken in order to undertake the research. Additionally, those handful of studies spanned several countries, thus extending concerns of the generalizability of the findings, although it was noted that those

studies included in the review, were undertaken in countries with similar western cultures and psychiatric provision.

Undoubtedly a similar critical appraisal of the research to date could equally be levelled at this study, due to the pragmatic compromises that have also had to be made to account for the levels of finance, time and experience. Although as Tappen (2016) suggested, it is the completion of multiple studies and the synthesis of those studies that will further expansion of knowledge on the subject.

Whilst this study took a systematic and independent approach to the literature review, extracting data and information, the exercise largely replicated the results of Dziopa and Ahern's (2009) meta-synthesis of the limited available studies, presenting an early indicator of nine descriptive categories that capture the relational endeavours of acute psychiatric nurses. They suggested; skilfully conveying understanding and empathy; providing support; promoting individuality; being there and available; being genuine; promoting equality; demonstrating respect; demonstrating boundaries; and utilising self -awareness. Whilst all of these concepts were certainly manifest in the accounts of the participants in this study, they did not emerge as themes in their own right but more as components of the much broader themes identified in this study.

In terms of the knowledge to date of how acute psychiatric nurses formed a therapeutic relationship within a contemporary acute psychiatric ward, the conclusion of the literature search was that understanding was as yet limited to the emergence of some of the concepts of the phenomenon, and concurred with Pazargardi et al.'s (2015) view, that knowledge of the formation of the nurse-patient relationship within the context of a contemporary acute ward remains largely hidden from view. Hence offering the justification for such research as this.

A passing observation from the literature search was the number of studies that were excluded from this literature view as they focused upon identifying the barriers to a therapeutic relationship, mostly based upon psychotherapy informed notions that a therapeutic

relationship, was tri-partite arrangement of relational bond with goal and task agreement (Bordin, 1979). A stance that may require some further thought in future research, if it is accepted that the therapeutic relationship of acute psychiatric nurses is founded on the establishment of a relational bond and often in the absence of goal and task agreement.

7.4 Conclusions that relate to the chosen methodology and methods

Both the theoretical review and literature review indicated a need to undertake further exploratory research that adopted a qualitative design in order to generate and uncover the components and themes of how the therapeutic relationship was formed within the context of acute psychiatric nursing. Additionally, a belief that much of the strategic endeavours of the nurse-patient relationship in acute psychiatric care remained hidden from view and were contained within the minds of the nurses themselves, led to the selection of a phenomenological approach with its focus upon capturing the lived experiences of the participants. Furthermore, an interpretive phenomenology was selected; partly based on a personal attunement with Heidegger's philosophy of the impossibilities of presenting an un-interpreted account, bracketed from external influence (McConnell and Henry, 2009), but equally based on a perceived value of an interpretive account in building and connecting the findings to existing knowledge.

In terms of a method, the study utilised the convergent interview method (Dick, 2017). The approach initially adopts an unstructured interview approach and initiates data collection through the asking of broad questions that outlines the breadth of the phenomenon, then questions becoming increasingly structured and focused in order to test and expand understanding. In keeping with the convergent interview method (Dick, 2017) each interview is analysed following its completion; themes, concept, and any quotes that illustrate a point, are noted are then compared and contrasted with previous interviews. Probe questions are developed after each analysis, that then explore agreements, disagreements, novel or

contentious ideas with subsequent interviewees; analysis is a live and ongoing process, and continues until a convergence of ideas that relate to the phenomena occurs.

With the benefit of reflective hindsight both methodology and method choices offered a philosophically congruent and practical means by which to consider the research question. The method enabled a structured approach to exploratory research, and a structured analytical frame; which not only enabled the phenomenon to be investigated robustly but to the researcher, as a novice researcher, provided a manageable and understandable process of data collection and subsequently a structured process of analysis.

The concurrent analysis and data collection did provide some challenges and concerns. The ability to engage in the accepted custom of transcribing each interview is impractical (Dick, 2017) and a line-by-line detailed analysis of all that is spoken is not possible. Although listening and re-listening to recordings, with the interview notes and analysis sheet in hand went some way to addressing this, and the lack of transcription enabled sufficient interviews to take place to explore the phenomenon from a wider perspective.

Additionally, as the process is a dynamic one that moves forward with each interview; it is the most recent analysis sheet that forms the focus of the comparison with the next interview. Some good house-keeping practices were required to ensure themes or concepts had not dropped off the radar and were forwarded for further exploration even when not raised by the last interviewee. Ultimately at the end of this circular process of data collection, and analysis, it is the final analysis sheet that contains the research findings with a record of themes, concepts and a series of quotes that illustrates the findings in the words of the participants. With good house-keeping, in terms of ensuring themes or questions had not been left behind, this did indeed provide a very pragmatic approach to arriving at a set of conclusions about the phenomenon.

With the benefit of post research experience, that good house-keeping could have been extended to ascribing quotes on the analysis sheets with the relevant alphanumeric code of

the participant also being forwarded to the final sheet along with the quote. Whilst Dick (2017) had not laboured such points possibly due to the market research background, this ascribing of alphanumeric codes would have enabled an accepted healthcare research reporting custom, of each quote being assigned against an alphanumeric code, which post event and without a significant trawl of each contributing analysis sheet it became impossible to do.

This study is also limited by the decisions that have to be made in any research based on a pragmatic assessment of available time and finance whilst still offering a robust enough study to further knowledge (Polit and Hungler, 1993); this study, out of necessity, has remained relatively small scale, to enable a sufficiently in depth exploration of the phenomenon as to be meaningful. Additionally, all research method choices have advantages and disadvantages (Treece and Treece, 1986) and the choice to conduct the research from an insider perspective, which whilst arguably enhancing and deepening understanding, as subtle nuances and inferred meanings are understood and audiences granted, this does increase the likelihood of a localised context of the phenomenon being reported. Additionally, the reflexivity of the researcher with the data, which as Mills (2000) suggested allows for a deeper understanding to be presented; it equally presents a challenge to the presentation of an impartial view. Thus the research report requires a critical reading by the consumer.

Furthermore, this study has chosen to examine the insights offered by psychiatric nurses themselves based on their lived experience and cognition of the phenomena, and so the findings are not based on observations of their actual behaviour but on their reported behaviours. It is a one-sided account of a two way relationship and the patient perspective may indeed differ. The focus of the research was on enquiring of the positive endeavours of psychiatric nurses, an exercise in itself that is likely to account for an increased focus on positive behaviours (De Shazer et al., 1986), which may in itself skew the self-report of participants. The findings of this research are therefore offered as tentative insights that contribute to increasing an understanding of how acute psychiatric nurses form a therapeutic relationship with patients within the acute inpatient environment.

7.5 Conclusions on an answer to the research question

This research has sought to understand, through the insights of acute psychiatric nurses, how they form a therapeutic relationship with patients admitted to an acute psychiatric ward, despite high levels of symptomatic mental illness, enforced treatment plans and contested risk management regimes, all of which run alongside a high task orientated workload (Mc Andrew et al., 2014).

In answering that question this study has demonstrated a complex inter and intrapersonal strategy that encompasses both internal reflective and self-sustaining processes as much as it involves a behavioural endeavour. A strategy that utilises personal attributes and skills, interwoven with professional insights, knowledge and behaviours.

Six major themes emerged from the data, three of which can be further divided into sub themes, and they present a means by which to construct an account of how those relationships are formed (see table 7.1 overleaf)

Table 7. 1 How acute psychiatric nurses report the formation of the therapeutic nurse-patient relationship in acute psychiatric wards

Major Theme	Sub Theme
Making connections and relating to each other	Initiating contact Acknowledging and validating the distress Getting to know each other Making the most of your personal style
Utilisation of a value base	
Appraising the situation and manoeuvring	Reflecting in action Utilising clinical supervision
Using and working with boundaries	Stating the care agenda Stating and managing the Boundaries
Manage the challenges and pressures of acute psychiatric work	
Working as a team	

Making connections and relating to each other is characterised by the nurses' creating opportunities and time to undertake a friendly and attentive social interaction. An interaction that draws upon the personal social abilities of the nurse; the ability to convey friendliness and interest; being able to open a conversation, discovering mutual interests or common ground, or maybe the use of humour, alongside adopting a matched language and vocabulary to that of the patient.

However such inherent social competence was not enough alone to describe the participant's strategy above; it is a social strategy that is then carefully adjusted to reflect professional

understandings of the impacts of illness, power and the altruistic and boundaried nature of the relationship.

Participants spoke of values and of their utilisation of them as a strategic endeavour employed in the formation of the relationship, revealing both a reflective and behavioural component. In terms of the reflective strategy; this entails checking in with both a personal and a professional set of values when the patient's behaviours or beliefs challenge the nurses own; with an increasing move towards the professional in parallel to the increasing challenge encountered. Participants spoke of an embodied enactment of the professional value set at such times, a professionally engineered version of themselves. Participants reveal it is the direct communication and demonstration of those altruistic values that is most instrumental in the formation of the therapeutic relationship. For example, in the delivery of a simple act of kindness, compassion or care based on attentiveness to the patient's everyday needs.

For acute psychiatric nurses the endeavour to form a therapeutic relationship is as much a dynamic reflective exercise as it is a behavioural one. A reflective process that sees a constant monitoring of the reaction of the patient to the approach of the nurse, followed by adjustments to the approach, and if necessary, resetting the footing of the relationship all together. An observation akin to Erskine's (1998) descriptions of finding attunement with the patient. Such reflection is reported to be constant and operates along a continuum from what appears to be the subconscious and intuitive, as Schon (1992) would describe reflection in action, through to the more formal practices of clinical supervision, which could be described as a reflection on action. That continuum operates in parallel to the level of complexity or challenge that the nurse faces in their relationship forming endeavour, with increasing formal reflection as the degree of challenge increases.

Whilst the acute psychiatric ward is indeed a place of rules, restrictions, and boundaries; acute psychiatric nurses reported that embracing, working with, and managing those restrictions offered a unique relational forming opportunity. A relationship that developed on a basis of a shared experience, of being together at the most difficult of times. An opportunity for nurses to

be seen, with hindsight, by patients as a beneficent guardian of security and safety, as someone that took the responsibility to make a difficult decision when it was needed to secure longer term benefit.

Participants spoke of the need to carefully manage the situation if it was indeed to offer an opportunity to build a therapeutic relationship. Participants spoke of a need for direct, honest and clear communication of what was required or what was to happen, coupled with a clear indication of the care and security intention behind their actions. Of a need to own unpopular messages, and to present any decision as a unified team one. Participants laboured the point that at such times of managing rules and restrictions, there needed to be an increased internal focus on their non-verbal communication to ensure that a reassuring calm confident and decisive exterior was seen, and any anxiety or negative emotion remained hidden. Participants spoke of an increased need to appraise the situation and manoeuvre in such scenarios and be quick to exercise relational rescue moves or change tack. Additionally, they spoke of identifying and keeping open 'wiggle room' and negotiating what concessions they could, without compromising the intention of their actions.

Those participants also spoke of the personal emotional toll of their relational endeavour in such difficult scenarios, and spoke of the need for a mental toughness, of seeing past any challenge or insult, to depersonalise any such occurrence as the words and actions of someone with mental distress or illness. A strategy that drew comparisons with what Goleman (1998) would have described as the utilisation of emotional intelligence.

Participants stressed the importance of engaging in self-sustaining behaviours if they are to be able to maintain an ability to form the therapeutic relationship. They spoke of the function of humour with colleagues, taking time away from patients in the working day, not just in terms of breaks but also in the back office doing paperwork, as well as making the most of rest and recuperation time outside of work.

Finally, participants spoke of an awareness of how their interpersonal relationship forming strategies may impact upon the patient's relationship with the team, both at ward level but also the much wider mental health team; they spoke of tempering their own personal strategies and manoeuvres in deference to an approach that was more likely to secure a therapeutic relationship with the wider team. To achieve such an aim, participants spoke of the need to utilise robust communication systems and utilised a more formulated understanding of the relationship, and in turn a more formulated and agreed strategy of communication and engagement; they spoke of the need for consistency between members and required a sacrifice of some personal style and strategy, and some curtailment of the intuitive response. This phenomenon was particularly noted in working with those that presented the greatest challenge to forming a therapeutic relationship.

7.6 Recommendations

A number of recommendations arise from this study, not only from the answering of the research question, but also from the insights and learning gained through the processes of the research itself. Recommendations not only relate to the research question itself but also to the undertaking and process of research; both will be discussed within this subsection.

This study has shown; the use of the inherent social abilities, and the employment of the natural relational style of the nurse, are significant components within the formation of a therapeutic relationship between nurse and patient. An observation that drives a recommendation for recruitment practices that enable the identification of a pre-existing developed social skill set, within applicants that are looking to work in acute psychiatric nurse settings. However the possession of such pre-requisite skills was reported to be insufficient in their own right; and an understanding and education in the relational impacts of psychiatric symptoms, power imbalances and professional boundaries upon the social relationship was also needed, in order to make informed adjustments to the 'natural' social strategy. It is thus recommended that professional education and development programmes are also available that not only offer a

focus upon such concepts, but in turn promote an understanding of how they may impact upon the nurse –patient relationship, and then in particular what strategic adaptions to the nursing approach is required.

Furthermore participants spoke of the utility of values in the formation of that relationship. They referred to the need to be able to tap into an inherent set of altruistic values, as a reflective exercise that enabled them to continue to approach and work with individuals that challenged their perspective or even their morality. An observation that adds weight to the argument of the protagonists of value-based recruitment. Whilst this research certainly supports such an argument and naturally draws a recommendation for such practices, it would appear that participants also referred to a professional value set that was learnt and embodied, and was also utilised as a reflective reference point; which further enabled their continued engagement in circumstances that may have started to challenge the more personally held values. An observation that leads to a recommendation that alongside value-based recruitment there is a need for education and development in the expected professional value set of nurses. Whilst participants spoke of the importance of the possession of these personal and professional altruistic values, they revealed it is the communication and enactment of those values, which has significant benefits in the formation of the therapeutic relationship. It is recommended that any such educational programmes on the values of nursing, also needs to contain a practical element that focuses upon how those altruistic values are communicated to the patient. One such example described by participants in the communication of those values, is the provision of informal caring acts, such as making a drink, running a hot bath or just simply spending time around someone in distress. Such revelations of the importance of such caring acts by registered acute psychiatric nurses, as a mechanism by which values are communicated, and in turn the therapeutic relationship developed, drives a recommendation that time for such acts needs to be accounted for and recognised within any work load appraisal.

The importance of such relational social skill and the possession and utility of an altruistic value set within nursing is not an isolated finding of this study, but was brought into sharp focus with

the Francis (2013) report into the failings of care within a mid-Staffordshire hospital, which identified that dis-compassionate, depersonalised and relationally distant nursing care, had led to the development of mechanistic task orientated processes, that took little account for the individual needs of patients; and led to the missing of key information communicated by patients. Since then the Nursing and Midwifery Council (2018) set out within the standards of competence for nursing, the importance of robust communication and interpersonal skill sets alongside the possession and demonstration of professional values. Health Education England (2016), takes this a step further than a post registration competence, and directs the need for such traits and aptitudes to be identified prior to professional training programmes, and stresses the need for values based recruitment as a matter of course for healthcare professions. Such altruistic values and compassion is enshrined within the National Health Service constitution (Department of Health, 2021). A position that is further re-iterated within the principles outlined within the UK National Health Service's (2019) long term plan, although it should be considered, that this text also notes the current pressures to fill the substantial nursing vacancies across the National Health Service, and that whilst that report goes on to suggest standards should not be compromised as a result of such pressures, there is clearly an observable tension between attaining the numbers and ensuring recruitment of those with the necessary pre-requisite skills, values and aptitude. As such the recommendations made here, based on the findings of this study, offer a timely reminder of the importance, of the ongoing importance of the standards of competence around interpersonal communication, values and the demonstration of those values if a therapeutic relationship is to be formed in acute psychiatric nursing practice.

In addition to the use of an adaptive social skill set and the utility of values, reflective practices are noted as a core strategic component in the formation of the relationship, they allowed for appraisals of the relational approach and in turn modification when necessary. Participants' spoke of the need for quick, intuitive reflection and adjustments in real time, a skill reportedly developed through professional and personal experience of the nurse-patient and from

experience within wider area of interpersonal relationship. An insight that prompts a recommendation that the level of experience with interpersonal and professional relationships should be considered at the recruitment and workforce / skill mix planning stages within acute psychiatric provision. Participants also spoke of the use, and need, for more formal clinical supervision, particularly when facing high levels of challenge to their attempts to form an interpersonal connection. Indeed the expectation that nurses engage in supervision is also detailed within the Nursing and Midwifery Council's (2018) standards of competence, and is a condition of revalidation for continuing nurse registration (Nursing and Midwifery Council. 2021): that demands nurses take responsibility for such continuous self-reflection, in order to develop their professional knowledge and skills. However the establishment of opportunities for supervision within acute psychiatric settings has faced many barriers over many years (Cleary, Horsfall and Happell, 2010); Masamha et al. 2022). Never the less the importance of such supervision to the establishment of the therapeutic relationship has been re-iterated by the participants in this study, and therefore a recommendation for the provision of meaningful opportunity for clinical supervision is reiterated here. Certainly the requirement to provide such opportunities for nursing staff, is detailed and expected by the Care Quality Commission (2014) within their healthcare regulatory function.

Seminal writings on the practice of acute psychiatric nursing purport a need for a focus on the management of conflict points, in order to prevent a breakdown in the nurse-patient relationship (Bowers, 2005; Crisis Prevention Institute 2022). However this study also noted that targeted and skilful conflict management, not only avoided a relational fracture, but also provided an opportunity for relational development, believed to be realised through the mutual experience of a shared adversity. An observation that challenges beliefs on the impossibility of therapeutic relationships within acute psychiatric care, on the basis of the inherent presence of conflict points (Cutcliffe et al., 2015; McAndrew et al., 2014). Either way; whether skilled conflict management is limited to the avoidance of relational fracture or opens the door to a deeper therapeutic relationship, it suggests the importance of recommending continued staff training

and the development of experience and strategy in conflict resolution. Indeed such training is a regulatory requirement of healthcare (Care Quality Commission, 2020). Beyond that, this study also suggests a recommendation of a need to further understand the nature and strategy employed by nurses in how such shared adversity, as reported by participants, within acute psychiatric wards could lead to the possibility of a stronger nurse-patient relationship.

The participants within this study also spoke of actively employing self-preservation techniques, in order to be able to continue to face, and constructively work through conflict points, whilst remaining focused on the goal of the therapeutic relationship. They stressed the importance of making the most of the days off from work and time in between shifts. The Nursing and Midwifery Council's (2018) recognises the importance of such downtime to nursing practice and lists the requirement for nurses to have the ability to create a healthy lifestyle as a standard competence, which enables them to withstand the rigours and psychological demands of the role. Despite this, as service providers have faced an increasing challenge to have adequate numbers of staff present within wards; long shifts and extra hours have now become common place in healthcare (Ball et al., 2014; Jones-Berry, 2019; Potera, 2011; Rogers et al., 2004: Stimpfel, Sloane, and Aiken, 2012). Whilst negative impacts have been documented on patient safety, staff stress and burnout (Ball et al., 2014; Jones-Berry 2019), it is recommended that further study and examination on the impacts upon the relational labour of acute psychiatric nurses is particularly considered.

Apart from time away from work the participants also revealed 'in shift' pragmatic strategies of self-preservation; such as finding space away from patients, creating opportunities for time out alone, or taking time to be with colleagues to share a joke or a hot drink. Apart from guidance upon break time entitlement (Jones-Berry, 2019)), there appears to be little acknowledgement and understanding of such in shift self-preservation strategies. It is therefore recommended that acknowledgement and further study of the concept and practice is warranted, if the extent of the relational strategy is to be more fully, understood and documented.

Aside from the employment of pragmatic self-sustaining steps in their endeavours to build the therapeutic relationship, participants also revealed an intellectual strategy. One which involved the depersonalisation of hurtful remarks, or the hostile actions directed at them. They spoke of seeing past the face value of what was in front of them, and of the need to contextualise challenge in terms of illness behaviours or 'only' work related. The similarities of such a strategy to Goleman's (1998) descriptions of emotional intelligence has been made in the discussion chapter. The Nursing and Midwifery Council (2018) now list this alternate intellectual ability as a key competence for future nurses. The observation of the utility of emotional intelligence within this study in the formation of the therapeutic relationship, leads to recommendations for both the recruitment of those with such attributes / traits into nurse training / employment (Cadman and Brewer, 2001). Or as Fitzpatrick (2016) noted practicing nurses and nursing students be afforded opportunities to develop such intellect.

This research has indicated that the relational endeavour of acute psychiatric nurses are not necessarily always focused on the individual nurse- patient relationship but also concerned itself with the relationship with the team. Whilst team work is seen as central to the core competencies of nursing (Nursing and Midwifery Council, 2018), in respect of the nurse-patient relationship examined in this research, this phenomenon was presented as a surprising finding. Indeed there appears to be little reference to this concept within texts upon the therapeutic nurse patient relationship. Although Thibeault (2016) did touch upon it, suggesting that the formation of a relationship on behalf of the expanded psychiatric team, is perhaps the unique contribution of acute psychiatric services, in a patient's recovery journey that takes place across a number of teams and clinical settings. Further investigation and consideration of such a team–patient relationship is certainly recommended. Then if such investigation, does lend further support to the notion of a team –patient relationship, it drives a further recommendation for the implementation of strategies to support and develop team cohesion, clinical supervision and training.

Two key observations from the review of theory and in the light of the experience of the research have emerged. Firstly it is an observation that whilst psychotherapy, psychology and mental health nurses have entwined theoretical backgrounds, ultimately they have differing therapeutic objectives, and hence understanding of what constitutes a therapeutic relationship is likely to different. This was particularly evident in the essentiality of goal alignment and task agreement alongside relational bond to the therapeutic relationship within psychotherapy; whereas for acute psychiatric nurses it is apparent that relational bond is sufficient in its own right to achieve therapeutic outcomes. An observation that suggests that the intellectual and practical framing and measurement of the therapeutic relationship based on the achievement of the goal and task alliance associated with psychotherapy does require some re-thinking, if the relational endeavours of acute psychiatric nurses are to be understood and represented more accurately.

The second key observation is an apparent lack of a meaningful theoretical frame that focuses upon how a therapeutic relationship is formed; a frame that accounts for the practical and intellectual relational endeavours of acute psychiatric nurses. It is clear that greater theory development and consideration is needed if the concepts generated from research like this are to add to the body of knowledge.

Such theory development will require sufficient research into the phenomenon to identify and confirm key concepts of how the relationship is formed. At present the literature search indicates a paucity of contemporary research into the phenomenon. An observation that has been re-iterated post the literature search conducted for this study (Hartley et al., 2020). Whilst this study offers a further account, there remains a need for further focussed research into how acute psychiatric nurses are forming therapeutic relationships within acute psychiatric wards, with the phenomenon being recorded, triangulated and synthesised through a number of methods and from a variety of perspectives. There is a need for observational studies as well as further self-report studies, and ones that collate the patient experience of what nurses did

to form that relationship. Followed by research that seeks to then test the concepts before theory can be robustly developed.

A summary of the recommendations from this research is presented below in table 7.2

Table 7. 2 Summary table of recommendations

There is a need for recruitment practices that enable the identification of a high level of pre-requisite social skill.
Education programmes should promote an understanding of the impacts of power, symptoms and professional boundaries upon the therapeutic relationship, with a practical focus upon how social intervention strategies can be adjusted to manage those impacts
There is a need for recruitment practices that identify a pre-requisite altruistic value-base
Educational opportunities in the expected professional values of nursing are required, with a practical focus on how those values are communicated to patients.
The time to provide simple ‘everyday’ acts of kindness or care, should be accounted for in the workload of acute psychiatric nurses, and be considered as part of the labour to form a therapeutic relationship
The intuitive ability to reflect in practice (as it happens); and in turn the skill to make relational adjustments in real time, should be considered in the recruitment of nurses.
Opportunities to reflect on practice through clinical supervision are required.
Continuing staff training in conflict resolution and management is indicated.

Further research is indicated in how the shared experience of adversity between nurse and patient in acute settings is managed to possibly deepen the therapeutic relationship
Self-sustaining strategies such as finding space away from patients and time out in a shift, or interacting socially with colleagues in the working day, alongside adequate rest and recuperation between scheduled shifts need recognising as important aspects of nurses being able to work relationally with patients. They appear to be the psychological equivalent of taking a physical rest break in manual labour.
The research supports an argument for both; recruitment practices that are able to identify the pre-requisite attribute of emotional intelligence; and secondly, that acute psychiatric nurses should be afforded opportunities that serve to develop that emotional intelligence
The concept of a team based therapeutic relationship requires further investigation. If this does prove to be a significant concept within the relational practices of acute psychiatric nurses, then a focus on team cohesion, development, communication and shared clinical supervision would be recommended in practice.
It is the establishment of a relational bond often in the absence of full goal and task agreement that underpins the therapeutic relationships of acute psychiatric nursing. Therefore it is recommended that future measurement and research into the therapeutic relationships of acute psychiatric nurses should consider such a frame.
There is a need for further focussed research into how psychiatric nurses are forming therapeutic relationships within contemporary acute psychiatric wards; with the phenomenon being investigated, triangulated and synthesised through and from a number of methods and perspectives.
There is a need for further theory development into how the nurse-patient therapeutic relationships are formed in contemporary acute psychiatric wards

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Appendices

Appendix 1

Individual data base search terms and results

CINAHL 01/01/00 - 20/08/19

#	Query	Results
S20	S5 AND S15 AND S18	297
S19	S5 AND S15 AND S18	433
S18	S16 OR S17	830,772
S17	(MH "Nurses")	59,567
S16	nurs*	830,772
S15	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14	12,135
S14	(MH "Psychiatric Units")	2,348
S13	(MH "Hospitals, Psychiatric")	6,304
S12	"mental health ward*"	158
S11	"mental health hospital*"	221
S10	"mental health unit*"	495
S9	"psychiatric unit*"	3,373
S8	"psychiatric ward*"	802
S7	"psychiatric hospital*"	3,584
S6	S1 OR S2 OR S3	3,322
S5	S1 OR S2 OR S3 OR S4	28,562
S4	(MH "Nurse-Patient Relations")	25,636
S3	(MH "Therapeutic Alliance")	37
S2	"therapeutic alliance*"	1,206
S1	"therapeutic relation*"	2,197

Save Cancel

Psychinfo 01/01/00 – 20/08/19

68	S55 AND S63 AND S66	41
S67	S55 AND S63 AND S66	44
S66	S64 OR S65	830,772
S65	DE "Nurses" OR DE "Nursing"	59,567
S64	nurs*	830,772
S63	S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62	7,848

S62	DE "Psychiatric Hospitals" OR DE "Psychiatric Units"	2,348
S61	"mental health unit*"	495
S60	"mental health ward*"	158
S59	"mental health hospital*"	221
S58	"psychiatric ward*"	802
S57	"psychiatric unit*"	3,373
S56	"psychiatric hospital*"	3,584
S55	S52 OR S53 OR S54	3,322
S54	DE "Therapeutic Alliance"	37
S53	"therapeutic alliance*"	1,206
S52	"therapeutic relation*"	2,197
S51	S38 AND S46 AND S49	180
S50	S38 AND S46 AND S49	253
S49	S47 OR S48	830,772
S48	(MH "Nurses")	59,567
S47	nurs*	830,772
S46	S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45	29,275
S45	(MH "Hospitals, Psychiatric") OR (MH "Psychiatric Nursing")	24,646
S44	"mental health unit*"	495
S43	"mental health ward*"	158
S42	"mental health hospital*"	221
S41	"psychiatric unit*"	3,373
S40	"psychiatric ward*"	802
S39	"psychiatric hospital*"	3,584
S38	S35 OR S36 OR S37	3,322
S37	(MH "Therapeutic Alliance")	37
S36	"therapeutic relation*"	2,197
S35	"therapeutic alliance*"	1,206
S34	S21 AND S29 AND S32	180
S33	S21 AND S29 AND S32	253
S32	S30 OR S31	830,772
S31	(MH "Nurses")	59,567
S30	nurs*	830,772
S29	S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28	29,275

S28	(MH "Hospitals, Psychiatric") OR (MH "Psychiatric Nursing")	24,646
S27	"mental health unit*"	495
S26	"mental health ward*"	158
S25	"mental health hospital*"	221
S24	"psychiatric unit*"	3,373
S23	"psychiatric ward*"	802
S22	"psychiatric hospital*"	3,584
S21	S18 OR S19 OR S20	3,322
S20	(MH "Therapeutic Alliance")	37
S19	"therapeutic relation*"	2,197
S18	"therapeutic alliance*"	1,206
S17	S4 AND S12 AND S15	180
S16	S4 AND S12 AND S15	253
S15	S13 OR S14	830,772
S14	(MH "Nurses")	59,567
S13	nurs*	830,772
S12	S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11	29,275
S11	(MH "Hospitals, Psychiatric") OR (MH "Psychiatric Nursing")	24,646
S10	"mental health unit*"	495
S9	"mental health ward*"	158
S8	"mental health hospital*"	221
S7	"psychiatric unit*"	3,373
S6	"psychiatric ward*"	802
S5	"psychiatric hospital*"	3,584
S4	S1 OR S2 OR S3	3,322
S3	(MH "Therapeutic Alliance")	37
S2	"therapeutic relation*"	2,197
S1	"therapeutic alliance*"	1,206

Medline 01/01/00 – 20/08/19

#	Query	Results
S54	S41 AND S49 AND S52	180

S53	S41 AND S49 AND S52	253
S52	S50 OR S51	830,772
S51	(MH "Nurses")	59,567
S50	nurs*	830,772
S49	S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48	29,275
S48	(MH "Hospitals, Psychiatric") OR (MH "Psychiatric Nursing")	24,646
S47	"mental health unit*"	495
S46	"mental health ward*"	158
S45	"mental health hospital*"	221
S44	"psychiatric unit*"	3,373
S43	"psychiatric ward*"	802
S42	"psychiatric hospital*"	3,584
S41	S38 OR S39 OR S40	3,322
S40	(MH "Therapeutic Alliance")	37
S39	"therapeutic relation*"	2,197
S38	"therapeutic alliance*"	1,206
S37	S24 AND S32 AND S35	180
S36	S24 AND S32 AND S35	253
S35	S33 OR S34	830,772
S34	(MH "Nurses")	59,567
S33	nurs*	830,772
S32	S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31	29,275
S31	(MH "Hospitals, Psychiatric") OR (MH "Psychiatric Nursing")	24,646
S30	"mental health unit*"	495
S29	"mental health ward*"	158
S28	"mental health hospital*"	221
S27	"psychiatric unit*"	3,373
S26	"psychiatric ward*"	802
S25	"psychiatric hospital*"	3,584
S24	S21 OR S22 OR S23	3,322
S23	(MH "Therapeutic Alliance")	37

S22	"therapeutic relation*"	2,197
S21	"therapeutic alliance*"	1,206
S20	S5 AND S15 AND S18	297
S19	S5 AND S15 AND S18	433
S18	S16 OR S17	830,772
S17	(MH "Nurses")	59,567
S16	nurs*	830,772
S15	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14	12,135
S14	(MH "Psychiatric Units")	2,348
S13	(MH "Hospitals, Psychiatric")	6,304
S12	"mental health ward*"	158
S11	"mental health hospital*"	221
S10	"mental health unit*"	495
S9	"psychiatric unit*"	3,373
S8	"psychiatric ward*"	802
S7	"psychiatric hospital*"	3,584
S6	S1 OR S2 OR S3	3,322
S5	S1 OR S2 OR S3 OR S4	28,562
S4	(MH "Nurse-Patient Relations")	25,636
S3	(MH "Therapeutic Alliance")	37
S2	"therapeutic alliance*"	1,206
S1	"therapeutic relation*"	2,197

Set	Results	Save History / Create AlertOpen Saved History
# 14	12	#13 AND #12 AND #11 *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 13	15,082	#3 OR #2 OR #1 *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 12	4,191	#5 OR #4 *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 11	8,166	#10 OR #9 OR #8 OR #7 OR #6 *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*

# 10	5	**TOPIC:** ("admissions mental*") *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 9	4	**TOPIC:** ("admissions psychiatr*") *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 8	570	**TOPIC:** ("acute admission*") *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 7	1,347	**TOPIC:** ("acute psychiatr*") *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 6	6,504	**TOPIC:** ("psychiatric hospital*") *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 5	1,831	**TOPIC:** ("psychiatric nurs*") *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 4	2,650	**TOPIC:** ("mental health nurs*") *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 3	8,768	**TOPIC:** ("interpersonal relation*") *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 2	3,355	**TOPIC:** ("therapeutic relation*") *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*
# 1	3,432	**TOPIC:** ("therapeutic alliance*") *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2019*

Appendix 2

Literature review data extraction /analysis sheets

Literature Search of Research up to 2008	Author	Country / location	Critic and method **(NOTE all studies bar one nurses on nurses)**	Main points/ focus relating to registered nurses articulation of their therapeutic relationship forming strategies
Include metasynthesis	Dziopa and Ahern 2009a	N/A	**Not acute inpatient but included some studies that were but unsure of mix and influence on outcome** (just under a decade old) It is unclear how the quality of the 31 research studies was appraised for inclusion Utilised a systematic search, with a focus on broad inclusion criteria The study acknowledges that the literature sampling was heterogeneous with research from multiple settings / perspectives, and may over-represent perspectives from any over representative groups, there is no demographical illustration of the study context Additionally the individual components within the 9	**Focus was on broad inclusion of multiple settings and perspectives and thus cannot be attributed to a particular group or setting.** ***Skilfully Conveying understanding and empathy*** Instilling a sense of Importance- actively listening, knowing the patient – helps the patient to understand-thus empowering, promoting care to be individualised, attending and being attentive /interested. Skilled use of interpersonal technique, eye contact/summarizing/clarifying/reflecting. Understanding unique communication problems of diagnosis, thus looking beyond the behaviour and ascribing /developing mutual meaning. Accepting the unique experiences and reactions of the individual without judgement or sanction. Interact as a friend or a neighbour rather than counsellor or expert, sharing of common experiences and similarities, getting involved,

			constructs some were from single studies and offered some single responses But Trustworthiness made by d the conclusions make sense within the context of my work---probably The aim to create constructs and operationalize the therapeutic relationship in order for future detailed studies in understanding how nurses achieve this.. Some overlap and contradict- and some feel like arbitrarily assigned concepts Recommended that constructs tested in different contexts and specific perspectives	remaining stubborn with the objective of conveying understanding and empathy ***Individuality*** Seeing people beyond mental illness, being mindful of stereotyping, supporting the patient to self -manage the illness in the context of their life. Not allowing your own values to influence, flexibility with rules coupled with experience to appraise the risk accurately ***Providing Support*** Helping patients to feel safe by creating supportive and safe environments, Active responses – making helpful suggestions or offering advice, conveying hope and reflecting concern. Knowing when to do 'small' things like making a drink or fetching extra pillows. Mothering those that require it and knowing those that do not. Delivering appropriate and acceptable touch to ease distress ***Being There / Being Available*** Willing, available and present to invest time, giving offering time to talk, offering time to listen, allowing time for meaning and understanding to emerge. Knowing when to just be present and when to be

				present and engage physically and psychology. Making time (evidence that a lack of time or distancing has a negative impact ***Being Genuine*** To be natural and authentic, congruent with own values and being aware of conflict if this requires a non-judgemental front, consistency and following through on actions, showing genuine emotion, knowing when to offer blunt feedback, straight talk, share life experiences. Open and honest, use humour that is individually sensitive, to be friendly and intimate at an individually assessed level ***Promote Equality*** Managing the power imbalance or use it constructively teaching, imparting expert knowledge, problem solve and assume control when the patient needs it, and to know when. Also empower, encourage patients to take control. Include ordinary talk speaking about mutual experiences other than problem talk, ask patients about themselves, closing the space-being close, giving the patients choice within the limitations of choice, shared activity.

				Being conscious to keep signifiers of power keys / brief cases unobtrusive, assessments conducted informally through conversational interactions. ***Demonstrating Respect*** Taking the time to utilise many of the aforementioned skill to demonstrate worthiness, ***Demonstrate Clear Boundaries*** Appropriate limit setting to protect dignity and create feelings of safety and containment. Demonstrate professionalism but to know the fine line between being overly professional. To be highly skilled in knowing how far is individually (and professionally) acceptable in a number of the areas in other constructs ***Demonstrate self-awareness*** Whilst supervision , discussion etc is seen as important to support nurses to develop the therapeutic relation how this translates into a demonstration is unclear (My Notes: Perhaps changing tact when it just is not going well, knowing when to stop or go some more)

Qualitative research Include	Scanlon (2006) (Peer reviewed)	Ireland / inpatient	Grounded Theory ? relationship to the researcher Semi Structured N=6 small, 2-10 year 1 ward only, experience. purposeful sample. Constant comparison, adopted coding and analysis system Saturation point and is 6 sufficient to hold the knowledge? (also noted skills are developed through exposure, socialization, teaching, both personally and work, these are reflected upon (consciously or unconsciously) and intuitively applied. (seems like Novice – expert type stuff)	**Focused directly on my research question** Trust linked to safety and security Use Intuition based on life and work experience, react and change and progress – then provide individual response Friendliness instead of professional cold approach Show respect and dignity Good Mannerly Behaviour Understand boundaries Use personality but bracket/ hide prejudice and negative feeling- non-judgemental (ish) Manage time, give the nursing minute, keep to loose contracts over time / tasks Care for / help Homeliness, welcoming- work hard to provide Understand the patients point of view Continuity Humour- establish rapport /lessen professional increase friendliness Affinity and emotional closeness Provide information Technical Skills: Listening , reflecting, clarifying, questioning, encourage ventilation

Metasynthesis of qualitative research But in-direct but remained useful when looking at relationships as results section contained much information Included	Delaney and Johnson (2014) (peer reviewed)	USA -American eyes	Undertook a planned methodical synthesis, appropriate databases etc.. Inpatient, Nurse perception	**Focus on role of inpatient nurses, and their perceptions of work rather than their relationship** But two of three themes relate to relationships: forging engagement and educating / empowering Engagement: Patients viewpoint Caring and connecting over small basic need Being there- physically available Seeking opportunity to be with Rapport-through conveyed respect Honest, authentic, genuine Empathic Non judgemental Patients lead Listen Warmth Consideration positive regard Care and help to alleviate suffering Saw education and empowerment as the enactment of that relationship
Qualitative Include	Bjorkdahl A, Palmstierna T and Hansebo G (2010) (peer reviewed)	Sweden	Inpatient / interviews PICU not general acute (but in Sweden argued not separated, but they are)	**Focus was on caring, but saw this as equating to relationship in their work** Notion of continuum control------care Bulldozer-shield of power to stop chaos-but presents a relationship opportunity if

			Note good Intro…V good intro Purposeful, maximum variation sample, Multiple wards, urban , rural N=19 3-6 from each ward Registered 10 HCSW 9 but all nurses ? skill set homogenous 9 men 10 women, impact of local culture? ? could be 0 qualified male or whatever? Is sampling too broad to represent anything? Interview guide / to encourage narration Constructivist enquiry Systematic analysis of phenomenology or grounded theory	taken- utilising approaches from the ballet dance in with the bulldozer—this was opinion not found Also opinion bulldozer approach is seen as a guarantee of safety and order- opinion The Ballet dancer- means of forming relationships Sensitive behaviour based on perception of need Or Guardians of order (sometimes force and coercion) Utilise subtle non-verbal signals Putting yourself in the patient shoes Signalling Caring Talking with Being with Being available if needed ***** Convey **unconditional** feelings of warmth- conveyed through basic human needs such as food, drink, touch and physical comfort Patients shoes – an understanding of their behaviour (sometimes psychological / medical understanding/ knowledge) Tailor individual response Intuition Patience Caring Presence-

Meta-synthesis of Qualitative Studies Include	Cleary, Hunt, Horsfall, Deacon (2012b)	NA Synthesized with the perspective of Australian although one author from UK	Acute inpatient In English, search criteria, expressed the need for strong inclusion / exclusion criteria, as advantage of single qualitative is to detailed account of a highly contextualised situation and to not to allow heterogeneity of contexts to – collection of stories stuff (note 10 step of critique utilised of data) What nurses do : highlights themes…. Critique broad subject themes have scant evidence (-sub categories not related to relationship e.g. sophisticated communication includes such as non-relationship building communications etc. Acknowledged loss of data depth and contextual integrity	**Focus not completely on the relationship formation but on what interactions take place between Nurses and patients. However some part of that inevitably related to relationships** **Category 1: Sophisticated Communication** ***The ordinary:*** - any opportunity - nothing to small ***Weaving:*** –dealing with practical issues, - observed this as non-confrontational way of making connections and building relationship ***Listening- understanding-Responding*** Or not ***Empathy under distress /*** remain calm and soothe Intense close relationships: maintain empathy no matter how angry **Category 4 Ordinary Communication:**

			Only 8 studies of nursing view reflected in therapeutic relational aspects, according to nurses (Mc Cleary 2012- the processes / structure and containment limit setting- but seen as opportunities to develop relationship The synthesis lost focus- obvious interest in relationship- conclusions pre-conceived?	Used patient interviews to identify showing an interest Giving info (but not related to relationship) Being there repeatedly mentioned by nurses, subtle not observable, nurses tried to formalise this with a descriptor of 1:1 time. Knowing the patient: not just like a friend science and art, psychological underpinnings to behaviour / reasons etc.. **Category 6 Personal Characteristics** imagination, patience and intuition Imagining yourself in that situation Humour –From personality rather than training Non Judgemental- promoting the positive aspects of individuality and not hold the negative against Patience and perseverance – Internal calmness in face of fire

				opinion: raw materials warm and fuzzy are not inferior to the technical
Qualitative study Include	Berg and Hallberg (2000) (Peer reviewed)	Sweden (Are acute wards in these Nordic countries like ours, they seemed very different when I worked in Norway?)	Team psychiatric ward, looks like acute inpatient, but smaller localised units rather than hospital based 16 beds- diagnosis Borderline personality disorder / psychosis Length of stay 55 days—this is over double average length of stay in acute in uk n=22, interviews, transcribed texts, latent content analysis (all nurses on the unit) 10 registered 10 licenced mental practical nurses 1 licenced practical nurse 1 nurse aid How does this translate into a uk context: does not having a homogenous sample impact on findings.. ? relationship to researcher---university staff	**Focus is on what it's like to work rather than the how of the therapeutic relationships.** Developing a working relationship in everyday care giving. The relationship seen as the most important aspect of work Being with and doing for… Networking, teaching, containing and protection **Expert** – knowing what's best / then **collaborato**r mutual co-operation and work Handling emotionally distraught situations Waiting for the moment Working with practical tasks Insecurity about tenderness but felt needed Supporting activities of daily living

			Quite thin analysis really when comes to forming the relationship but discussion enriched—more informed by lit than research Not sure how the described behaviours fit the categories, maybe lost in translation? Note study was now 17 years ago---and acute is a fast changing pace (Five year forward plan 2016 demonstrates how fast.. Participants regularly received supervision which made the used to narrating about their work	Supporting social interaction ***Teaching:*** As an expert: get them back to normal, eat , drink etc….demand they wash etc.. As a collaborator: work alongside to encourage to do for themselves- motivate ***Networking*** As an expert do for, practical stuff like housing social care etc… co-ordinate As a collaborator work to encourage contact with others, kids etc… ***Containing*** As an expert: listen, understand, support, when anxious make it safe and secure around As a collaborator: establish mutual confidence ***Protecting*** Tuck them in, warm some milk, potter about with them, soothe, comfort, sit with, fetch and offer blankets 24 hour being there for **psychologically, physically, existentially, and socially (these would have been better categories) Finding solutions for:::** All descriptions in the doing- Nursing is doing and may have a meta – communicative value

				Questioned the sole use of psychotherapeutic or counselling techniques
Qualitative include	Chiovitti (2008) Peer reviewed	Canada (Comment: Professions contribute to (caring) dependant on the unique scope of their practice) (knowledge translated from other disciplines to nursing- Alligood 2006) (Comment: Tendency to discuss (caring) rather than analyse)	Acute inpatient x 3 All urban, 2xgeneral hospital 1x psychiatric All registered nurses n=17, mostly Caucasian and female Convenience sampling to start the ball rolling---then theoretical sampling, and constant comparative analysis to direct next 2x taped interviews, during work hour's 60-90 mins. Shift of research question after 3 interviews- from what do you do that is caring----- what is the meaning of caring in your role Reports this shift in question was part of the intended methodology…. Really?	**Focus on caring not the therapeutic relationship, however relationship perhaps a part of caring, assumption. Chiovitti; observed caring translated into everything nurses do..** **It's been hard to translate caring to therapeutic relationship, concept not used by Chiovetti, but some interchangeably of concepts in keyword searching** ***Protective empowerment:*** Respecting the patient, Not taking the patients behaviour seriously, Keeping the patient safe Encouraging the patients' health Authentic relating Interactive teaching The doing examples fit all other descriptions of therapeutic relationships… listening, care, etc etc etc…

		(Thought- do nurses describe everything they do as forming the therapeutic alliance as they did with caring concept)	Grounded Theory process.. Enhanced with a personal journal and post interview reflective comment sheet. Which included emotional tone, difficulties etc.. Also took steps to stay close to meaning.. Conducted 2006 (now 11 year old), interviews were 1996--- old data, but whilst changes argued consistent based on experience and contacts and experiences at conferences etc.. Lecturer…..? how acceptable to participants	Concluded all nursing actions relate to protective empowering through a relationship. Goal- to achieve participation in health related goals.
Qualitative Research Include	Hem and Heggen (2003) (Peer reviewed)	Norway	Inpatient/ but not clear if this was acute as we understand in the uk, was there for 2.5 months and only included nurses n=6 pts n=5 Daily Life Participant observation / field notes deepened through Narrative interviews (Transcribed	**Focused upon the relationship and the relationship skills, but more on how nurses managed the relationship through conflicting roles** Strong Nurse--- vulnerable nurse Human-----Professional Intimacy-----Distance Utilise Humanistic Psychology--- Biomedical Process Being at the Pts Disposal---therapeutic distance

			Exemplary case study to encapsulate the findings. Categorisation used Quite a focus on role and probably relationship based on role theory Participant observation advantage over what is said but offers the observer interpretation rather than the direct perceptions of nurses Of course this closes the gap between we said we do and what we actually do	Regulating to achieve the correct therapeutic position Some tactics for doing this: Behave naturally and authentically Involved Emotionally / feelings Friend Mother Affection Stubborn empathy Self- disclosure- including vulnerability But held back to maintain a connection with a professional stance.
Qualitative Research Include	Cleary (2003)	Australia	Inpatient ethnographic study 5 months in one ward, one researcher who was a senior lecturer ? impact. Also could be highly contextual as just one ward Participant observer in accordance with usual ethnography Views, field notes and opinions recorded at the time, also a number of discussion groups, details of analysis are scant in	**Focus was on how nurses constructed their practice in light of increasing acuity, detention and shortening lengths of stay** However the relationship was seen as a central construction and managing that relationship through the acute environment as a central concern Making time for one to one work Just being there Honesty and Trust Making sure they know they are respected Do not adopt an authoritarian position Work with patients

			the article and presents a descriptive account	Make their stay as easy going as possible No matter how angry the reaction show empathy and understanding Always provide information and explanation Help patients feel some sense of control Understand the perspective of the patient-what it's like to be in hospital Understand the patients hopes Know the patient-likes and dislikes, preferences, circumstances and motivations Negotiate, if it can be let go when the patient objects then it go Communicate that restrictive intervention is a last resort Calmness Provide opportunity for questions, education and explanations as the patient recovers Retain a belief that abuse and challenging behaviours are transient
Qualitative not included as once read the focus of the study was very broad on the activities of nurses	Cleary et al (2012a) Different to the meta-synthesis of same year	Australian	Inpatient care Interpretive approach based on participants narratives of practice 4 acute wards conducted in June and July 2011 A familiar researcher minimal disturbance and acceptance and trust	**Focus was on identifying what nurse's saw as good work- some of which was on interaction But not related directly to the formation of relationship, very little info**

			Interviews based on foreseen questions 40 interviews, thematic analysis, iterative process, close engagement with the data, labelled categorised and checked by fellow researchers	
Qualitative research not included as whilst the q sort is an interesting tool only applied to 8 people and argued three types identified**---- gross generalisation of findings**)	Dziopa and Ahern (2009b)	Australia	Inpatient acute After developing a 140 item Q sort instrument through gathering all terms used in connection with the therapeutic relationship, through theory, research, literature, opinion or TV then presented through a panel of expert nurses was reviewed Also this process uses terms and phrases not from nursing- therefore rather than record their perceptions could be putting words into their mouths Presented to 11 nurses 10 returned 2 could not be used due to missing data n=8	**Whilst the focus was very much on nursing perceptions of what they thought was most important in establishing a therapeutic relationship and there was some considerable effort in producing a Q-sort instrument, the application was exceptionally small scale.** The following should be accepted with extreme caution. Three types of relationship identified all identifying different rankings: Equal Partner Senior Partner Protective Partner I'ts almost impossible then to say what makes up each one.

			ranked in order of importance and least importance using a 13 point scale -6 to +6 Then rather than arguing a lack of consensus or fluctuating importance- concluded three types of nurse relationship…. From n=8. Statistical analyses conducted and argues some significance for results however this might only relate to internal significance and given the numbers is not really trustworthy in terms of greater generalizability Also participants report two hours to complete-potentially introducing participant fatigue and end of interview bias around the q sort elements	
Qualitative research Do not include as focus too distant	Cleary (1999)	Australian	Inpatient ward Fixed point, one ward (proximity of influencing factors on that day maybe an issue) n=10 reports random sampling but how? Maybe random on the basis of being there? Semi structured interview and thematic analysis	**Focus was on what influenced nurse interactions, rather than the nature of the interactions** Only point really is about the need for time

Qualitative Rejected as didn't really offer information on the establishment of the therapeutic relationship	Gijbels (1995) (peer reviewed)	UK	Inpatient over 20 years old, nurses n=8 non nurses n=8, volunteer sample, self-selecting distorts view through elite bias —however acknowledged Transcribed data, thematic analysis	**Focus was on the perceptions of Nursing Skills in acute psychiatry and mostly concluded that were not able to use them due to barriers etc..** Nurses did not articulate or consider themselves as independent therapeutic agent Rather than list skills they would list personal qualities Didn't really go on from here… but classified knowledge and barriers to effecting that
Qualitative Research Rejected on the basis that interviewed Healthcare assistance and focus was on trying to	Brown (2013) Unpublished doctoral thesis Psychology- hence focus on understanding the nature	UK	Inpatient acute care, healthcare assistants. Interviews, focused on analysing relationships from the perspective of 5 relationship types suggested by Clarkson (1994) Working Alliance	**Focus was on the psychological analysis of nurse (assistants) perceptions of their interaction with acute inpatient patients.** Painted a picture of psychological ineptness in the understanding of the nurse-patient relationship Also records a deep personal connection and mothering between nurses and pts

understand / theorize the nurse pt relationship rather than identify how it was established			The Transference- Counter Reparative /Developmental The I-You , the normal interpersonal healing relationship Transpersonal / spiritual Stated did not consider the last two as too complex. This led to nursing aspects that relate to these being considered in light of other theories more appropriate to the others. i.e putting an arm around and crying alongside a pt was seen as problematic counter-transference etc.. Managing exposure to the number of painful conversations was suggested as avoidance and defensive, rather than humanely sensible..	and then defensive distancing--- saw both as un therapeutic in accordance with psychotherapeutic understandings.
Qualitative research Rejected on basis of Iranian and likely substantial contextual	Pazargadi et al (2015)	Iranian	Semi structured interview / inpatient….. (Retain in list for methodology review)	**Focus on understanding the barriers to nurse patient relationship.** But if were included results see the same

differences, also because of Focus				
Qualitative Research Rejected on basis of United Arab Emirates and likely substantial contextual differences, also because of Focus	Hawamdeh and Fakhry (2014)	United Arab Emirates	Interpretative phenomenology Inpatient Initially Semi-structured. 3 questions As a psychiatric nurse what do you do on a day to day basis How do you go about developing the therapeutic relationship Can you describe an event a story that would help me to understand that. Then in follow up interviews refocussed on primary data Interesting that the first question then led to some domination of the results like other studies.	**Focus was very close to my research question but the context of inpatient in United Arab Emirates appears very different from the report** But if were included results see the same

Qualitative Research Do not include as does little to illuminate the 'how'	Bray (1999)	UK	Old research now Acute wards and culture has changed Lecturer on the ward observing for 12 months --- but a lecturer in this context argued as normal for there Ethnography observation and interviews. Observation of interaction and activities overt – semi structured interviews argued that two together was important. 3 acute units in one hospital authority Opportunistic sampling Interviews n=15 Utilised a systematic and planned analysis Plenty of example text	**Focus on broader inpatient psychiatric nursing- but relationships lack of feature strongly;** Bray opinion: Similarities with the interpersonal, closeness and intimacy but focus on client. Also recorded nurses lacked the psycho-therapeutic knowledge. Whilst attempting to study found that closeness equated to painful withdrawal to a safe distance Wanting to deliver close care but incongruent. ? if these are managed would the relationship be better.

Narrative review Reject as analysis of nursing perception does not add and focus shifts to patient view	Moreno-Poyato et al (2016) (peer reviewed)	Seen from a Spanish context	Narrative lit review / content analysis Very broad inclusion and multi-contextual / settings, included pt views, and barrier studies Some Systematic search then snow balling- half again found through snowballing…. Justified because of poor concept construction across the field Reported found a large number of studies but few empiric Highlighted 5 studies of which one in the united arab emirates, one that looked at what nurses do, and the other caring Cleary 2012 and Chiovitti 2008 Inpatient psychiatry Poor conceptual definition used therapeutic relationship interchangeably with caring- when examined studies considered: But noted conceptual ambiguity….	**Focus on the understanding the concept of therapeutic relationship and significance both staff and patients** Apart from drawing the main themes detailed in the abstracts of Scalon, Chiovitti, Dziopa and Ahern, Cleary et al and Hawamdeh and Fakhry… does not really seem to add- and there is a few issues with these studies in their own right… However main focus seems to be the lit that relates to pts descriptions of what they want: Empathy, respect, honesty, friendliness and availability----- but not always so…. Equally significant for nurses and patients Barriers……

Not to be included due to different focus Qualitative research	Gilburt, Rose and Slade (2008) (Peer reviewed)	UK	Participatory interviews, user led Post admission n=19 ? relationship and influence of researcher, also poss strength, Inductive thematic analysis, taped verbatim, coded and memo included abstract thinking to include researchers reactions and thoughts.	**Not psychiatric nurse's view, and main focus was on life on the ward- however 5 out of the 8 categories had relational aspects.** Standard of communication Safe and secure Establishment of Trust Levels of coercion or not Culturally sensitive
Not to be included due to different focus Qualitative Research	Awty, Welch and Kuhn (2010) (peer reviewed)	Australia	Naturalistic Inquiry / inpatient (Taken no further as rejected for this study, but referred to in a metasynthesis- which maybe show an issue with that synthesis- need to revisit	**Focus was on nurses expectations to provide psychodynamic care, rather than aspects** Some aspects walk in front nurture, and care for, walk alongside and partnership, walk behind supporting progress.
Metasynthesis Not included because very strong focus on service user evaluation and no systematic search strategy identified	Cutcliffe et al (peer reviewed)	Multi-national perspective	Review of published service evaluations	**Focus on service user evaluations, but exceptionally close to the findings in nursing research,** Friendliness, available, warm, authentic, genuine, understanding, giving time freely, intimate.

Qualitative research Rejected based on pts view not nurses perceptions Focus was also mixed	Wyder et al. (2015)	Australian	Acute inpatient / pt view pre discharge View may have changed…st this point n==25, 14 male , 11 female n=16 were taped	**Focus was on experiences of inpatient stay as a detained patient, however they reported relationships with staff to be an important part of that.** They valued: Trusting Caring Sense of Humour / Happy Being There Being Helpful Nice / Kind Good Natured Finding Time Staff that would guide and inform on rules and restrictions Those that would involve and encourage participation (All of these would negate the impact of normal barriers to relationship building)
Qualitative (Include)	Thibeault (2016)	Canadian	dsemistructured interviews and nonparticipant observation in an interpretive phenomenological inquiry. T he data consisted of texts that were transcribed from narratives and observations. The meanings that were generated led to the uncovering of patterns of commonality,	Mindful approach- strategically creating encounters construct relational approaches in response to patient distress, and patients recognized that patients were experiencing intense psychological distress and potential behavioral

			or themes	volatility and who adopted a consciously strategic approach to achieving a therapeutic connection. constantly repositioning, each seeking a position of relative security reconciliation of differences situate their searches for a place and time of engagement even when they themselves were experiencing anxiety and fear: think through her responses in a frontline encounter: to create the possibility of a more authentic exchange that was less focused on the patient's tactics and more focused on discovering her actual need recognizing her own feelings and the patient's feelings and her knowledge, rooted in professional values of patient well-being and patient choice "one-to-ones" or "talktime," although a few registered nurses labeled their work as psychotherapy. nurses and patients sought to establish a kind of shared understanding where

				clarity did not have to be sought constantly develop common ground “connecting conversation “ground the patient, bring into the reality of the situation shared understanding, be less directive and adopt a more collaborative role
Qualitative (Included)	Gerace et al. 2018	Australian	Mostly interested in the relational processes surrounding empathy, in the context of conflict situations Semi structured interviews both pts and nurses Thematic analysis Purposeful sampling	Empathy, empathy, empathy Empathy is the therapeutic relationship establishing it enables all the difficulties of acute psychiatric environments to be transcended. Need to regulate own emotions Manage the control –freedom tension To be fellow human beings To be professionals Perspective sharing

				Put on the emotional uniform, consciously lock part of myself out Barriers that sway with the wind rather than a solid wall Being there Listening , questioning Don't over react, don't be patronising Respecting personal space Tone and body posture appropriate Show genuine compassion Brief regular contact giving time
Qualitative (included)	Gabrielsson, S.; Sävenstedt, S.; Olsson, M. (2016).	Sweden	Mostly looks at good psychiatric nursing practice in acute, however the preface is that good nursing practice is the therapeutic relationship and hence it examines positive aspects of practice that lead to the formation of such a relationship 12 (purposeful samples) of relationship orientated nurses, but only 8 were adult acute ,	Take a personal responsibility for forming the relationship Treat patients with respect Make time to connect Work as a competent team with critical daily discussions To be physically present Personal style use the team diversity

			others included geriatric and substance use acute facilities. Only 7 in acute and some may have been HCSW but unclear who. Insider research half known to interviewer Interviews	Be confident in ability to help—(optimistic) Build trust Tell the truth Take responsibility for the decisions made

Appendix 3

Literature review data extracted into Dziopa and Ahern (2009) nine categories

Skilfully Conveying Understanding and Empathy	Empathic (D and J) Understand the patients point of view SC Patients viewpoint (D and J) Technical Skills: Listening , reflecting, clarifying, questioning, encourage ventilation SC Utilise subtle non-verbal signals to convey Bjork Putting yourself in the patient shoes Bjork Listening- understanding- remain calm and soothe Cleary HHD Empathy under distress / maintain empathy no matter how angry the pt is Cleary HHD imagination, patience and intuition Imagining yourself in that situation Cleary HHD Stubborn empathy HH No matter how angry the reaction show empathy and understanding Cleary Understand the perspective of the patient-what it's like to be in hospital Cleary Instilling a sense of Importance- actively listening, knowing the patient – helps the patient to understand-thus empowering, promoting care to be individualised, attending and being attentive /interested. Skilled use of interpersonal technique, eye contact/summarizing/clarifying/reflecting. Understanding unique communication problems of diagnosis, thus looking beyond the behaviour and ascribing /developing mutual meaning. Accepting the unique experiences and reactions of the individual without judgement or sanction. Interact as a friend or a neighbour rather than counsellor or expert, sharing of common experiences and similarities, getting involved, remaining stubborn with the objective of conveying understanding and empathy DZ and Ah Empathy is the therapeutic relationship establishing it enables all the difficulties of acute psychiatric environments to be transcended. Empathy Empathy Empathy Gerace Listening , questioning to convey empathy understanding Gerace
Providing Support	Make their stay as easy going as possible Cleary Caring and connecting over small basic need D and J Care and help to alleviate suffering D&J Care for / Help SC Provide information SC Signalling Caring Bjork Convey unconditional feelings of warmth-conveyed through basic human needs such as food, drink, touch and physical comfort Bjork nothing to small Cleary HHD Helping patients to feel safe by creating supportive and safe environments, Active responses – making helpful suggestions or offering advice, conveying hope and reflecting concern. Knowing when to do 'small' things like making a drink or fetching extra pillows. Mothering those that require it and knowing those that do

	not. Delivering appropriate and acceptable touch to ease distress DZ and AH dealing with practical issues, - observed this as non-confrontational way of making connections and building relationship Cleary HHD Working with practical tasks Supporting activities of daily living Supporting social interaction B&H Tuck them in, warm some milk, potter about with them, soothe, comfort, sit with, fetch and offer blankets B&H Always provide information and explanation Cleary
Individuality	Individual tailored response Bjork promoting the positive aspects of individuality and not hold the negative against Cleary HDD Understand the patients hopes Know the patient-likes and dislikes, preferences, circumstances and motivations Cleary Seeing people beyond mental illness, being mindful of stereotyping, supporting the patient to self -manage the illness in the context of their life. Not allowing your own values to influence, flexibility with rules coupled with experience to appraise the risk accurately, use humour that is individually sensitive Dz and AH
Being There / Being Available	24 hour being there for psychologically, physically, existentially, and socially Waiting for the moment B&H Being there- physically available D and J Seeking opportunity to be with D&J Manage time, give the nursing minute, keep to loose contracts over time / tasks SC Being with Being available if needed Bjork Being with B&H Caring Presence- Bjork Being there repeatedly mentioned by nurses, subtle not observable, nurses tried to formalise this with a descriptor of 1:1 time. Cleary HHD any opportunity Cleary HHD Being at the Pts Disposal HH Take a personal responsibility to find time for forming the relationship Gabrelsson Willing, available and present to invest time, giving offering time to talk, offering time to listen, allowing time for meaning and understanding to emerge. Knowing when to just be present and when to be present and engage physically and psychology. Making time Dz and AH Making time for one to one work Just being there Cleary Be there, Brief regular contact giving time Gerace Mindful approach- strategically creating encounters Thibeault searches for a place and time of engagement Thibeault “one-to-ones” or “talktime,” although a few registered nurses labelled their work as psychotherapy. Thibeault

Being Genuine	Friendliness instead of professional cold approach SC - non-judgemental (ish) SC Humour- establish rapport /lessen professional increase friendliness SC Affinity and emotional closeness SC Authentic relating Chiov Behave naturally and authentically Involved Emotionally / feelings HH Honesty and Trust Cleary and D& J To be natural and authentic, congruent with own values and being aware of conflict if this requires a non-judgemental front, consistency and following through on actions, showing genuine emotion, knowing when to offer blunt feedback, straight talk, share life experiences. Open and honest, , to be friendly and intimate at an individually assessed level DZ and AH Demonstrate professionalism but to know the fine line between being overly professional. DZ Build trust Tell the truth Take responsibility for the decisions made Gabrelsson Personal style use the team diversity Gabrelsson To be fellow human beings Gerace Show genuine compassion Gerace to create the possibility of a more authentic exchange that was less focused on the patient's tactics and more focused on discovering her actual need Thibeault
Promote Equality	Help patients feel some sense of control Cleary Patients lead D&J then collaborator mutual co-operation and work B&H As a collaborator: work alongside to encourage to do for themselves- motivate B&H As a collaborator: B&H Empowering through a relationship. Goal- to achieve participation in health related goals Chiov Self- disclosure- including vulnerability HH Do not adopt an authoritarian position Work with patients Cleary Managing the power imbalance or use it constructively teaching, imparting expert knowledge, problem solve and assume control when the patient needs it, and to know when. Also empower, encourage patients to take control. Include ordinary talk speaking about mutual experiences other than problem talk, ask patients about themselves, closing the space-being close, giving the patients choice within the limitations of choice, shared activity. Being conscious to keep signifiers of power keys / brief cases unobtrusive, assessments conducted informally through conversational interactions. DZ and AH nurses and patients sought to establish a kind of shared understanding where clarity did not have to be sought constantly, develop common ground Thibeault

	shared understanding, be less directive and adopt a more collaborative role Thibeault
Demonstrating Respect	Rapport-through conveyed respect D&J Show respect and dignity SC Good Mannerly Behaviour based on respect SC Respecting the patient, Chiov Making sure they know they are respected Cleary Taking the time to utilise many of the aforementioned skill to demonstrate worthiness, DZ and AH Treat patients with respect Gabrelsson
Demonstrate Clear (and working with) Boundaries	Trust linked to safety and security SC Understand boundaries SC Or Guardians of order (sometimes force and coercion) Bjork containing and protection Expert – knowing what's best B&H As an expert: get them back to normal, eat , drink etc….demand they wash etc.. B&H make it safe and secure around B&H Manage the control –freedom tension Gerace A container B&H Keeping the patient safe Chiov Strong Nurse HH Maintain a therapeutic distance HH hold back to maintain a connection with a professional stance. HH Put on the emotional uniform, consciously lock part of myself out, Barriers that sway with the wind rather than a solid wall Gerace Negotiate, if it can be let go when the patient objects then it go, Communicate that restrictive intervention is a last resort, Calmness, Provide opportunity for questions, education and explanations as the patient recovers, Retain a belief that abuse and challenging behaviours are transient Cleary Appropriate limit setting to protect dignity and create feelings of safety and containment. DZ To be highly skilled in knowing how far is individually (and professionally) acceptable in a number of the areas in other constructs Show professionalism Gerace ground the patient, bring into the reality of the situation set the boundary Thibeault
Utilising Self Awareness	Use Intuition based on life and work experience, react and change and progress – then provide individual response SC Actively use personality but bracket/ hide prejudice and negative feeling SC Sensitive behaviour based on perception of need Bjork Regulating oneself to achieve the correct therapeutic position HH Whilst supervision , discussion etc is seen as important to support nurses to develop the therapeutic relation DZ and AH

	Work as a competent team with critical daily discussions Gabrelsson Need to be aware and regulate own emotions Gerace To be aware of not over react, don't be patronising, Respecting personal space, application of the acceptable tone and body posture Gerace conscious strategic approach to achieving a therapeutic connection Thibeault constantly repositioning based on an awareness of what the cause and effect Thibeault think through her responses in a frontline situation (on the job) Thibeault recognizing her own feelings and the patient's feelings and her knowledge, rooted in professional values of patient well-being and patient choice Thibeault

Appendix 4

Sample analysis sheet

Analysis protocol / Probe question development sheet Version 1 (11/1/18)

Date;_____ Interview no. (1-?)_____

Alphanumeric Code:_____

Probe questions will seek out exceptions to agreement and when present data disagrees, probe questions will seek explanations for the disagreement (Dick 2017)

What similarities are there between interviews?	
What differences are there between interviews?	
Are there any novel ideas?	
Are there any ambiguities	

Are there any contentious issues?	
Are there any loose ends? (Aspects not understood)	

Probe questions that seek out exceptions to agreements	a) b) c) d) e) f)

Probe questions that seek out explanations to disagreements?	a) b) c) d) e) f)

Appendix 5

Pre-worded e-mail to invite to attend a presentation of the study

From: Fieldhouse Christopher (RLY) NSCHT
Sent: 22 July 2019 11:03
To: Potential Participant
Subject: Invitation to a Presentation of a Research study that is taking place within your area of practice.

You are being invited to attend a 20 minute presentation, by my-self, about a research project that I am conducting within the acute wards of Harplands Hospital, Combined Healthcare NHS Trust. I am undertaking this research to explore how psychiatric nurses form a therapeutic relationship with patients in an acute psychiatric ward. The research is being undertaken as part of my professional doctorate programme at Keele University.

The presentation will inform you of why the research is being done and outlines how the research will be conducted.

Insert date and time….

The presentation forms the first stage of recruiting participants into the study. You are being invited because you are a psychiatric nurse with current experience of working in acute psychiatric wards, and as such are in a position to be able to offer a perspective on this subject.

At the end of the presentation, you will be asked if you would like to take part in the study. You will be then left for a further 7 days to consider the research further and to ask for any clarification. After those 7 days I will e mail you to make arrangements for the research interview with my-self. If I do not hear from you within those 7 days, I will send one reminder e mail only. Your right not to be involved can either be communicated directly or by declining to respond to e mail.

Exercising your right to refuse participation will be fully respected and is without consequence.

If you are keen to take part, but are unable to make the presentation, or missed invite e mails, please let me know and I can either come and talk to you individually or invite you to a further presentation.

Please find enclosed the research information leaflet for further detail of the research study.

Chris Fieldhouse
Consultant Nurse in Co-occurring Substance Use and Mental Health
Combined Healthcare NHS Trust.
(Principle Investigator for this Research)

Christopher.Fieldhouse@combined.nhs.uk
c.j.fieldhouse@keele.ac.uk

01782 441600 (Request to be put through to Chris Fieldhouse)
Tel. 07855181891 (8.00am-6.00pm)

Appendix 6

Pre-worded e-mail reminder to invite to attend a presentation of the study

From: Fieldhouse Christopher (RLY) NSCHT
Sent: 22 July 2019 11:17
To: Potential Participant
Subject: Research Presentation Reminder

I am just sending you a reminder about the presentation I e-mailed you about last week, please see the detail and dates below:

You are being invited to attend a 20 minute presentation, by my-self, about a research project that I am conducting within the acute wards of Harplands Hospital, Combined Healthcare NHS Trust. I am undertaking this research to explore how psychiatric nurses form a therapeutic relationship with patients in an acute psychiatric ward. The research is being undertaken as part of my professional doctorate programme at Keele University.

The presentation will inform you of why the research is being done and outlines how the research will be conducted.

Insert date and time....

The presentation forms the first stage of recruiting participants into the study. You are being invited because you are a psychiatric nurse with current experience of working in acute psychiatric wards, and as such are in a position to be able to offer a perspective on this subject.

At the end of the presentation, you will be asked if you would like to take part in the study. You will be then left for a further 7 days to consider the research further and to ask for any clarification. After those 7 days I will e mail you to make arrangements for the research interview with my-self. If I do not hear from you within those 7 days, I will send one reminder e mail only. Your right not to be involved can either be communicated directly or by declining to respond to e mail.

Exercising your right to refuse participation will be fully respected and is without consequence.

If you are keen to take part, but are unable to make the presentation, or missed invite e mails, please let me know and I can either come and talk to you individually or invite you to a further presentation.

Please find enclosed the research information leaflet for further detail of the research study.

Chris Fieldhouse
Consultant Nurse in Co-occurring Substance Use and Mental Health
Combined Healthcare NHS Trust.
(Principle Investigator for the Research)

Christopher.Fieldhouse@combined.nhs.uk
c.j.fieldhouse@keele.ac.uk

01782 441600 (Request to be put through to Chris Fieldhouse)
Tel. 07855181891 (8.00am-6.00pm)

Appendix 7

Study information sheet

Christopher Fieldhouse
Consultant Nurse
C/o Ward 2, Harplands Hospital
Hilton Road
Stoke- on-Trent
ST5 6TH
Tel. 01782 441600 (ext 4702)

Email: Christopher.Fieldhouse@combined.nhs.uk

INFORMATION SHEET

(Version 2 05/11/19)

Study Title: An interpretive phenomenological study to explore the insights that acute inpatient psychiatric nurses hold, with regards to the strategies they utilise in forming therapeutic relationships with the patients of inpatient psychiatric wards

Invitation

You are being invited as a Registered Nurse to take part in this study. This project is being undertaken by; Christopher Fieldhouse as part of a Professional Doctorate in Health Science at Keele University.

Before you decide whether you wish to take part, it is important for you to understand, why this research is being done and what it will involve. Please take time to read this information carefully and discuss it with friends and colleagues if you wish. Please ask if there is anything that is unclear to you or if you would like more information.

Introduction to the Study

The therapeutic relationship between psychiatric nurses' and the people they support is said to be the cornerstone of their practice (Barker and Buchanan-Barker, 2005). However little is known of how nurses within acute psychiatric settings establish such relationships. Therefore this research aims to record and analyse how acute psychiatric nurses form such relationship within the context of their work.

This information will be gathered through the process of a confidential interview exploring your thoughts on the matter.

Why have you been invited?

You are being invited because you have experience of working within the acute psychiatric setting and of forming relationships with patients within that environment.

Do you have to take part?

You are free to decide whether you wish to take part or not. You are also free to withdraw from this study at any point and without giving reasons. To withdraw, please contact; Christopher.Fieldhouse@combined.nhs.uk

What will happen if you have an interest in taking part?

You will be given an opportunity to hear a 20 minute introduction to the research study, and more specifically the aims and procedures of the study. You will be offered the opportunity to ask questions to clarify understanding.

Following this you will be invited to leave an e-mail contact. After 7 days an e-mail will be sent to you inviting you to make the practical arrangements for a confidential interview. A second reminder e mail will be sent 7 days after this.

No further requests will be made after this point and it will be assumed that you have decided that you do not wish to take part. There is no requirement or expectation of an explanation of your reasons for this.

At the commencement of the interview process, you will again be provided with a brief description of the study aims/procedures, and will have time to ask any further questions. Those who agree to participate will be asked to sign a consent form to indicate their understanding and agreement to take part, and for the data generated to be used.

Interviews will last up to 60 minutes, but you will be at liberty to stop at any point. Those interviews will be taped using a digital recording device and listened to by the researcher after the interview, additionally a flip chart will be used to make notes, you will be free to clarify and alter these notes during the process.

What are the benefits of taking part?

The interview process offers time to reflect and give voice to your own practice in a confidential and supportive environment; with access to a digital recording for your own professional portfolio should you wish. Additionally you will experience and play an active part in nursing research, with access to myself as the researcher to answer your questions about that research.

You will be contributing to the development of professional education and the development of the skills of other acute psychiatric nurses through adding to the body of knowledge in this area

What are the risks (if any) of taking part?

Some individuals find an interview with a senior clinician to be anxiety provoking. Steps to make you feel at ease will be part of the process and reassurance given that the objective is to gather your views and opinions on the subject matter not to test you.

Occasionally a respondent may feel a sense of frustration if the interview questions are confusing or poorly presented. Adjustments to the presentation of the question will be made during the interview to offer clarity. Frustration may also occur, where the participant feels they have not adequately been understood. Participants will be offered time to clarify their statements.

The researcher is aware that some nurses may have traumatic experiences of acute psychiatric wards; there is a possibility that discussion around these areas may raise some uncomfortable memories. Should this occur the researcher will offer immediate support, terminating the interview if necessary, followed by information of where further help and support can be accessed: An example of the support which would be offered is North Staffordshire Combined Healthcare staff support services who can be contacted by telephone on 0300 123 0995 (ext 4429) or mobile 07710906118

How will information about you be used?

The interviews will be digitally recorded and they will be listened to only by the researcher. Then along with reference to the flip chart notes, themes will be identified, and points of agreement or differences with other interviews will be noted. The researcher will use a recording sheet to note the main points that emerge from your interview, making a note of areas that need further exploration. From this further questions will be developed, so the researcher can explore in more focused detail those points with subsequent participants. Direct quotes will not be used in any subsequent interview to ensure there is no attribution of any remarks to your-self. However, if you consent, anonymized quotes maybe utilized in the reporting of the research to illustrate a particular insight.

Who will have access to information about you?

Throughout the research process, confidentiality will be maintained. As a participant, all data will be anonymized using a letter and number code. There are no co-researchers on this project so only the researcher will have access to the data, alongside the Research Supervisor and the Research Administrator within the School of Nursing and Midwifery, Keele University.

In keeping with Keele University guidelines, data will be stored within a password protected file within a password protected Keele University encrypted computer account. The document that identifies yourself with your letter/ number code will be kept in a separate password protected file to your data, again within the password and encrypted Keele account. Hard copies of

consent forms will be stored within a locked cabinet identified solely for the purpose of the research, within a locked room within the School of Nursing and Midwifery.

Keele University is the sponsor for this study based in the United Kingdom. Keele University will act as the data controller for this study. This means that Keele University are responsible for looking after your information. Keele University will keep identifiable information about you for the 12 months to 3 years it will take to complete the study; or up until the point that you express a wish to withdraw from the study if this is before that time. Your identifiable data will be securely deleted by the researcher at these points.

Non- identifiable data such as uploaded digital audio recordings, digital images of flip charts and digitally recorded notes, will be retained for 10 years post completion of the research within the secure electronic data storage facility detailed above. This will be securely deleted by the research administrator within the School of Nursing and Midwifery after this time period. Your rights to access, change or move this information are limited, as Keele University needs to manage this information in specific ways in order for the research to be reliable and accurate

Original hard copies of notes or temporary digital files, such as that on the audio recorder, will be securely and permanently destroyed by the researcher after a digital copy and upload to secure storage has been completed within 24 hours of its origin.

Until data is uploaded or deposited in the secure storage facilities within Keele University, the researcher will keep any such hard copies of data, or recording devices, secure and on person. In the unlikely circumstance that prevents an immediate transfer, the researcher will utilize a locked storage facility within the NHS study site for which only the researcher has a key.

You can find out more about how we use your information at https://www.keele.ac.uk/business/privacynotice/ .

Please Note: The Researcher has to work within the confines of current legislation over such matters as privacy and confidentiality, data protection and human rights and so offers of confidentiality may sometimes be overridden by law. For example, in circumstances whereby I am concerned over any actual or potential harm to yourself or others the Researcher must pass this information to the relevant parties.

Who is funding and organizing the research?

This research is being organized by the researcher themselves as a student on the Professional Doctorate program at Keele University. North Staffordshire Combined Healthcare NHS Trust are funding and providing time, in order for me to complete the programme of which this research study is a part of.

What if there is a problem?

If you have a concern about any aspect of this study, you may wish to speak to me as the principle researcher, I will do my best to answer your questions. Or alternatively you may wish to speak with my supervisor or the research governance office. Please see contact details below:

Harplands Hospital
Hilton Road
Stoke on Trent
ST4 6TH Tel: 01782 441600

E Mail: Christopher.Fieldhouse@combined.nhs.uk

You may also contact the research supervisor: Dr Alison Pooler

School of Nursing and Midwifery
Keele University
Clinical Education Centre
Royal Stoke Hospital
Newcastle Road
Stoke on Trent
ST4 6QG Tel: 01782 679659
Email: a.pooler@keele.ac.uk

If you remain unhappy about the research and/or wish to raise a complaint about any aspect of the way that you have been approached or treated during the course of the study please write to or telephone The Research Governance Office;

Project Assurance Research Integrity team in the Directorate of Research, Innovation and Engagement
IC2 Building
Keele University
ST5 5NH Tel: 01782 733306
E-mail: research.governance@keele.ac.uk

Appendix 8

Pre-worded email to invite to the research interview

From: Fieldhouse Christopher (RLY) NSCHT
Sent: 22 July 2019 11:47
To: Potential Participant
Subject: Research Interview invite

Thank you for expressing an interest in taking part in the research study that I am conducting. The study seeks to explore how psychiatric nurses form a therapeutic relationship with the patients within an acute psychiatric ward.

I am now looking to arrange a time and place that is convenient for you, so I can explore and record your views on this subject in a taped research interview. If you could let me know dates and times that you are available and whether you would like to be interviewed in a confidential room on the ward where you work or at another place within the hospital or Keele University, I will then make the arrangements and let you know.

If after consideration you no longer wish to take part, either let me know or simply do not reply to this and the single reminder email that I will send in 7 days-time. If I have not heard from you I will accept this as notification that you do not wish to be involved. Your involvement is entirely voluntary and there is no consequence whatsoever of not taking part.

If you would like more information before deciding to take part, or not, please contact me and I will be able to discuss any queries you have, additionally I have included the study information leaflet.

Chris Fieldhouse
Consultant Nurse in Co-occurring Substance Use and Mental Health
Combined Healthcare NHS Trust.
(Principle Investigator for the Research)

Christopher.Fieldhouse@combined.nhs.uk
c.j.fieldhouse@keele.ac.uk

01782 441600 (Request to be put through to Chris Fieldhouse)
Tel. 07855181891 (8.00am-6.00pm)

Appendix 9

Pre-worded reminder email to invite to the research interview

Chris Fieldhouse: Student Number 16023766 IRAS ID 261539 Sponsor reference RG-0298-19 SNM HRA version 1 sponsor review version 0.1

From: Fieldhouse Christopher (RLY) NSCHT
Sent: 22 July 2019 12:01
To: Fieldhouse Christopher (RLY) NSCHT
Subject: Research Interview reminder

This is a follow up e-mail in respect of the following:

Thank you for expressing an interest in taking part in the research study that I am conducting. The study seeks to explore how psychiatric nurses form a therapeutic relationship with the patients within an acute psychiatric ward.

I am now looking to arrange a time and place that is convenient for you, so I can explore and record your views on this subject in a taped research interview. If you could let me know dates and times that you are available and whether you would like to be interviewed in a confidential room on the ward where you work or at another place within the hospital or Keele University, I will then make the arrangements and let you know.

If after consideration you no longer wish to take part, either let me know or simply do not reply to this email. If I have not heard from you I will accept this as notification that you do not wish to be involved. Your involvement is entirely voluntary and there is no consequence whatsoever of not taking part.

If you would like more information before deciding to take part, or not, please contact me and I will be able to discuss any queries you have, additionally I have included the study information leaflet.

Chris Fieldhouse
Consultant Nurse in Co-occurring Substance Use and Mental Health
Combined Healthcare NHS Trust.
(Principle Investigator for the Research)

Christopher.Fieldhouse@combined.nhs.uk
c.j.fieldhouse@keele.ac.uk

01782 441600 (Request to be put through to Chris Fieldhouse)
Tel. 07855181891 (8.00am-6.00pm)

Appendix 10

Consent form

Christopher Fieldhouse
Consultant Nurse
C/o Ward 2, Harplands Hospital
Hilton Road
Stoke- on-Trent
ST5 6TH
Tel. 01782 441600 (ext 4702)

Email:
Christopher.Fieldhouse@combined.nhs.uk

Participation CONSENT FORM

Version 1 (IRAS ID 261539). (22/3/19)

Title of Project: An interpretive phenomenological study to explore the insights that acute inpatient psychiatric nurses hold, with regards to the strategies they utilise in forming therapeutic relationships with the patients of inpatient psychiatric wards.

Name of Researchers: Christopher Fieldhouse

Research Centre: Keele University

Please initial box if you agree with the statement

I confirm that I have read and understood the information sheet dated 15/1/19 (version 1) for the above study and have had the opportunity to ask questions and clarify my understanding of risk. ☐

I understand that my participation is voluntary and that I am free to withdraw from the study at any time before my data has been collected. ☐

I understand that anonymized insights gained from my data will be utilized to inform the questions asked in subsequent ininterviews. ☐

I agree to take part in this study. ☐

----------	----------	----------
Name of Participant	Date	Signature

----------	----------	----------
Name of Researcher	Date	Signature

(One copy of this form will be given to the participant and one copy will be retained within the research study folder)

Appendix 11

Consent form for the use of quotations

Christopher Fieldhouse
Consultant Nurse
C/o Ward 2, Harplands Hospital
Hilton Road
Stoke- on-Trent
ST5 6TH
Tel. 01782 441600 (ext 4702)

Email:
Christopher.Fieldhouse@combined.nhs.uk

Use of Data Consent Form
Version 2 (22/3/19)

Title of the Project

An interpretive phenomenological study to explore the insights that acute inpatient psychiatric nurses hold, with regards to the strategies they utilise in forming therapeutic relationships with the patients of inpatient psychiatric wards.

Name of Researchers: Christopher Fieldhouse

Research Centre: Keele University

Please initial box if you agree with the statement.

I agree to allow the data collected to be used for the purpose of this research and the reporting of the that research, which will include using that report as part of the assessment criteria for a professional doctorate in health sciences ☐

I agree that anonymized quotes may be used for the purpose of illustrating insights within the reporting of this study for academic purposes ☐

I agree that anonymized quotes may be used for the purpose of illustrating insights within the publication of this study ☐

----------	----------	----------
Name of Participant	Date	Signature

----------	----------	----------
Name of Researcher	Date	Signature

(One copy of this form will be given to the participant and one copy will be retained within the research study folder)

Appendix 12

University ethics approval letter

Keele University FMHS Faculty Research Ethics Committee
health.ethics@keele.ac.uk

16 April 2019

Dear Chris,

Project Title:	An interpretive phenomenological study to explore the insights that acute inpatient psychiatric nurses hold, with regards to the strategies they utilise in forming therapeutic relationships with the patients of inpatient psychiatric wards
REC Project Reference:	MH-190014 + MHFI-0005
Type of Application	Further Information

Keele University's Faculty of Medicine and Health Sciences Research Ethics Committee (FMHS FREC) reviewed the above Further Information submission.

Favourable Ethical opinion
The members of the Committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, and there was agreement of reviewers that all concerns have been addressed.

Reporting requirements
The University's standard operating procedures give detailed guidance on reporting requirements for studies with a favourable opinion including:

- Notifying substantial amendments
- Notifying issues which may have an impact upon ethical opinion of the study
- Progress reports
- Notifying the end of the study

Approved documents
The documents reviewed and approved are:

Document	Version	Date
Those documents submitted with MH-190014 & MHFI-0005		

Yours sincerely,

Ed Chadwick

Dr Ed Chadwick
Committee Chair

Appendix 13

Sponsors approval letter

15/AUG/2019

Short Project Title: Therapeutic relationships in acute psychiatric wards
Sponsor Reference: RG-0298-19 SNM
IRAS ID: 261539
Chief Investigator: Dr Alison Pooler

Confirmation of Sponsorship

Dear Dr Pooler,

I confirm that Keele University agrees to take on the duties of Sponsor as defined under the UK Policy Framework for Health and Social Care for the above research project in accordance with the agreed ***Delegation of Sponsorship Functions Agreement***.

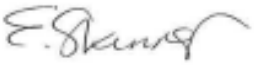
Keele University has relevant insurance in place for the duration of the study in relation to its role in the design and management.

To monitor GCP compliance the Research Integrity Office reserves the right to perform monitoring visits and / or audits.

The Research Integrity Office must be contacted (research.governance@keele.ac.uk) if any advice is required regarding compliance with regulatory issues or if there are any doubts about participant safety, safety reporting requirements or scientific integrity of the trial.

This letter does not constitute authorisation to commence research activity. Research activity may only begin following confirmation of the Regulatory Green Light by the Research Integrity Manager (or their delegate) which will only be granted once all applicable agreements and regulatory approvals are in place.

Yours sincerely



Emma Skinner
Research Integrity Manager
Directorate of Research, Innovation and Engagement
Keele University

cc: Christopher Fieldhouse, Principal Investigator

Directorate of Research, Innovation & Engagement
Keele University, Staffordshire ST5 5BG, UK
www.keele.ac.uk +44 (0)1782 732000

Appendix 14

Health research authority approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Alison Pooler
School of Nursing and Midwifery, Keele University,
Clinical Education Centre.
Royal Stoke Hospital, Newcastle Road
Stoke-on-Trent
ST4 6QG

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

12 November 2019

Dear Dr Pooler

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

Study title:	**An interpretive phenomenological study to explore the insights that acute inpatient psychiatric nurses hold, with regards to the strategies they utilise in forming therapeutic relationships with the patients of inpatient psychiatric wards**
IRAS project ID:	**261539**
Protocol number:	**RG-0298-19 SNM**
REC reference:	**19/HRA/5986**
Sponsor	**Keele University**

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

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

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

Appendix 15

Confirmation of capability and capacity and host organization's acceptance of the study

Wed 18/12/2019 12:54

Alston Louise (RLY) NSCHT

IRAS [ID.261539] Student Research - NHS Confirmation of Capacity and Capability at North Staffordshire Combined Healthcare NHS Trust

To Fieldhouse Christopher (RLY) NSCHT

Cc Alison Pooler (a.pooler@keele.ac.uk); research.govenance@keele.ac.uk; Mason Kerri (RLY) NSCHT; Booth Zoe (RLY) NSCHT; Winckley Caroline (RLY) NSCHT; Forrester LynnK (RLY) NSCHT; Alston Louise (RLY) NSCHT; Sylvester Carol (RLY) NSCHT; Griffiths Nicola (RLY) NSCHT

OID NSCHT CF 18.12.2019.pdf
.pdf File

Dear Chris

NHS Confirmation of Capacity and Capability at North Staffordshire Combined Healthcare NHS Trust

Short Title:	Therapeutic Relationships in Acute Psychiatric Wards
IRAS ID.:	261539
R&D ID.:	CHC0188/RS
Principal Investigator:	Christopher Fieldhouse

This email confirms that North Staffordshire Combined Healthcare NHS Trust has the capacity and capability to deliver the above referenced study. Please find attached our agreed Organisation Information Document as confirmation.

We agree to start this study on a date to be agreed when you as Sponsor give the green light to begin.

NHS Confirmation of Capacity and Capability for the above research has been granted on the basis described in the HRA approval application. The documents received are:

Document	Version	Date
Protocol	1.0	15/08/2019
Participant Information Sheet	2.0	05/11/2019
Consent Form	1.0	22/03/2019
Email Invitation Presentation	1.0	22/07/2019
Email Invitation Presentation Reminder	1.0	22/07/2019
Email Invitation Interview	1.0	22/07/2019
Email Invitation Interview Reminder	1.0	22/07/2019

For further information regarding how to notify us of any amendments to the study please refer to the Amendments Guidance for Researchers .

If you wish to discuss this further, please do not hesitate to contact me.

Kind regards

Louise Alston

Appendix 16

Sponsors green light to commence the study

13 /JUL/2020

Short Project Title: **Therapeutic relationships in Acute Psychiatric wards**
Sponsor RG code: **RG-0298-19**
IRAS ID number: **261539**
Chief Investigator: **Dr Alison Pooler**

Sponsor Regulatory Green Light

Dear Dr Pooler,

I can confirm that the regulatory green light checks, as defined in ***SOSOP01: Sponsorship, Regulatory Approvals and Green Light***, have been completed by the Sponsor and the following documentation has been received:

- REC approval letter, 16 April 2019, and all conditions are confirmed as having been met
- HRA approval, dated 12 November 2019

The research must be conducted in accordance with the ***Delegation of Sponsorship Functions Agreement*** signed 03/JUL/2020 and all regulatory approvals, including (but not limited to):

- Protocol Version 1.0 dated 15/08/2019
- Organisation Information Document (OID) Version 2.0 dated 15/08/2019

The referenced version of the OID is considered to be authorised by the Sponsor. Amendment to information contained in this authorised version must be submitted to the Sponsor for review and authorisation; with the exception of local information pertaining to participating sites during the site set-up process.

Subject to appropriate approval / agreement by participating sites, the research may now commence. It is your responsibility to ensure that the HRA processes for confirming capacity and capability are followed (http://www.hra.nhs.uk/resources/hra-approval-guidance-for-sponsorschief-investigators-working-collaboratively-with-nhs-organisations-in-england/), that appropriate training is provided, site initiation visits are arranged if required and that agreements with sites are in place prior to the start of recruitment.

Any amendments to regulatory approved documents must be approved by the Sponsor in accordance with ***HSCR SOP50: Amendments*** prior to submission.

Project Assurance Research Integrity (PARI) must be contacted if any advice is required regarding compliance with regulatory issues or if there are any doubts about participant safety, reporting requirements or scientific integrity of the research.

Yours sincerely

Joanne Simon
Research Integrity Manager
Directorate of Research, Innovation and Engagement
Keele University

cc: Christopher Fieldhouse