An Interpretation of Nurse–Patient Relationships in Inpatient Psychiatry: Understanding the Mindful Approach

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Abstract

Nurses who work in acute inpatient psychiatry, where lengths of stay are increasingly shortened, struggle to establish therapeutic nurse–patient relationships. The purpose of this inquiry was to illuminate the nature of relationships between inpatient psychiatric mental health (PMH) nurses and their patients. The author used semistructured interviews and nonparticipant observation in an interpretive phenomenological inquiry. The data consisted of texts that were transcribed from narratives and observations. The meanings that were generated led to the uncovering of patterns of commonality, or themes. Of the themes uncovered, the theme of mindful approach highlighted PMH nurses as engaging with patients in distress, strategically creating encounters to establish a basis for ongoing therapeutic work. The PMH nurse–patient relationship in acute inpatient psychiatry continues to be under pressure, but nurses still carefully construct relational approaches in response to patient distress, and patients in these settings experience these approaches as meaningful to their recovery.

Peplau (1952) described the nurse–patient relationship as "a significant, therapeutic, interpersonal process . . . that makes health possible" (p. 205). Historically, psychiatric mental health (PMH) nurses have operated within a paradigm that values the critical role of the nurse–patient relationship (Barker, 2001; Peplau, 1952) and "human to human connection" (Mohr, 1995, p. 365). Numerous studies have focused on the nurse–patient relationship in PMH nursing (Altschul, 1971; Björkdahl, Palmstierna, & Hansebo, 2010; Cleary, Walter, & Hunt, 2005; Forchuk & Reynolds, 2001; Gildberg, Bradley, Fristed, & Hounsgaard, 2012; Martin & Street, 2003; Mullen, 2009; O'Donovan, 2007; Pazargadi, Fereidooni Moghadam, Fallahi Khoshknab, Alijani Renani, & Molazem, 2015).

Research focused on the practice of acute inpatient PMH nursing has uncovered a troubling picture. It has been claimed that a high concentration of severely ill patients, related to a trend toward reductions in numbers of acute inpatient beds, has forced PMH nurses to abandon caring relationships in favor of symptom objectification and standardized treatment (Jonsdottir, Litchfield, & Pharris, 2004). Finfgeld-Connett (2009) reported that patients "fear confinement and losing control of their lives" and that they are "apprehensive about receiving impersonal . . . care" (p. 532).

Lilja and Hellzén (2008) reported that hospitalized psychiatric patients were forced to mute their identities, having been "forced into an environment where their individuality is lost" (p. 283).

It has been suggested that the therapeutic relationship in inpatient psychiatry is "in the shadow," essentially unseen (Pazargadi et al., 2015, p. 551). Cleary, Hunt, Horsfall, and Deacon (2012) stated that the nature of nurse–patient interactions in inpatient psychiatric care has changed because of occupancy and length of stay pressures. PMH nurses in these circumstances find it difficult to focus on the therapeutic alliance (Mullen, 2009); they are concerned about the limited time they have available to spend with patients (Cleary et al., 2005). In addition, PMH nurses are highly influenced by the medical model, and this constitutes a major constraint on patient-centered PMH nursing (Awty, Welch, & Kuhn, 2010; Carlyle, Crowe, & Deering, 2012). As inpatient PMH nurses focus on observation and monitoring (Bowers, 2005), the

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amount of time spend in meaningful engagement declines (Fourie, McDonald, Connor, & Bartlett, 2005; Mullen, 2009; Sharac et al., 2010).

Acute inpatient PMH nurses often work with patients whom they may have physically restrained or otherwise controlled (Fourie et al., 2005; I. M. Johansson, Skärsäter, & Danielson, 2006), often engaging in containment (Bowers, 2005). In O'Donovan (2007), PMH nurses described "the use of coercion, strict enforcement of rules and lack of choice offered to service users" (p. 545). Indeed, the fact of being hospitalized alone may "provoke aggression" (Finfgeld-Connett, 2009, p. 532). Carlsson, Dahlberg, Ekebergh, and Dahlberg (2006) reported that an engaged, authentic relationship enhances a person's self-control and helps the person regain it if it is lost. Patients who were receiving inpatient psychiatric care cited "the existence and quality of the helping relationship" (H. Johansson & Eklund, 2003, p. 343) as central to their experience of good care. People who use psychiatric services value the experience of having a nurse listen to them (McAndrew, Chambers, Nolan, Thomas, & Watts, 2014).

Acute inpatient psychiatric care is an increasingly limited resource; it is critical that nurses engage with patients in ways that help them achieve the best possible health outcomes.

Barker (2001) and Buchanan-Barker and Barker (2005) asserted that it is possible for PMH nurses to create engaged relationships by reaching out to patients and gaining "access to the person's lived experience" (p. 546), but Barker and Buchanan-Barker (2011) also suggested that few PMH nurses can articulate the nature of their relational work. The ongoing challenge is to understand the variations in practices and paradigms that exist in inpatient PMH nursing. The purpose of this hermeneutic phenomenological inquiry was to explore the relational experiences of patients who were hospitalized for treatment of acute mental illness and their nurses. In this inquiry, I defined relational experience as any planned or unplanned, brief, incidental, or long-term interaction or series of interactions between nurses and patients.

The Research Process

The setting was a large tertiary care hospital with the only acute inpatient psychiatric service in the region. Participants were recruited from three of four available acute care units; no participants were recruited from the fourth unit. The research ethics boards of the clinical facility and educational institution granted ethical approval.

Participants

I invited nurses and patients to engage in a series of audiotaped conversations about their relational experiences on the inpatient unit. Using purposive sampling, I recruited nurses who had worked on the study units for at least 6 months by posting study information and giving verbal presentations at staff meetings. I sought patient-participants who met the following criteria: (a) currently admitted to an acute inpatient psychiatric unit, (b) capable of consenting to treatment, and (c) within 2 weeks of planned discharge. The latter criterion was established on recommendation from a PMH nurse expert who suggested that patients who were closer to discharge were more likely to be well engaged with unit nurses and that researcher contact was less likely to substantively interfere with existing nurse–patient relationships. To avoid enrolling patients for whom participation might have posed a significant risk to health, the charge nurse screened eligible patients in terms of symptom severity and ability to engage in conversation. When I approached potential participants, I created many opportunities for participation refusal, ensuring that "data collection sessions involve only those who are genuinely willing to take part and prepared to offer data freely" (Shenton, 2004, p. 66). Nine PMH nurses and six patients were enrolled in the study, and their participation was not discussed with their peers or treatment teams. All participants gave informed consent, and all were free to withdraw from the study at any time. I reconfirmed consent at each meeting and ensured that participants knew that I was not formally connected with their clinical decision-making teams or their nursing supervisors. Unit managers were not informed about the participation of any particular nurse. During nonparticipant observation, those who were present on the unit were informed that the researcher would be present and observing study participants and that no observation data relating to study nonparticipants would be recorded or used unless their specific consent was given.

Data Collection

Conversations took place over a 13-month period. Interviews lasted between 1 and 1½ hours. Approximately 40 hours of nonparticipant observation also took place. Patients were interviewed while in the hospital, and nurses were interviewed during or immediately after their work shifts. I conducted semistructured interviews in a formal, quiet interview room in or near the inpatient unit. I followed the interview guide, and at the same time, I attempted to establish rapport with each participant to encourage a free flow of ideas. I used a form of iterative questioning whereby I relied on earlier information to suggest and create new lines of questioning. With patient-participants, I ended the interview if I sensed that the patient was seeking a therapeutic encounter rather than engaging in a research interview. In our first meetings, I asked patients the following: "Tell me about the interactions you have with nurses while you have been a patient here on this unit" and "When have you been with a nurse in a way that you have found to be helpful? Not helpful? Tell me more." I asked nurses similar questions: "What is it like to be with patients on this unit?" and "Tell me about times when you were with a patient and you felt it was working/not

working as it should." All 15 participants initially agreed to engage in serial interviews, but only half actually participated in more than one, due to scheduling challenges, patient discharge, or withdrawal of interest. Data consisted of texts transcribed from participant accounts as well as data from nonparticipant observations and journal notes.

Analysis

The interpretive process began as soon as interviews took place after the informed consent (Crist & Tanner, 2003). Data analysis entailed (a) identifying "the way the person is oriented meaningfully in the situation" (Benner, 1994, p. 105); (b) summarizing central concerns and identifying exemplars of important themes; (c) discovering linkages between accounts, meanings, and themes (Crist & Tanner, 2003); and (d) developing in-depth interpretations and summaries. I attempted to remain open to any new lines of inquiry that emerged from the data, and I used these to provide a focus for subsequent interviews (Crist & Tanner, 2003). To be credible, my analysis needed to be a fitting representation of (a) my conversations with participants and (b) the meanings that emerged from my experiences and those of the study participants (Shenton, 2004). To enhance credibility, I actively reviewed the accounts of the patients and nurses before I conducted the secondary interviews, so that I could focus my attention on emerging themes and questions for discussion that arose from their previous accounts. I engaged in reflective writing, which helped me to clarify my own perspective on my research experiences. I used multiple sources of data (interviews and nonparticipant observations) to help me fully understand participants' experiences.

As is always the case in hermeneutic phenomenology, my interpretation must be understood by readers to be speculative, imperfect, and incomplete. Although it has been suggested that saturation is "the key to excellent qualitative work" (Morse, 1995, p. 147), the meaning of saturation in hermeneutic inquiry is not well understood. Because phenomenology involves perceiving meaning (Benner & Wrubel, 1989), the researcher may struggle to grasp the participant's meaning at the beginning. Given the ontological foundations and interpretive epistemology of phenomenology, saturation, "the point at which no new information is produced" (Guest, Bunce, & Johnson, 2006, p. 65), can never be achieved. According to Ast, in Ormiston and Schrift (1990), "no individual inspection of a work ever exhausts its meaning . . . interpretation can always be rectified" (p. 97). Guest et al. (2006) argued that the concept of saturation could be best served by identifying a required number of participants in a qualitative study, and the authors agreed with Morse's (1995) recommendation for six participants in a phenomenological study. Other than exceeding the number of interviews necessary for saturation suggested by Morse and Guest et al., I make no claims for saturation.

The Theme of Mindful Approach

I uncovered patterns of commonality, or themes (Benner, 1994; van Manen, 1998). The focus of this article is the theme of *mindful approach* (Oxford University Press, 2010). In this case, a mindful approach represented the experiences of PMH nurses who recognized that patients were experiencing intense psychological distress and potential behavioral volatility and who adopted a consciously strategic approach to achieving a therapeutic connection. In the words of Nurse Charles, "There is a certain kind of conscious outreach. It is often, what does that mean for you?" The word "mind" is a building block in this theme, and it references the authentic and conscious manner in which nurses and patients focused their gazes on each other and the intense and often rapidly unfolding process of meaning-making that followed. To be mindful is to "take thought or care," to be "heedful"; a more ancient definition is to be "intending or inclined to do something" (Oxford University Press, 2010). The theme of mindful approach must be distinguished from the therapeutic technique of *mindfulness*, in which the person is in "a state of intense concentration on one's own thought processes" (Oxford University Press, 2010). I identified three subthemes in the theme of a mindful approach: "frontline," "common ground," and "shift." The language of all three helps us to visualize nurses and patients as moving in space and time, constantly repositioning, each seeking a position of relative security before engaging in therapeutic work. The theme of a mindful approach is illuminated in the following accounts of nurses and patients, who are identified by pseudonyms.

Frontline

PMH nurses and patients frequently engaged each other in moments of patient distress, and this distress sometimes led to conflict. I understood conflict between the nurse and the patient as expressions of differences that needed to be reconciled before patient and nurse could work relationally. I employed the metaphor of the frontline to signify these experiences. A frontline is a place where parties first engage. It can be a place of courage and confrontation, but above all, a frontline is a place of possibilities, where each party meets the other and conflicts eventually dissipate.

In the following anecdote, a nurse recounts a frontline experience:

> I went in to relate to him . . . his attitude was "I don't need to be here" . . . He didn't really want to have anything to do with me other than "Get me this, get me that, do this, do that." I stopped him for a moment, and I said, "OK, this is what I'm here for, this is my role as a nurse, to help you out here, but you have to work with me too." So we talked. I sat where we were eye to eye. I sat in a relaxed manner and just said, "Let's get together. I can get to know you better and you can get to know me too, so we can work." (Nurse Diane)

This account illustrates a conflict in which the patient attempted to establish himself in a position of control. The nurse's intention was to engage, but the patient's need to express his status meant that there was little shared agreement. Initially, the patient did not get that the nurse was there to "relate." By positioning herself at the patient's level, the nurse consciously used her body to communicate the value of power sharing.

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

> The first thing I did is sit with him to explain that I am really concerned about him and how he's going to hurt himself or hurt somebody else . . . He settled down and said "OK, all right, I'll listen for a minute" . . . There's that window to get in. "Ok, let's talk a minute." I only take a few minutes. I don't continue on and on.

In this encounter, the patient created the space wherein the nurse could move toward him, and the nurse sensed that the patient's temporary receptivity created the possibility of mutual understanding. The nurse aimed at a future engaged relationship, which she characterized as a time when she and the patient could "sit and talk." Similarly, in the following anecdote, Nurse Joy describes the moment when the patient "starts to stop" by turning his attention toward the nurse so that he can take in the nurse's expectation for the encounter:

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

The moment when the patient opened a "window" was recognized by the nurse, and understanding that the window could be easily closed, she responded by asking the patient for time. Whatever the patient's intention, Joy recognized that she had only a moment to help the person understand the nurse's point of view. The nurse in the following exchange looked for an opening, but that moment was difficult to find:

> There was no break in the conversation for me to get in. It was unleashed anger continually. How you know that a conversation is going to go anywhere or get anywhere positive is if there is an

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

The following experience highlights different qualities of frontline encounters. Nurse Samantha recounted an experience in which a patient surprised her with his threatening actions:

> I had my chair in the doorway and he came over the chair to get out of the room because he thought somebody was coming to kill him. I didn't expect that; he just sat right up out of his bed and bolted for the door. I knew that he had this fear of people coming to kill him . . . so I should have known not to have my chair totally blocking the door, but I just hadn't thought about it . . . He came to the point where he recognized me . . . I was able to redirect him and do some reality orientation.

This patient experienced hallucinations and delusions and acted out a scenario that the nurse only partially understood. For Samantha to establish shared meaning with the patient would have required her to uncover the patient's own internal narrative, and in this situation, only a portion of the story had been revealed to the clinicians. Samantha's response was to help the patient situate himself in the immediate environment and help him shed light on his own fear, and the confrontation was over quickly.

Patients gave accounts of conflict with nurses. Patient Marie stated, "I was agitated and for some reason, I picked up the jar of beads and I threw them. I don't know why to this day." In this situation, Marie said that the nurse made little attempt to help her understand the meaning of the outburst; no mindful approach was enacted, and Marie spent 2 days in seclusion. At the time of our conversations, Marie still did not comprehend the experience, and she had made little progress in working with her nurse in a more engaged manner.

Nurses reported that they continued to situate their searches for a place and time of engagement even when they themselves were experiencing anxiety and fear:

> You can't show anxiety. Sometimes you think, "This person might not listen; maybe I just better back off and get them into TQ (therapeutic quiet, seclusion) now." It's kind of a feeling you get that you know you can't show your anxiety . . . I would admit there are times that you don't know what they are going to do, so I kind of back off a little bit but never show, and I always have to show the professionalism because they will remember that long after they are gone. (Nurse Diane)

Furthermore, Nurse Samantha seemed to understand that she needed to think through her responses in a frontline encounter:

> There is always something going on in the back of my head . . . Am I taking this person down the road where they're going to

get really agitated, then I'm going to need to act on an emergency basis?

Even though Samantha valued the emergence of any possibility of common ground, she continually reviewed her approach: A value such as personal safety came into the foreground and Samantha would question the route she was taking.

So far, the nurses in these frontline exchanges have responded in fully embodied ways by positioning their anxiety-infused bodies in supportive positions and directing their minds toward creating the relational space that would allow them to respond to the patient's distress. Nurse Hilary gave an account of a different reaction. She had been confronted by an angry patient and she responded in a manner that she later regretted:

> This patient has a propensity for . . . getting people angry at her. I forget what I said to her. I thought afterwards I could have handled it differently . . . She made some kind of a remark about me, and I said no, no, no, that's not true.

This exchange revealed the challenge of enacting a mindful approach. After experiencing the patient's hostility, the nurse responded by presenting her own truth, moving toward the patient but expressing herself defensively. At the same time, the nurse rejected her own initial interpretation of the exchange, understanding that the patient's hostility was misdirected and part of a more complex array of feelings. She adjusted her response 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:

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

Nurse Hilary's response was based on her recognizing her own feelings and the patient's feelings and her knowledge, rooted in professional values of patient well-being and patient choice. She worked hard to uncover the possibility of a more engaged relationship in the future.

In the following interaction, Nurse Lydia and the patient were unable to find a space where the patients' anger could be defused:

> She was saying things like, "Oh, you're so stupid, you are the stupidest nurse I've ever met. Why aren't you dead? I could kill you." This woman was very, very angry; it just really got to me, and I thought, How much is too much? I think in psychiatry we are used to a little bit of verbal abuse because nobody wants to be here and they don't think they are ill. So there are those conflicts, right?

Lydia interpreted the patient's verbal attack as personal, reaching to the core of her worth as a nurse, and she needed to create distance to prevent herself from launching her own defensive verbal attack. Upon later reflection, Nurse Lydia recognized that her response did not conform to her own professional standards; she understood that in the social matrix of nursing practice, nurses do not always act in their own defense:

> It is real, but it isn't real in our personal lives . . . You have to say, this is a person who is ill; this is not a personal attack.

Other examples of the frontline emerged as nurses talked about the formal relational experiences that facilitate intense exploration of patients' emotional suffering. Nurses variously labeled these experiences as "one-to-ones" or "talk time," although a few registered nurses labeled their work as psychotherapy. Nurse Tim, who viewed much of his relational work as psychodynamic psychotherapy, understood that when patients uncover thoughts and feelings previously hidden, they often experience anxiety:

> They say, "Gee, you are getting too close." The anxiety wells up. I check and make sure, "Where is the anxiety?" I just pull back. Some patients will say "I would like to expose more," and some patients say, "That's enough."

Tim expressed an understanding of the patient's apparent insecurity and shifted his strategy accordingly. In this experience, both Tim and the patient moved toward and away from exploring the patient's core feelings. In another account, Nurse Colleen also used language that illustrated the movement of nurse and patient in this shared relational space: "I push until I get resistance and I stop." As did Tim and Colleen, Nurse Charles shared how he created opportunities for intense exploration and was prepared to see the patient retreat. These nurses understood the frontline as an experience filled with motion, at once a place of possible convergence and a place of disjuncture that participants constantly approached, held their positions in, retreated, and encircled.

Common Ground

It became evident to me that both nurses and patients sought to establish a kind of shared understanding in which each was able to talk about a concern without a constant need to seek clarity, explain one's feelings, or defend one's position. Each highlighted a moment when the frontline shifted, and confrontation and explanation appeared to be replaced by a more comfortable connection. I used the term *common ground* to highlight this kind of relationship, where each person is more at ease with the other and the patient feels less of an object. Patient Laura stated,

> When I talked to my nurse . . . it was a connecting conversation. We were engaging and we were on the same page. I didn't feel like an idiot; she was talking to me properly . . . She was listening to me, and she gave me an intelligent answer back.

The patient's expectations of a formal encounter receded into the background as Laura experienced a "connecting conversation." She stated, "She treated me like I was intelligent"; Laura felt respected. Patient Elsie reported the value of this kind of exchange: "It makes you feel better about yourself that they can relate to what you're going through." Patient Marta stated, "That's always made a difference to me, coming into a situation where you feel somebody's talking to *you* . . . I can't receive it when I feel like they're (just) fascinated."

Nurse Tim articulated a very specific intention to "ground" the patient, which suggested to me that he understood that the patient need a more solid connection. He stated, "It comes down to bringing the patient into the room where you are, instead of this psychotic state, so that they actually can start to be grounded in some type of reality." Nurse Tim's later conversation helped me understand his perspective more clearly:

> You've got to have some kind of shared experience with a patient . . . He'd already become very defensive around words he felt were derogatory, like psychosis or illness, so I had to try to ease him into that idea . . . I'll test some words to see which words are going to work so we will not be adversaries, and we will have an agreement on which word is going to frame this experience for him because if I start putting the words on him without him agreeing to the words, then of course it could become a battleground, or it can be lots of interpretations . . . it has to be a nonthreatening word that he can start to get some frame around the experience of coming to hospital.

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

Nurse Charles recounted his experience with a patient with schizophrenia in which each party uncovered "common ground" in a different way.

> He had this thing that was important to him and he had a chain on it . . . He takes out this old pocket watch that he had . . . he remembers it's his grandfather's. And one of the things on the pocket watch itself says "rest in peace," and he got his grandfather's name on the other side of it, so I said, "Obviously this means a lot to you, so what do you use it for?" He says, "Every time I get frustrated and angry now, I will look at this watch and it says, rest in peace, and right away I think nothing really matters much more than that." One of the great things that was there right off the bat is that I had a deep connection to my own grandfather who used to carry a pocket watch all the time.

So obviously there was that commonality that I can see how much his grandfather meant to him and right away made that little bit of extra connect, people connection.

In characterizing their connection as "extra connect" or "people connect," Charles understood that he and the patient had uncovered common ground almost accidentally, unrelated to any therapeutic strategy. Charles illustrated how he explored his own intentions and motivations; he later articulated to me that he knew that his perspective was only one constituent of shared understanding. In establishing "people connect," both the nurse and the patient would understand each other's human qualities. Nurse Tim explained that "sometimes it is that ability to go wherever they are at and you are there."

It seems then that in these accounts, common ground is characterized by the presence of a respectful and knowing person-to-person connection and each person's commitment to inhabit a shared space of understanding. The notion of place seems to be particularly present in these experiences: being "on the same page," "going wherever they are," and "connection." It is reasonable, however, to question the "commonness" of common ground. How could nurses and patients create shared understanding when their worldviews appeared to be so different? Perhaps the answer lies in the overarching theme of mindful approaches. In this inquiry, the accounts of nurses and patients appeared to suggest that frontline encounters were often filled with tension and defensiveness. It makes sense then that nurses and patients, having experienced the frontline encounters, would wish to uncover and inhabit a more shared, intersubjective space. Each would be able to understand the other and, without losing the identities of patient and nurse, create an encounter that more closely resembles a person-to-person connection. It may be that nurses and patients who inhabit common ground are beginning to cocreate a new and more shared perspective, thereby setting the stage for a new relationship.

Shift

I used the term "shift" to signify those changes that participants experienced as turning points in their relationships, in which patients sought deep understanding of their illness experience. In the "shift", patients demonstrated a willingness to engage in therapeutic work so that they could move away from their confusion and suffering and toward a more healthy way of being. Nurse Charles recounted the following:

> I don't know how, what opened up, but he finally one day, he said, "Let's have a chat." That was a long conversation.

Prior to this relational shift, Charles understood that the patient did not yet trust him, but he continued to create potential for a shift by "allowing" the patient to keenly observe him from a distance and learn about Charles through his

interactions with other patients. The patient, having satisfied himself that Charles was safe and trustworthy, approached him with curiosity, and the relationship changed.

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

> There was a young fellow; he had a hard go of it. We didn't have a good rapport, and I had a very hard time getting to him because he basically didn't want to talk to me . . . So with patience I slowly got through to him. He would say, "I don't want you to be my nurse today." I said "I have to talk to you this afternoon because that's my job, but you have to carry on and if you need me, I am here." We actually had a great conversation about his situation and how he was feeling . . . then he said, "You know, honey, you are not that bad." I said, "No, I'm not."

Joy approached the patient carefully and made manifest her intentions. Given control and allowed to choose the time and place for the encounter, the patient's initial rejection moved into the background, and the nurse and patient were able to explore his situation; the patient could safely expose his perspective to the nurse.

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

> Before, what we talked about was always my suggestion, whereas once he started to feel a little bit better and we were able to link better to each other, I was able to ask him more. I remember a picture on his windowsill. He had a picture of his family and another picture of his brand new grandson, and I remember before it was, "Oh, how beautiful, your grandson," and it was all my value judgment placed on these pictures. When we were speaking more as adults, it was "I see your grandson there and when was he born? Do you get to visit him often? How do you feel after these visits? It looks like you have family gatherings—what is that like for you?" I didn't have to put words in his mouth.

From Samantha's perspective, the shift meant that she could be less directive and adopt a more collaborative role in which she encouraged the patient to explore the meaning of his experiences.

For some nurses and patients, the shift seemed to relate to expose the patient's vulnerability. Tim revealed his psychoanalytic framework when he commented that, "Shifting . . .

they start to feel their defenses crashing, then they get trapped. Should they let their defenses down or should they put them back up?" Tim constructed his relational practice so that patients' vulnerability was exposed and, in his view, the patient would make the choice between remaining stationary or creating the shift; Tim's intention was to help the patient experience a willingness to move forward. Patient Marie described how she experienced this kind of vulnerability as being on a pathway to recovery: "I used to come into hospital, and my Mom would say, 'Oh my God, you've got worse . . . you are worse than when you left (home).' It is the first step to wellness really." Marie appeared to accept the intensification of her own vulnerability if it led her toward a more healthy state. At one point, I observed a nurse and a patient operating within this space of shifting vulnerability. A sad and angry patient expressed puzzlement at a question the nurse posed, and then his eyes filled with tears. "You don't know me," stated the patient, with a hint of anger. "Tell me, then," replied the nurse. In the ensuing conversation, the patient recounted specific aspects of his story that were clearly uncomfortable and anxiety-provoking and that had not previously been a focus of their conversation. At the end of the conversation, the nurse understood the patient in a different way; he had both articulated and argued for his vision of his future, and the nurse considered the experience to signify a change in their relationship.

Discussion

Within the context of responding to patients' distress, because of their unique view of the possibilities of the nurse–patient relationship, PMH nurses engaged patients in a manner that helped them to assign meaning to their experiences and that served as a starting point for ongoing therapeutic work. Within each of the subthemes of frontline, common ground, and shift, patient-participant accounts highlighted changes in openness to engagement, willingness to share uncomfortable experiences, and visions of the future. Patient experiences with unknowing and defensiveness inhabited the subtheme of frontline. The importance of being viewed as a person and not an object inhabited the subtheme of common ground. The subtheme of shift highlighted the significance to the patient of a safe connection where his or her perspective could be fully articulated and given meaning. In contrast, nurse-participant accounts across all themes highlighted the importance of being alert to changes in patient experience and committed to achieving shared understanding.

The theme of a mindful approach illuminates the concept of nurse as counselor (Peplau, 1952) and the *care face* (Barker, Jackson, & Stevenson, 1999). In particular, the theme of frontline bears clear relationship to Barker's transmutation of the term *coal face*, which is the place where miners actively dig coal from the seam, to *care face*. The care face is the place where PMH nurses are directly engaged with patients for aims that are unique to nursing practice

(Barker et al., 1999). In this inquiry, the frontline was one example of the care face. It was a place of active approach and exchange of perspectives, in which patients and nurses seemed to jostle for position, sometimes to seek advantage or exercise power and sometimes to open a window of opportunity or declare a temporary truce. On an acute inpatient psychiatry unit, nurses are highly engaged in responding to patients' rapidly changing feelings and behaviors; in fact, they are the clinicians who are primarily responsible for responding to patients in these circumstances. For their part, patients want nurses to recognize and anticipate their needs (Barker et al., 1999).

Many aspects of Peplau's (1952) work on the phases of the nurse–patient relationship are reflected in the mindful approach theme. Peplau (1952) stated that a patient in the *orientation phase* "provides leads on how he visualizes the difficulty, providing opportunities for a nurse to recognize gaps in information and understanding" (p. 20). In this inquiry, the subtheme of frontline was illuminated when patients made statements such as "I don't need to be here," leading the nurse to respond with an explanation of her role; these statements highlight some dimensions of Peplau's orientation phase. In the subtheme labeled *shift*, a nurse gave an account of a turning point in his relationship with a patient, stating that, "There was something . . . that opened up" when the patient said, "Let's have a chat." This relates to Peplau's (1952) *identification phase* of the nurse-patient relationship, in which the patient's feelings of threat to self are "minimized as the patient identifies with persons who help him to feel less threatened" (p. 31), and the phase of *exploitation*, which takes place when a patient "explores all the possibilities of the changing situation" (p. 37). Mindful approach accounts resonate with other aspects of Peplau's work, such as her framework for understanding and working with anxiety. For example, a nurse attempted to guide a patient to the point of anxiety before allowing him to decide if he wanted to press forward and risk more anxiety or stay at his current level; he discussed the challenge of transforming the patient's anxiety by discovering shared experience, or common ground. Peplau (1952) said that PMH nurses focus on a patient's "unexplained discomfort" or anxiety (p. 119): "Anxiety is a potent force in interpersonal relations and the energy it provides is converted into destructive or constructive action depending on the perception and understanding of all parties in the situation" (p. 156). Furthermore, "Nurses can recognize the anxiety factor inherent in doubt and permit expression of feelings, aiding the patient to see what the situation means to him" (Peplau, 1952, p. 143). In frontline exchanges and while finding common ground, nurses worked actively to uncover feelings, helping patients to understand what was happening to them and using this understanding to frame their experiences.

Mac Neela, Scott, Treacy, and Hyde (2007) suggested that PMH nurses tend to distance themselves from formally associating their therapeutic work with a counseling model, but Peplau's (1952) description of the nurse as counselor is present in accounts of mindful approach. It may seem counterintuitive to uncover the notion of nurse as counselor in the theme of mindful approach when so many encounters were enacted in moments of acute distress. Counseling is conventionally understood to take place over a longer time period and within the context of a formally contracted therapeutic relationship with specific goals. In this inquiry, however, the mindful approach exposed the nurses' intentions and actions as they "expand(ed) experiences dimly intelligible to the patient at first, so that they become better understood by patient and nurse"; this indicates a counseling relationship (Mac Neela et al., 2007, p. 63). Furthermore, Peplau (1952) stated,

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

In Peplau's (1952) view, the nurse works with the patient to explore "how he feels about what is happening to him" in his illness state (p. 63). In accounts of mindful approach, nurses sought this kind of exploration.

I do not mean to imply that the theme of a mindful approach is a full representation of Peplau's (1952) framework, nor that Peplau's framework fully articulates the theme of mindful approach; aspects of the framework relate to other themes that were uncovered in this inquiry but are not reported here. Peplau's framework is psychodynamic, and as such, it makes clear reference to the nurse's role in responding to the patient's ego defense mechanisms, anxiety and transference, and the nurse's self-awareness and countertransference, as well as identifying patient readiness for problem resolution. These ideas are expressed in some accounts of the mindful approach subthemes of frontline and shift, but not all accounts illuminate Peplau's work.

As I discussed this work with colleagues, a few suggested that the frontline subtheme too strongly evoked an image of battleground and war, but as I reviewed the accounts, I continued to see strong evidence of confrontation. I alternatively considered replacing the label frontline with the label "tactics" but that seems no less bellicose. I considered changing the label of common ground to that of "truce," but again, this is even more illustrative of battleground sensibilities. I have yet to uncover a more peaceful metaphor for the mindful approach, which after all is only one dimension of the PMH nurse–patient relationship: nurses and patients moving toward each other, retreating, setting up camp on common ground, repositioning, and moving toward change.

Strengths and Limitations

The inquiry had both strengths and limitations. The inclusion of accounts of both nurses and patients strengthened

authenticity in that data from interviews and nonparticipant observation broadened "the landscape of the inquiry" (Tobin & Begley, 2004, p. 393). The research design and data collection process support my claim that the study meets the criterion of dependability. I ensured that participants knew that I was not connected in any formal way with their clinical team or nursing supervisors. I conducted interviews in a formal interview room and adhered to the interview guide, bringing the interview to a close if researcher boundaries were threatened. I reviewed initial accounts before secondary interviews, and I engaged in reflective writing. After data collection was completed, I sought feedback from my peers by presenting some accounts to a national conference of PMH nurses and a seminar of graduate students.

There were a number of challenges in conducting this inquiry. Prior to study initiation, two of the units were changed from acute care to rehabilitation, thus reducing the pool of acute psychiatric inpatient nurses and patients. On any given day, there were more patients on the study units who were certified as incapable of consenting than were certified as capable. Sample size is typically small in studies of this nature, but in this inquiry, the sample size was both small and unevenly distributed: six patients and nine nurses. Although rich and meaningful texts emerged from conversations with both groups, many may consider that the nurse perspective at times overwhelmed the patient perspective. Although I do not hold that the results of this study are transferable or generalizable in the postpositivist sense, and some may assess this as a study limitation, I attempted to make firsthand accounts the centerpiece of this work so that readers can understand both the context of the inquiry and how participants interpreted the phenomena. Furthermore, by explaining the study context and offering my interpretations of participants' experiences, I encourage readers to reflect on these experiences themselves.

Implications for Nursing Practice and Research

In this inquiry, nurses and patients revealed that in a psychiatric inpatient setting, it is possible to create knowing and transformative relationships. Nurses approached patients with the intention of creating meaningful encounters even when they were uncertain of the potential for intimacy and long-term engagement. Patients responded to nurses by meeting them at the frontline, seeking recognition, and working with nurses to find meaning in their experiences.

Despite the fact that acute inpatient PMH nurses experience serious constraints on their ability to work relationally with patients, they continue to find ways to engage patients in therapeutic work. These kinds of person-centered encounters have been linked in the literature with enhanced patient satisfaction and reduced incidents of aggression, and future research should focus on making connections between PMH nurses' relational practices and other patient outcomes, such as patient and family engagement with care planning, patient safety indicators, and changes in mental health. This is the kind of evidence that acute inpatient PMH nurse leaders will need in order to make a strong case for program funding that supports nurse–patient engagement in acute inpatient settings and leads to more effective utilization of inpatient services.

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