PSYCHIATRIC NURSES' PERCEPTIONS OF COMPETENCE IN DEVELOPING THERAPEUTIC RELATIONSHIPS

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Abstract

Psychiatric Nursing as a specialty is over 100 years old. The specialty has roots to the Mental Health Reform Movement of the 19th century, which reorganized mental health asylums into hospital settings. Throughout the progression of this specialty, one skill that has created the foundation of psychiatric nursing practice is the one-to-one therapeutic relationship. As with the entire nursing profession, psychiatric-mental health nursing is undergoing significant difficulty in recruiting and retaining nurses in the profession due to many obstacles created by current conditions in acute care units in psychiatric hospitals. A qualitative study with phenomenological approach was used since the objective of the study was to explore the perceptions of nurses actually working in the field of psychiatric nursing. Four themes and subthemes emerged from the data analysis; the role of the nurse, with subthemes of patient safety, unit management, patient support, and nursing tasks; trust development based on three subthemes, person-centered, communication/listening, and boundaries; skill acquisition through life experiences, on-going education, and observation of others' skills; and the final theme was student experiences regarding recruitment to the specialty of psychiatric nursing.

DESCRIPTORS: PSYCHIATRIC NURSES, THERAPEUTIC RELATIONSHIPS, COMPETENCE, NURSING ROLE

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Chapter 1

Introduction

Psychiatric Nursing as a specialty is over 100 years old. The specialty has roots to the Mental Health Reform Movement of the 19th century, which reorganized mental health asylums into hospital settings. Throughout the progression of this specialty, one skill that has created the foundation of psychiatric nursing practice is the one-to-one therapeutic relationship. In her study on counseling and mental health nursing, Stickley (2002) points out that in the last 50 years, both the theory and practice of mental health nursing have been influenced by the emergent psychotherapies. She pointed out that counseling skills have become an essential component in nursing education in England. She focused her study on exploring opinions of mental health nurses about the need for counseling or counseling skills training in preparation for working with mentally ill individuals. Her research found that nurses did not feel they were equipped to do one-to-one work and that effective supervision would help them in their one-to-one counseling work. The American Nurses Association (2007) clearly identified that the "work of psychiatric-mental health registered nurses is accomplished through the nurse-client… (ANA, 2007). A component of the clinical practice activities for psychiatric-mental health nursing in ANA's scope of practice is the nurse's use of self is a therapeutic resource that is evidenced through one-to-one interactions.

The counselor role and the development of the therapeutic relationship have long been viewed as key practice skills in psychiatric nursing; however, little research has

been done to clearly define this role. Hildegard Peplau developed the theoretical base for mental health nursing more than fifty years ago when she and others created the National League for Nursing in 1952 and suggested that all schools of nursing have a basic theory and practice course in psychiatric nursing (Sills, 1998). She firmly believed that the psychiatric nurse's greatest tool was use of self in the therapeutic relationship. In 1968 she wrote an article describing use of self through language to assign meaning to a patient's behavior as a therapeutic intervention. (Peplau, 1999/1968). She outlined therapeutic interventions using the language of patients. Psychiatric and mental health nursing concepts are present in all practice settings of nursing because the development of a one-to-one relationship is instrumental in the creation of the patient's trust in the caregiver. Assessment skills and communication are essential in all areas of nursing in order to gather the information needed to make an accurate nursing diagnosis and subsequently treat the patient holistically.

Psychiatric-mental health nursing is undergoing significant difficulty in recruiting and retaining nurses in the profession due to many obstacles created by current conditions in acute care units in psychiatric hospitals. Many nurses entering the specialty have limited experience and educational background in psychiatric nursing, creating a lack of confidence in their ability to form one-to-one therapeutic relationships with patients. Other factors that contribute to the lack of nurses' comfort with the therapeutic relationship is the increase in violence and aggression of patients, increased paperwork requirements leading to less time for direct patient contact, and inadequate preparation by schools of nursing in specialty skills required for psychiatric nurses. This is creating a crisis in psychiatric nursing and mental health care in the United States and other

countries such as Australia, New Zealand and the United Kingdom because of the lack of adequately educated nurses to provide care to an increasingly complex and seriously ill patient population. Nursing research in Australia has been devoted to discovering what will promote a sustainable mental health-nursing workforce (Cleary & Happell, 2005). In the United States, the focus of research in psychiatric nursing has primarily been interventions and patient response to those interventions. There are few studies that have been completed around psychiatric nurses' perceived competence in their field of nursing.

The assumption underlying this research is the belief that if nurses understood the role of the psychiatric nurse more clearly and were better prepared in the skills necessary to be successful in the psychiatric-mental health setting; they would be more likely to consider this specialty as a career choice.

Issues and Progression of the Profession

Hildegard Peplau's vision for nursing provided the foundation for the profession and established psychiatric mental health nursing as a separate specialty with its own standards and scope of practice (Sills, 1998). Peplau clearly identified the therapeutic relationship and use of self as the underlying necessary skills for psychiatric nurses. In 1980, she published an article that explored the changing environment and psychiatric nursing, which created a greater need for psychiatric nurses to be accountable. Because of the increased number of regulatory bodies, third-party payers and consumer oversight groups, it is imperative that psychiatric nurses be accountable for their scope of practice. Peplau pointed out the most important tasks for psychiatric nurses are to define and clarify what nurses do in psychiatric setting (Peplau, 1999/1980). The therapeutic

relationship underpins all other nursing interventions in psychiatric nursing and yet, the focus of the "Era of the Brain" on the biological basis for psychiatric disorders has eroded this assumption. Dr Christine Silverstein in 2006 strongly advocated for psychiatric nursing and the necessity of the profession to uphold, promote and implement therapeutic interpersonal interactions to improve outcomes. She outlined how throughout history, psychiatric nurses have led the nursing profession in treating the after effects of war, disasters and the rising number of mentally ill individuals in society.

Purpose

The purpose of this study was to explore how nurses in the acute care psychiatric setting perceive their role as psychiatric nurses particularly related to developing a therapeutic relationship. The study also explored whether there are differences in nurses with less than 2 years experience in inpatient psychiatric nursing and those with greater than five years experience. Finally, nurses' perceptions of their preparation for conducting one-to-one counseling were explored.

Research Questions

The research questions that were addressed in this study are:

- How do psychiatric nurses perceive their role in developing therapeutic relationships with patients?
- What are psychiatric nurses' perceptions of the adequacy of their education in preparing them to conduct one-to-one counseling?
- Are there differences in perceptions of psychiatric nurses with less than six years experience as compared to psychiatric nurses with six or more years experience in inpatient psychiatric nursing?

Definitions

Psychiatric Nurses- Nurses are qualified for the psychiatric-mental health specialty at two levels according the American Nurses Association, basic and advanced (ANA, 2007). For the purposes of this review, the focus will be on the basic level of qualification in psychiatric nursing, which are nurses who have complete a nursing program an passed the state licensure examination. They work as staff nurses, case managers, nurse managers and other nursing roles in the field of psychiatric-mental health nursing.

Therapeutic Relationship-The therapeutic relationship is an abstract concept that may be defined in many ways. For the purposes of this review, the therapeutic relationship is defined as "a planned and goal-directed communication process between a nurse and a client for the purpose of providing care to the client and the client's family or significant others" (Shives, 2005). The therapeutic relationship in nursing is different than other professions particularly around the area of counseling. As Stickley (2002) pointed out in her study, "there is widespread understanding that although nurses may counsel their clients, they are not counselors in as much as they have not gone to counselor training. However, individual one-to-one work utilizing counseling skills is intrinsic to mental health nursing."

Chapter 2

Review of Literature

A review of the literature demonstrates that research towards evidence-based practice is fairly new in psychiatric nursing despite its long history as a specialty. One study by Barker, Jackson & Stevenson (1999), of Newcastle, England, concluded that nurse need to be several different things to several different people and be able to alternate between these roles. They also point out that instead of trying to create new roles that psychiatric nurses might focus on developing new ways of fulfilling traditional functions like human caring in a complex and increasingly technological health care arena.

Much of the research conducted in the late 20th century and early 21st century focused on the role of the mental health nurse and the different interventions used with patients (Jormefedt, Svedber, Arvidsson, 2003; Hellzen, 2004). An interesting study conducted in Canada explored the role changes of nurses as their patients progressed or did not progress through recovery from psychosis. The outcome of the study found that as patients progress through recovery, the role of nurses changes from one of observation to one of support and education. Again, the authors emphasized the need for nurses to maximize their potential as counselor (Forchuk, Jewell, Tweedell, and Steinnagel, 2003).

Mental disorders affect 22% of Americans ages 18 and older and the World Health Organization cited depression as the number one health problem worldwide (ANA, 2007). In an effort to address this need, researchers have focused on the effectiveness of interventions with major mental disorders like schizophrenia. Wai-Chi

Chan and Ka-Yi Leung (2002) found that Cognitive Behavioral Therapy, a useful intervention with schizophrenic patients, could be an area of practice for psychiatric nurses and required more research to enrich the body of knowledge of psychiatric nurses.

In America, the baby boomer population is aging, creating a larger elderly population who also has psychiatric disorders. Rabins, et al. (2000) studied the effectiveness of the Psychogeriatric Assessment and Treatment in City Housing (PATCH) program by screening 954 residents in public housing in Baltimore, MD and found this to be an effective intervention. The study also pointed out the challenges faced by effectiveness studies when trying to evaluate models of care. As in most treatment settings, one significant limitation was the lack of a single standardized treatment approach as an independent variable in this study and the study would best be viewed as a test of how care was delivered rather than what services were delivered. Cutcliffe, Black, Hanson and Goward (2003) compared the role of mental health nurses to palliative care nurses in the United Kingdom. They recommended changes in education of palliative care nurses to include similar education on the therapeutic relationship that mental health nurses receive. There is a great deal of research in this decade related to the effectiveness of new psychotherapy interventions to integrate into the therapeutic relationship and nurse-based programs for the mentally ill population (Barker, 2006; Caldwell, Doyle, Morris & McQuaide, 2005; McCann, & Bowers, 2005; Vasquez, 2001).

As the psychiatric-mental health nursing profession tackles the issues of recruitment and retention, researchers struggle to find answers. Robinson, Murrells and Smith (2005) cited pay, paperwork and lack of opportunity for professional development as aspects of job dissatisfaction in psychiatric nursing. Another study looked at attitudes

of psychiatric nurses towards inpatient aggression, which is often cited as a deterrent to potential recruits (Jansen, Dassen, Johnnes, Burgerhof & Middel, 2006). Two studies, one in Japan and one in Australia explored the emotions of psychiatric nurses towards their patients and their responses related to stress. (Katsuki, Goto and Someya, 2005; Humpel, Caputi & Martin, 2001). There are several studies in the literature related to adequately preparing nurses for mental health and inpatient psychiatry and their understanding of the role of psychiatric nurses. (Chambers, Connor, Davren, 2006; Scanlon, 2006; Willetts & Leff, 2003). In 1999, Higgins, Hurst & Wistow conducted a quantitative and qualitative study to identify the deficiencies of nursing care in acute psychiatric wards in the United Kingdom. Their findings indicated an increasingly diverse mix of patients in the hospitals, increased volume of administrative paperwork, weakness of the multidisciplinary team working together, and inappropriate education as factors influencing nursing care in acute psychiatric hospitals today. During the same year, Cleary and Edwards (1999) conducted a qualitative study with ten nurses who worked in the acute psychiatric setting where maintaining a safe environment was identified as taking much of the nurse's time, as well as, the unpredictability of the unit activity and demands on the nurses. In this study the nurses also discussed how nurse attributes such as understanding and being nonjudgmental were key components in nurse-patient interaction.(Cleary & Edwards, 1999) Another ethnographic study (Cleary, 2004) conducted later in 2004 focused on how nurses construct their day in an acute inpatient psychiatric unit. This study found that nurses in this type of setting have practice nursing under tremendous pressures like overcrowding, large amounts of paperwork and constant interruptions.

As health care becomes more consumer-driven, so does mental health care. Einsen, Wilcox, Idiculla, Speredelozzi and Dickey (2002) conducted research using the Joint Commission's Perceptions of Care Survey, which indicated that consumers want to be involved in their care and expect the nurse to collaborate with and listen to them, as well as educate them on their illness and medications. Other researchers have studied users of mental health services to discover what skills, attitudes and knowledge the patients view as necessary in the nurses who care for them (McAndrew & Samociuk, 2003; Rydon, 2005).

Similar to the United States, Australia has struggled with adequately educating psychiatric nurses. Clinton and Hazelton (2000) conducted a descriptive study of mental health nursing education in Australia because of inadequate numbers of recruits to the profession. They found that not only were the general and specialist programs lacking in courses that would allow nurses to achieve core competencies, but they also found that university staff lacked preparation for teaching mental health nursing at the postgraduate level. Several studies have been conducted on nursing students' perceptions of mental health placements, preceptors and the mentally ill in order to identify what kept` students from entering the field of psychiatry and mental health. Two studies in particular pointed to the necessity of practice settings and schools of nursing to create more supportive learning environments in clinical settings, through preceptorships and supportive nursing staff. (Charleston & Happell, 2005; Hayman-White & Happell, 2005; Rungapadiachy, Madill and Gough, 2004). An interesting study by Melrose and Shapiro (1999) used a personal construct theory in working with students in their practicums and discovered that the most difficult aspect of care for students in the mental health setting was their

perceived inability to help their patients. Even though the number of participants was small, this finding is significantly different from other research in the literature. In the study completed by Rungapadiachy, Madill and Gough (2004) the participants cited fear of mental illness, poor role models and lack of support in clinical settings as deterrents for students.

Summary Statement

Despite psychiatric nursing's long history as a specialty and profession, it is relatively young in terms of evidenced-base practice and research. The profession is struggling with recruitment and retention issues due to the unique skill base required and the difficult population needing services. The literature pointed to the lack of support in the clinical setting for nurses to practice psychiatric nursing as set forth in the profession's scope of practice. Many nurses do not feel they have the basic skills of developing a one-to-one therapeutic relationship with their patients. Others indicate a lack of time allowed for direct patient care and yet this is clearly the most important skill set at which a psychiatric nurse needs to be competent in any mental health setting. There are some interesting programs and innovative curricula being explored in academic settings to further the preparation of basic and advanced practice nurses. More research to develop evidence-based practice must be conducted in the United States because most of the studies available in psychiatric nursing have been conducted in Australia, Canada and the United Kingdom, with little research being conducted in the United States. There are some very promising studies from these countries that could be replicated in the United States with larger numbers, especially in the area of therapeutic relationships.

Chapter 3

Research Methodology

Design

A qualitative study with phenomenological approach was used since the objective of the study was to explore the perceptions of nurses actually working in the field of psychiatric nursing. This method of research recognizes the personal nature that may arise during the research process because nurses will be expressing their personal thoughts, feelings and experiences. (Creswell, 1998) The focus of this study was on the human experience of nurses working in an inpatient acute care psychiatric hospital. One acute psychiatric hospital in the Midwest was selected for identification of participants. There are two studies in the literature that have set the framework for this research study and components from each of these studies were utilized in the design of this project. In 2002, T. Stickley published a qualitative study with five mental health nurses with less than two years experience in mental health nursing to compare their perceptions of the need for one-to-one counseling skills in mental health nursing and the need for additional educational preparation in the counseling area for nurses entering mental health. The study produced four major themes. One theme that was evident for all five subjects was that their nurse education did not equip them for one-to-one counseling. Another study published by A. Scanlon in 2006, focused more on perceptions of nurses about the components of the therapeutic relationship and used a grounded theory approach in the data collection process. The interview schedule was more extensive in Scanlon's study than in Stickley's 2002 study, but again the sample size was small, involving six participants. In both studies, the participants identified the therapeutic and counseling

relationship as a key component of psychiatric nursing and both studies supported the need for additional preparation related to this area of psychiatric nursing.

Sample

A purposive sample from a freestanding psychiatric hospital from a small Midwestern rural community was used in this study. The hospital employs full-time and part-time registered nurses with varying psychiatric nursing experiences and educational backgrounds. Any full-time, part-time or per diem nurse that held a position involving patient care was asked to participate in the study because the important variables for comparison will be years of experience in psychiatric nursing and their thoughts on therapeutic relationships. The sample size was ten participants. Two of the participants were considered management level nurses, but they were included because of the daily patient contact they have as on unit managers. Nurses without direct patient contact on a daily basis were not included in this study. Data about the participants' years of experience in the nursing profession and years of experience in psychiatric nursing, and educational preparation were collected in addition to responses to the interview questions.

Ethical Considerations

A full IRB review and approval was received by the College of Saint Mary (See Appendix A). In addition, a second IRB approval was received from participating hospital's IRB Review Committee on November 6, 2008. All participants were invited to participate in the study by a flyer placed in their mailboxes at the hospital (See Appendix B) and an overview of the study was presented by the researcher at two staff meetings.

A letter describing the purpose of the study and the process to be used was given to each nurse who expressed an interest in participating. (See Appendix C) The letter included the purpose of the study and reviewed the risks and benefits to the participant and a description of their rights as a research participant. The letter also included a statement that indicated that participation was completely voluntary and the decision to participate or not in the research, would have no impact on their employment or performance evaluation. This was an important aspect in validating the findings because of the researcher's position in the hospital as executive management. In addition, each participant was given a copy of their rights as research participants as outlined in Appendix D. The interviews were taped and the tapes were labeled with date and number for the interview prior to being transcribed. The transcribed interview was labeled with the same date and interview number as the corresponding tape to decrease traceability to each participant's identity. The tapes were kept in a secure cabinet during the research process. The interviews were conducted during the nurse's off-duty time to further reinforce the separation of the researcher with her position in the hospital's management during the interview process.

Data Collection

The researcher conducted a semi-structured interview process that allowed up to sixty minutes per participant. The participants chose the time and place from several options for the interviews. Member checks were completed with nine of the participants. One of the participants was unavailable due to deployment shortly after the interviews so did not complete the member check follow-up. A follow-up meeting was held with participants to validate the findings. In addition to three demographic questions, a series

of eight open-ended questions were asked during each interview. The interview schedule is outlined in Appendix E. The interviews were audio taped and transcribed. The questions were drawn from both the research by Stickley (2002) and Scanlon (2006) and this researcher's experience as a psychiatric nurse. There are no data regarding the credibility of the questionnaire in these studies. The transferability is limited due to the small sample size in both studies. The plan was to have a second investigator who was a psychiatric nurse with similar years of experience and expertise with the researcher, conduct the interviews if it became obvious after the first one or two interviews that the participants were not freely expressing themselves because of the nature of the researcher's position in the hospital. This was not necessary as all the participants appeared at ease and open during the interviews. The interviews were conducted at an agreed upon site, either in the hospital or a local establishment in an area that provided for privacy, so that the nurses were encouraged to relax and feel like they might freely express themselves. The interviews were conducted during the nurses' off-duty time.

Data Analysis

The data analysis consisted of a comparative analysis using QSR NVivo8® (QSR International) software to code individual responses. The transcribed interviews were first read as a whole to derive any overall themes. Each interview was then reviewed in depth the responses to the interview questions were inductively indexed and initially coded into 16 major themes using the NVivo8 software. After several reviews and comparative content analysis, the sixteen themes were merged into four major themes and subthemes. The findings were then reviewed with participants to validate the findings.

Quality Review of Data

Several measures were taken to enhance the credibility and transferability of the data. During the interviews bracketing was used by the researcher to set aside and personal feelings and bias the researcher might have towards the participants. The researcher reaffirmed her role as a student and investigator rather than a supervisor, with the participant at the beginning of each interview. Prolonged engagement was used in the interview process by allowing sixty minutes each for the interviews which allowed participants to expand upon their responses to provide and rich data with depth in their comments.

In addition, member checks were completed with participants to validate the credibility of the data collected and a final review of the findings was completed with participants to view the overall dependability of the findings. A sample member check letter may be found in Appendix F. Peer review with two experts in the field of nursing and psychiatric nursing was conducted throughout the data collection process and analysis to confirm the dependability and transferability of the data. To confirm the authenticity of the data an audit trail was completed by the dissertation committee chair, Dr. Peggy Hawkins (See Appendix G).

Chapter 4

Results

The results of the study are presented in this chapter. Included are demographic profiles of the participants and the resulting themes and subthemes from the interviews conducted. The study involved ten participants (N=10) who participated in one face to face interview lasting no more than 60 minutes each.

Four themes emerged from this study with sub themes under each. The first theme to emerge was how nurses perceived their role in the psychiatric setting. The participants described their role as psychiatric nurses as having four primary functions; patient safety, management of the unit and staff, supporting patients to be successful, and a variety of traditional nursing tasks.

The second major theme focused on the development of trust as the underlying basis for all therapeutic relationships with patients. Trust tied in closely with the subtheme safety because in order for patients to feel safe, participants felt there had to be trusting relationships. Three sub themes surfaced in the data analysis that contributed to the development of trust; the relationship is person-centered, communication/ are present, and that there are clear boundaries in the relationship between nurses and patients.

The third theme to emerge was how nurses learned the skills to develop therapeutic relationships. The major sub themes in this area centered on life experience and ongoing education. A third important sub theme was being able to observe other professionals and paraprofessionals interacting with patients.

Finally, the fourth theme that emerged was that almost half of the participants promoted student experiences and mentoring in psychiatric nursing as a means of

recruiting to psychiatric nursing. The outline that follows summarizes the four major themes and subthemes from the data.

1. Theme One: Role
    a. Patient Safety
    b. Management of Unit
    c. Supporting Patients
    d. Nursing Tasks
2. Theme Two: Trust Development
    a. Person-centered
    b. Communication
    c. Clear Boundaries
3. Theme Three: Skill Acquisition
    a. Life Experiences
    b. On-going Education
    c. Observation of Others' Skills
4. Theme Four: Student Experiences as Recruitment

Definitions

Trust- is an abstract term, that when used in this study, refers to patients' reliance on nurses' ability to help them recover from their psychiatric illness in a safe environment.

The definition of patient safety is similar to how Wale and Moon (2005) described patient safety in their initiative to improve care for the mentally ill in New York City. They described patient safety as "the extent to which potential physical risks are avoided and inadvertent harm reduced in the care delivery processes"(Wale & Moon, 2005).

Boundaries- refers to professional boundaries in this study, which are defined as limits that protect the space between professionals' power and the clients' vulnerability (Santee, 2007).

Unconditional Positive Regard and ***Person-Centered Care-*** are used interchangeably in nursing to reflect theorist Carl Rogers' philosophy of a necessary component in therapeutic relationships. Basically Carl Rogers' definition of *unconditional positive regard* is blanket acceptance and support of a person regardless of what the person says or does. Rogers believed that unconditional positive regard is essential to healthy development (Videbeck, 2006).

Demographic Data

The participants in the study were 10 registered nurses employed by a psychiatric hospital in a small rural community in the Midwest. The primary investigator held the position of Director of Clinical Services at this hospital, so all participants reported up through their chain of command to the investigator; however, that did not include determining the salary of the individual nurses. Four of the nurses reported directly to the investigator. Table 1 summarizes the demographic attributes of the study participants. As outlined in Table 1, only two of the participants were men and eight were women. The majority of the nurses in this study had 14 or more years of experience in nursing. Eight of the nurses had 14 years of experience or more in nursing and five of those nurses had 25 years of experience or more. In terms of psychiatric nursing experience, participants were divided equally. Five nurses (50%) had less than six years psychiatric nursing experience and five nurses (50%) had six or more years in psychiatric nursing. Only one participant had less than two years experience and two had more than 19 years experience.

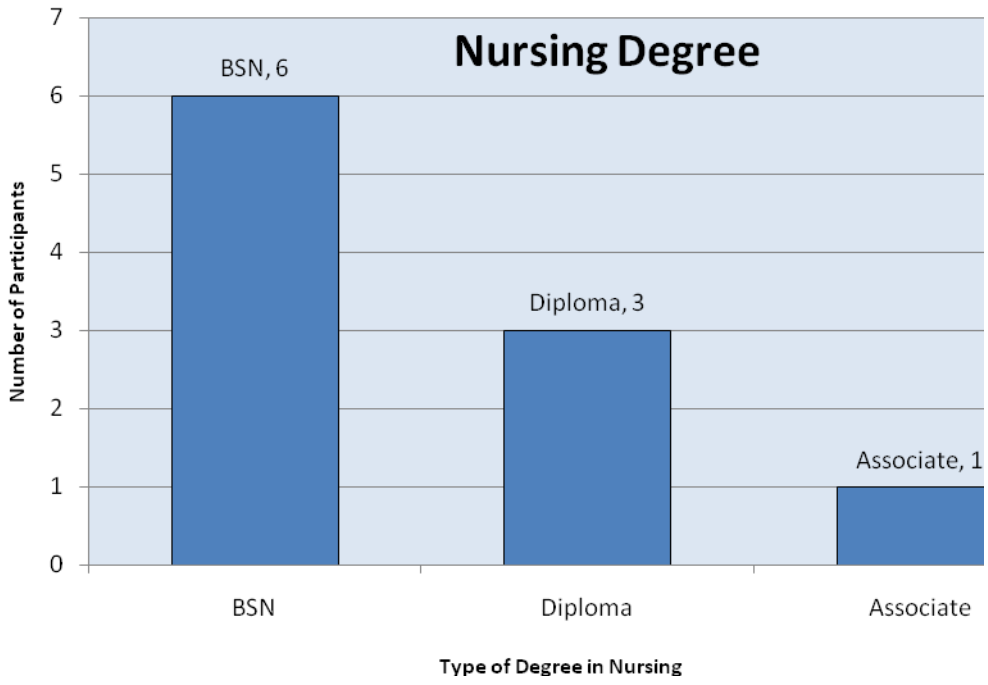
Table 1

Demographic Data

Gender	*Years in Nursing*	*Years in Psychiatric Nursing*	*Degree in Nursing*
Male	1.5	1.5	BSN
Female	7	2.5	BSN
Male	14	13	BSN
Female	18	19	BSN
Female	24	2.5	BSN
Female	25	2.0	Associates
Female	31	3	Associate +BSN
Female	35	6	Diploma + Non-Nursing Masters
Female	38	19	Diploma
Female	43	23	Diploma + Non-Nursing Masters

The chart in Figure1 summarizes the educational background of the nurses who participated in the study. The majority, (60%) had a bachelor's degree in nursing. Two of the participants had a diploma in nursing and a non-nursing master's degree in a mental health care field.

Figure 1. Nursing Education of Participants



Role as a Psychiatric Nurse

The first theme that emerged from the data was how nurses perceived what their role in the psychiatric setting involved. The primary role that participants described was making sure that patients felt safe on the unit and actually were safe. Seventy percent of participants identified this as a key part of their role and 43% of those identified it as their number one priority. There were 13 references to patient safety out of the 10 interviews. This component of care involves such things as observing the milieu to make sure that

patients are safe and accounted for, protecting their rights as patients, making sure they feel like they are in a safe place and creating trust so they feel psychologically safe. One participant with many years of experience in psychiatric nursing stated

> …and the most basic nurse to patient interactions, when it is a one-on-one with a patient, my primary role is to convey to them that they are in a safe place. They will be kept safe.

This sentiment was echoed by several participants. Another participant stated that

> The very first thing you always do when you are trying to get a therapeutic relationship established is, is you establish that relationship of trust. You have to have a relationship of trust first, because if they do not trust and they do not feel safe with you, you are not going to get to square one with a psych patient. You know they aren't going to tell you anything, and they won't let you help them; even the craziest people can sense whether or not they can trust you. Somebody that is totally psychotic will know if they are safe with you, or they are threatened by you, just by all that negative energy you are emitting; or all that positive calm energy you are emitting.

An additional component of patient safety that participants described was that the patient's personhood and dignity were respected and that safety issues in psychiatric settings are vastly different from medical surgical settings where most of these nurses practiced before psychiatric nursing.

The next most common subtheme identified was management of the therapeutic milieu and the program. Seven of the 10 participants (70%) identified charge nurse duties as one their main responsibilities as a psychiatric nurse. One nurse in fact, described her role as more administrative than direct care and spoke about how administrative duties impacted her relationships with patients. In talking about therapeutic relationships she stated,

> I think it is something that they (patients) initiate and seek out, because of the charge role nurse that I play, I do not seek out those therapeutic relationships. I

will look for opportunities to interact, but I also recognize that most of my job is administrative.

Another participant described her role "as making sure that everything kind of goes smoothly during the day." The charge nurse role for some included making sure there is adequate staffing on the unit. The majority of participants described themselves as a charge nurse in some form. Many charge nurse duties described also fell under the category of traditional nursing tasks. According to participants, they not only administered medications, completed nursing care plans, admitted and discharged patients, but they also supervised other staff on the unit and oversaw the operation of the milieu. Four participants (40%) mentioned how the role of the psychiatric nurse has changed over the last 20 years. One participant shared the following:

> My role as a psychiatric nurse, I feel like, through the years has changed. Acute psychiatric nursing twenty years ago, was a lot different, in the respect that we did a lot of therapy, one-to-one therapy as nursing, a lot of groups… I see my role as acute psychiatric nursing a lot different, in the respect that our insurance companies have made a lot of difference in mental health care. They have taken away our continuity of care… It used to be they would stay in and we'd work with them, but that's not the way it is now.

Two other participants described how their role had changed as psychiatric nurses over the last 20 years from having more patient interaction and using counseling skills to being more focused on stabilization and medication management. One nurse when describing her role with patients made the following comments about her relationships with patients,

> …but you know, they have to trust you and in the inpatient unit you can do stuff, but you don't ever have them a long time. You know, it's stabilization; and back in '89 they were there a long term admission still, we were still doing admissions like 45 days. I shouldn't say things like that, but I like it back then when I worked at (name of hospital). I liked that they had primary nurse systems.

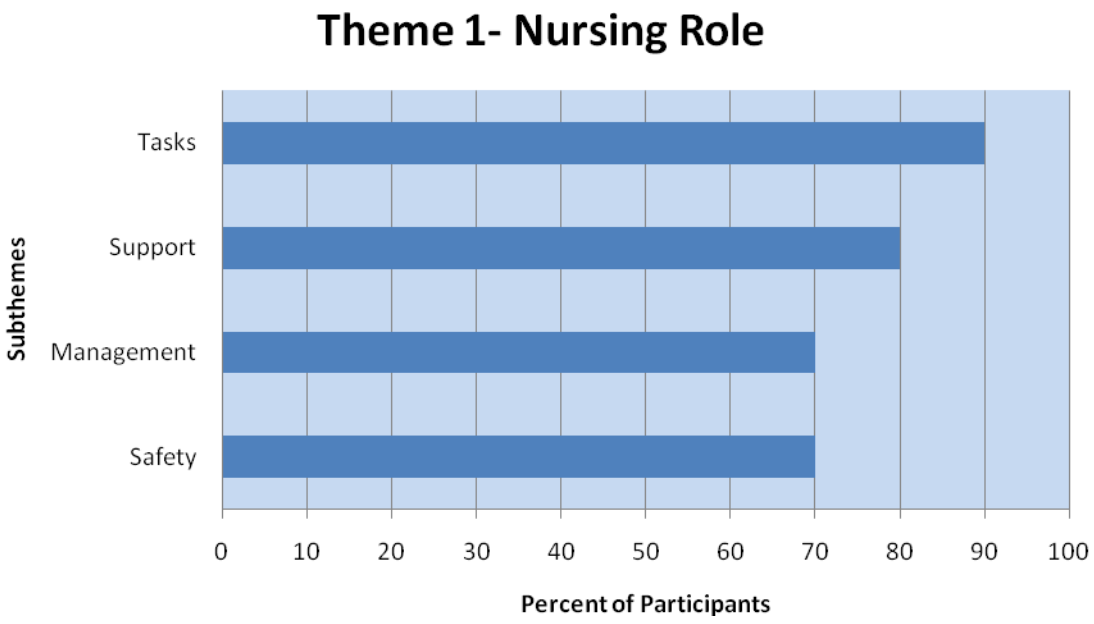
Being a resource for patients emerged as the third subtheme as participants described their role. Eight participants made 18 references to 'being a resource' aspect of nursing care as being important in their role. Being a resource to patients had an assortment of definitions according to each participant. Seven participants identified that acting as a guide or a helper was a significant part of their role. This role was succinctly summarized by one participant as "the nurse acting as a guide or helper in the process of the patient exploring their own life experiences and their perceptions to help to improve their ability to cope with day to day life and particular extreme stressors." Another nurse talked about giving the patients "the tools" to make better decisions in their lives. One participant equated this part of her role to being "like a professional mom to however many patients we have." She worked with adolescent patients and viewed her nurturing tasks as similar to those she uses in her role as a mother.

Finally, the last subtheme that emerged from interview data related to participants' role as psychiatric nurses involved a myriad of traditional nursing tasks, such as medication administration and monitoring, medical condition monitoring, admitting and discharging patients, and documentation. Figure 2 illustrates that 90 percent of the participants identified nursing tasks as a key part of their role. Forty percent (N=4) of the participants identified medication administration and monitoring as one of their key roles as a nurse. One participant with over 40 years of nursing experience stated, "The role of the psychiatric nurse is more medication related now."

Sixty percent of participants identified admissions and discharges as another priority for psychiatric nurses. A new nurse with less than two years experience in both psychiatric

nursing and nursing in general identified the importance of discharge planning through this comment; “and discharge planning, make sure it’s set up so they’re not just kicked out the door; they’ve got a plan you know.”

Figure 2. Theme One-Nursing Role



The Development of Trust

The second theme that emerged from the ten interviews was the perception that trust was a necessary element in all successful therapeutic relationships with patients. Three subthemes were identified as key components of developing trust; relationships must be person-centered and nonjudgmental, there is communication, and there are clear boundaries present between patients and the nurses. Ninety percent of the participants identified the presence of trust as being a key component in therapeutic relationships. The

data revealed 23 references related to the importance of the presence of trust in therapeutic relationships, making it the most frequent term mentioned throughout the interviews. The nurses identified that the nurse-patient relationship must be based on trust so that patients will feel safe and trusting in the inpatient environment and with nurses. Trust was identified as a key component in patients succeeding and getting well because trust must be present for patients to accept the interventions and treatment provided. One nurse summed up the importance of trust in the nurse-patient relationship as follows:

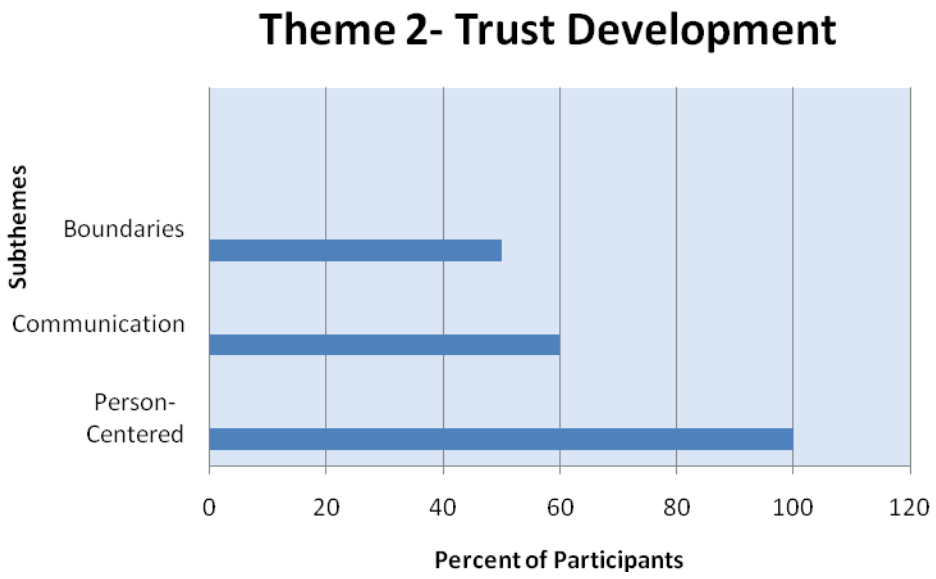
> The very first thing you always do when you are trying to get a therapeutic relationship established is you establish relationship of trust, you have to have a relationship of trust first because if they do not trust and they do not feel safe with you, you are not going to get to square one with a psych patient; you know they aren't going to tell you anything and they won't let you help them.

Another participant talked about the problems that patients have with trusting others in their life,

> …someone who does have real trust issues or someone who doesn't trust kindness for instance, you know they only know how to avoid negativity. They don't necessarily know how to deal with a positive relationship.

The chart in Figure 3 summarizes the data related to trust development and the three subthemes that emerged related to the development of trust in the nurse-patient relationship. The three subthemes were person-centered, communication/listening and clear boundaries.

Figure 3. Theme 2- Trust Development



The first subtheme to be discussed is the concept of *unconditional positive regard* or *person-centeredness*. All (100%) participants described a person-centered approach in their interviews with 32 references to person-centered concepts. One participant provided the following explanation of person-centered care that encompasses the concept very well;

> Accepting the patient where they are, meeting them at their model of the world and being more of a sounding board or resource to them as opposed to someone who is instructing them, a giver of information, nonjudgmental, neutral and avoidance of imposing ones own judgments on another person, avoidance of advice giving, opinions…

Two participants talked specifically about using Carl Rogers' unconditional positive regard and both of these nurses were working on a master' degree or already earned the degree. One nurse even stated, "My number one thing, way before stabilization and safety, is Carl Rogers' Unconditional Positive Regard."

Many participants talked about starting where patients are at or trying to determine their needs in order to help them. Honesty, respect and consistency were mentioned also as part of person-centered. The following are some sample of quotes from different participants:

> …involving them in their care and developing that therapeutic relationship.
>
> …and so there is that effort to communicate to them that they are first and foremost a person.
>
> Basically, honesty's the best policy and you just ask them and you know, they want to talk about what's going on, and what they're willing to share what's going on, and not be really afraid of addressing issues or what their concerns are…

And another participant commented on person-centered care in a little different manner;

> Honesty for some reason always seems to keep coming as a key one. You gotta work hard to make sure we're not lying to patients, that they don't perceive we are lying to them…

Communication was the second subtheme to emerge related to the concept of trust. Sixty percent of the participants mentioned communication as important to developing trust. There were 16 references to communication. Listening was described as a key aspect of communication by two participants. One nurse commented,

> I think the kids trust you a lot more and they're more apt to come talk to you, if they know you listen to them and maybe you don't always agree with what they say, but what can we do to compromise here..

Communication was described as involving respect and consistency by two nurses;

> …communication, trust, and respectability. I would hope that clients would feel that they can know what they are going to get from me in terms of consistency.

> …that effort to communicate to them that they are first and foremost a person. I think that is an important thing because, however it might be… it might even be asking them if they slept well or it might be if they have pain, or finding out… putting them and their needs out there, verbalizing it, so they even stop and think, well did I sleep well or do I have pain or what is it I need?

Another participant talked about rapport being important in communicating with patients, "…listening was the main thing and developing a rapport, where they feel comfortable in gaining their trust." Another comment about openness of patients was shared as follows:

> I just think they open up more if they know they can trust you, if they know that you're listening to them and you're wanting to help. I think they are more open.

One nurse talked about using humor in their communication to relax patients:

> I try to banter with patients a little bit if it's appropriate. Some are not receptive or they are not where they can banter. A little bit of humor kind of relaxes them.

The last subtheme in developing trust that emerged in the data was *professional boundaries.* Five participants talked about the importance of boundaries with eight references discussing boundaries. This was identified as an issue that was different for many of the nurses who had worked in the acute care setting prior to coming to an inpatient psychiatric setting. One nurse summarized the difference in her comment,

> …there is a question of distance also. Both physical and spatial distance in that working as a nurse like on a med/surg floor, you can actually touch them, where as you cannot touch them in a psychiatric setting.

Another nurse described boundaries in terms of being aware of one's own mental health as a nurse:

> I think the key components are that a psychiatric nurse has to be in tune with her own mental health before she can be in tune, therapeutic-wise, with the patient. And if you see nurses that are not, we develop issues on the unit….You have to be in tune with yourself; you have to be mentally healthy.

Three participants identified this type of relationship as different from a friendship. One nurse described this concept eloquently in the following quote:

> Well, a therapeutic relationship is where you gain growth; it's not a person relationship. You are not their friend, you are not their buddy and you are not there to be their friend you know. You are here to help them be the best they can be.

Five participants just talked about boundaries as a general concept of which they needed to be aware in professional relationships. This could be attributed to the hospital where these nurses worked had a mandatory education component for all employees that clearly defined what the limits and boundaries of professional relationships are in the psychiatric inpatient setting.

Skill Acquisition

The third theme to emerge from the data was a discussion of how participants had developed their skills as psychiatric nurses and continued to develop them. Seventy percent of the participants talked about feeling inadequate in being therapeutic with patients when first starting in the field of psychiatric nursing or feeling still somewhat inadequate with certain types of patients. Some of the comments made were:

> At first not very much because, like I said, I don't have a psych background, I'm more med-surg/critical care, so I wasn't sure how I would go into it…

> I'm not good at forming those or attempting to form a therapeutic relationship with someone who's not receptive.

> I'm not quite as easy with it in acute care again… it's taking me a little longer because it's the setting I think.

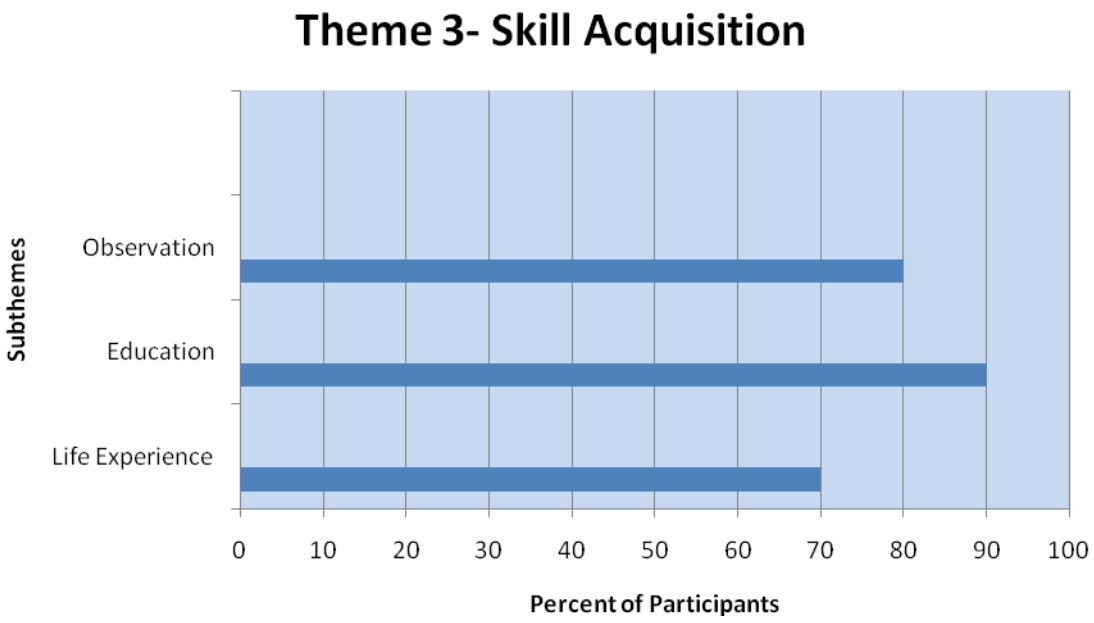
> When I first started working here I worked on the Adult unit and I had not a clue, they did not mention therapeutic relationship in orientation. I hadn't heard of it until I got into my third semester of grad school when we were at a post conference and the professor says "both of you need to work on your therapeutic relationship. This is not medical nursing."

> I think just finding my comfort level was the main thing. I think pushing myself to get out and sit with them. The first initial conversation is always somewhat a little awkward, but the patients are like the least judgmental people I've ever been around and once you realize that …

Interesting observation to note is that all the comments above were made by nurses with at least 18 years of experience in the nursing profession.

The chart in Figure 4 summarizes what types of learning helped the participants to improve their skills and acquire new skills in developing therapeutic relationships.

Figure 4. Theme 3-Skill Acquisition



Ninety percent of the participants identified continuing education such as workshops, reading, and videos helped them develop skills they now have in conducting therapeutic relationships. One nurse even requested additional training as indicated in her comments;

> I said to my boss, so if I really think I'm going to be a psych nurse, I better learn how to do this dang job, so that's when I started going to national conferences and I went to a lot of those, so I could learn how to be a psych nurse from the best of the best in the country.

Another nurse used reading as a way to grow in her skills; "I read a lot of books, almost to a fault. One of the things I have read a lot about is compassion." And another nurse simply stated, "more education; theory with new material is important and different levels moving on to a higher level of practice."

Eighty percent state that they learned through practice and observing others that were more skilled at interacting with patients. One nurse described her formative years in psychiatric nursing as follows:

> I had this wonderful opportunity to hear the therapists and counselors at work; I got to sit in on real therapy, real step work and I got to hear the professionals. The therapists taught me how to be the second, how to observe the group and how to pick up on the significant things or the things that were coming out and how to encourage other people and include them and how not to give advice.

Another participant loved the experience she was currently getting on the unit where she worked; "…watching others. I'm just loving this unit, where I get to observe people that have worked with this clientele for years and I love learning from them."

Seventy percent of the participants felt that life experiences helped them become more skilled at interacting with patients and of those seven nurses, three identified that skills in developing therapeutic relationships were "just common sense". Two participants had significant comments about how their life experiences prepared them to become psychiatric nurses in the following quotations:

> I think that my relationship with patients comes from years of learning to grow myself. And I couldn't have been a psychiatric nurse as a young nurse. I had to go through the bridges of growth and development really. But as the years grew and then I did more nursing and different kinds of nursing and was able to learn the skills of getting along with people and just everything that goes with being a nurse.

And the second comment;

> I used to laugh because I used to think all my other jobs actually blended me into this psych job. I think everything I did a head of time was training me to be a psych nurse; comes from working in the ER and working with surgical patients. I mean, they are terrified, so already there, you were learning how to put people at ease and get them to trust you so they will not be so afraid.

The comments that nurses made about these skills being common sense are interesting to note;

> Honestly, some of it was just common sense stuff that I thought, 'I can't believe they are writing a book on this and having us take a class,' but for some it wasn't common sense and it seemed to benefit them a lot.
>
> Forming a therapeutic relationship, I mean as far as boundaries and all that, to me that's kind of common sense stuff.
>
> Actually to me, common sense is the big thing. I mean you can have all the education in the world and if you can't talk to the kids (patients) you might as well just forget it.

Recruitment to the Profession

Mentoring and recruitment were recommendations that came from interviews with some participants. Five participants talked about how important educating student nurses in the psychiatric setting is for recruiting nurses to this specialty. They supported continuing to have clinical rotations as part of the basic nursing curriculum. One nurse talked about her own experience and entering psychiatric nursing later in her career;

> I know psych has always been an interest of mine over the years that I never pursued in any way. I was never really encouraged to, you know, starting my career. Now, of course, I think, man, I wish I had done this years ago, cuz I love it and I always knew I would. The inner workings of people, what makes them tick,

> what makes them go; some of the disasters they've lived through and still go on. It's amazing to me.

Another nurse discussed an experience with nurses floating from the acute medical departments to her unit and what a positive experience it was:

> When we had nurses that came from (the medical floor) and worked with us, they were just fantastic. They did a beautiful job, but it was the same old thing…'I don't want to work somewhere, where I have to take care of these people', but when we asked them to and they came over, they were so good. They felt good and they were open to it. And that says a lot about how we can develop good psych nurses.

Another participant talked about how he enjoyed mentoring students when they were on the unit with the following comment, "I really like when we have nursing students or somebody that does a rotation. I like to tell them to ask me why I did something and explain to them I'm not, the know all."

One participant strongly recommended that there be curriculum included on developing therapeutic relationships because it was not offered when she was in nursing school and she did not see the younger generation of nurses displaying person-centered and compassionate care to patients. Her comments about this were:

> It makes me wonder if there isn't enough of it taught; the therapeutic relationship. Maybe we need Therapeutic Relationship 101 with or without the psychiatric perspective. Do we need to teach new nurses the importance of that, positive regard, for themselves and others? The huge input that preparation makes, I think to the outcomes (in outpatient surgery), if they're (patients) informed, if they're regarded, if they're seen as human, if they have value, then the outcome's bound to be more positive.

Another piece of data that is interesting in relation to the comfort level that nurses reported in developing therapeutic relationships is that only three participants reported having covered therapeutic relationships in their basic preparations in nursing school. When asked about this finding during the member check, participants clarified their

earlier comments about the lack of curriculum in their basic program as perhaps related to the number of years that had passed since the nurses were in their basic education. In fact one participant remarked,

> I think this could be more a factor of when the nurses graduated. I know that in our program the techniques are covered extensively related to appropriate communication and therapeutic techniques. I wonder how many of the nurses you interviewed graduated several years ago.

The participants agreed during the face to face member check that perhaps more specificity about therapeutic relationships and the importance of trust would be important to include in current nursing education curriculum. Two participants commented that they had not truly understood therapeutic relationship until they attended graduate school and that it would be helpful to include in the basic nursing education curriculum. One comment made was,

> I really did not get it until I was in graduate school and then the light went on.

The results of this study produced a wealth of information about how nurses in the psychiatric setting perceive their role as nurses, focusing on four major themes. The roles they describe were most importantly patient safety, managing the unit, supporting patients in addition to performing the traditional nursing tasks required as part of hospital acute care nursing. The second major theme that emerged from the data was the development of trust as the crucial underlying element to all therapeutic nurse-patient relationships. The results identified four subthemes that contribute to the development of trust, which were the practice of person-centered care, being nonjudgmental, communicating and listening to the patient, and maintaining clear boundaries in the relationship.

The third major theme emerging from the data related skill acquisition as psychiatric nurses. The majority of the participating nurses described feeling inadequate when first entering the specialty of psychiatric nursing, yet most of them were able to develop their skills through continuing education, life experiences and observing others with skills greater than theirs.

The fourth and final theme that emerged from the data was the importance of student experiences in the psychiatric setting in recruiting nurses to the specialty of psychiatric nursing. This included mentoring students, adding to curriculum in nursing schools and providing clinical sites for students and other nurses to experience psychiatric nursing.

Chapter 5

Discussion of Findings

Discussion

The purpose of this study was to explore how nurses in the acute care psychiatric setting perceive their role as psychiatric nurses particularly related to developing a therapeutic relationship. The study attempted to determine whether there are differences in nurses' with less than 2 years experience in inpatient psychiatric nursing and those with greater than five years experience. Finally, nurses' perceptions of their preparation for conducting one-to-one counseling were explored. Ten nurses participated in 60 minute interviews each that involved answering a total of three demographic questions and eight open-ended questions related to their role as psychiatric nurses and how they developed their skills in therapeutic relationships.

Research Questions

The research questions explored during this study were:

- How do psychiatric nurses perceive their role in developing therapeutic relationships with patients?
- What are psychiatric nurses' perceptions of the adequacy of their education in preparing them to conduct one-to-one counseling?
- Are there differences in perceptions of psychiatric nurses with less than two years experience as compared to psychiatric nurses with more than five years experience in inpatient psychiatric nursing?

Presentation of Findings

The major theme that emerged related to how nurses perceived their role as psychiatric nurses involved four primary functions of patient safety, management of the unit and staff, supporting patients to be successful and traditional nursing tasks. It became very clear through the interview process that the nurses could not separate their identity and role as psychiatric nurses from how they perceived their role in therapeutic relationships. Several of the themes were interrelated as the nurses discussed them. For most of the participants patient safety was a primary objective and it dictated how they managed all their other duties and set priorities. This finding is supported by Cleary and Edwards study that they conducted with ten nurses in 1999. They also found that patient safety is primary concern for nurses on inpatient psychiatric units. When participants discussed patient safety, they included actions such as protecting patient rights, keeping them physically safe from harm and providing a safe place to be vulnerable and heal from their psychiatric illness. This theme related to the second major theme of developing trust as a key component of the therapeutic relationship. Several of the nurses talked about how a patient must feel safe in order to have trust to share their feelings and concerns with the nurses.

The second subtheme that emerged was the management of the milieu and staff. Nurses in psychiatric settings are often only one of two registered nurses or even the only registered nurse on duty during their assigned shift on each unit. This forces the nurse to assume the role of charge nurse because the remainder of the employees on duty are usually LPN's, or paraprofessionals with minimal education and no license. The nurses in the study who had worked in medical surgical setting prior to coming to the psychiatric

setting discussed how different this was and how at times they had difficulty adjusting to the different role. One participant even described herself as administrative rather than direct care. One participant talked about making sure that “things go smoothly during the day”

The third subtheme described by the study participants was that of a support person for patients. This involved patient education as well as supporting them to be successful in managing their illness. The majority of the nurses in the study described being a helper or guide to patients in helping them explore their life experiences and supporting them to be successful in life. One participant, who worked with adolescents, described herself as a “professional mom” This role involved giving patients the tools they need to make better decisions about their life and life circumstances. The literature supports this finding also. In a qualitative study completed in 1999 by Cleary and Edwards, the participants described positive, helpful and supportive interactions between staff as influencing nurse-patient interactions (Cleary, Edwards &Meehan, 1999). The nurses in the current study focused mostly on their relationships with patients. Interactions with colleagues were mentioned only as they related to advocating for a patient or protecting patient rights.

The fourth subtheme that emerged related to performing traditional nursing tasks. The majority of the nurses identified that admissions was a task that involved their time. This probably was due to the fact that the setting was an acute psychiatric hospital where the turnover of patients is quite rapid. Another large percentage of the nurses identified medication administration and monitoring as a second task that was involved in their role.

An interesting note was that 40 percent of the nurses discussed how their role had changed over the years from being more involved with patients and providing counseling to more focus on paperwork requirements and stabilization of patients. They attributed this to the shorter lengths of stays and more involvement of insurance companies in dictating care of patients. This finding is similar to the results of longitudinal study conducted in 2005 in Australia related to attrition and retention of the nursing workforce (Robinson, Murrells, Trevor & Smith, 2005). This same study however, cited other items of dissatisfaction in working in psychiatric nursing like overcrowding, increased paperwork and a stressful environment due to limited resources. Interesting to note, the nurses in the current study did not focus on the stresses in their environment other than mentioning the changes in how they have to focus their care. Their responses overall were positive and patient-centered with compassion for the patients.

The second major theme that emerged was the development of trust as the underpinning element in all relationships with patients. This is a unique perspective that was not evident in the literature review with similar studies that were completed related to nurses perceptions of their role in the psychiatric setting. Scanlon's (2006) study was the most closely aligned study with this research study and Scanlon identified the therapeutic relationship as a key component of nurse-patient relationships with an individualized focus of care, but the concept of trust was not articulated by those study participants as it was in the current study. Ninety percent of the nurses in this study identified trust as key in developing a therapeutic relationship and all participants felt that in order to develop trust in a relationship it had to be person-centered. Many of the nurses

were familiar with Rogers' concept of *Unconditional Positive Regard* (Videbeck, 2006) and adopted this model as the framework for their nursing practice.

The other two elements that the study participants identified as necessary to develop trust were a foundation of communication/listening and professional boundaries. The nurses discussed how communication needed to be consistent and honest with clear expectations in order to help patients feel safe psychologically in the inpatient setting. By developing an environment where patients feel safe, the nurses stated that then the patients would trust the staff enough to take their medications and try some of the interventions recommended by the treatment team for them to recover from their illness.

The fourth subtheme under the development of trust emerged as the nurses needing to establish clear, professional boundaries with patients. Several of the participants differentiated the therapeutic relationship from a friendship because patients and nurses sometimes mix these concepts up in psychiatric settings. One nurse talked about that when therapeutic relations and friendship are confused, it creates many problems on the unit for the patient involved and the entire program staff. Fifty percent of the participants identified clear boundaries as a key element in helping patients develop trust and therefore feel safe in their environment.

The third major theme that emerged in this study related to how the nurses acquired their skills in developing therapeutic relationships. The majority of the nurses identified not feeling prepared to interaction with patients when they first entered the field of psychiatric nursing, but as their experience increased the comfort level increased. Stickley's (2002) study supported this finding that nurses do not feel comfortable or prepared to work in psychiatric nursing when they first enter the field. All of the

participants indicated that they felt comfortable currently in their careers in developing therapeutic relationships the majority of the time. Two nurses indicated that there were certain types of patients they still had difficulty interacting with and these were patients who were negative or those unable to accept kindness. All of the nurses in the study had at least a year and half experience in psychiatric nursing and one nurse stated that it took her about a year and a half to feel comfortable in interacting with patients.

The majority of the nurses indicated that their life experiences and maturity helped them be better psychiatric nurses and more comfortable with developing therapeutic relationships. The nurses in Scanlon's (2006) study also identified experiential learning as an informal process for developing additional skills. One nurse commented that she would not have been able to work in the psychiatric setting as a young nurse. Ninety percent of the participants identified that they continuously participated in ongoing education throughout their careers to improve their skills as psychiatric nurses. Many attended workshops regularly and found these to be the most helpful, especially those focused on diagnosis and new medications. Others talked about reading articles and books and some used videos as a means to improve their skills. Eighty percent of the nurses also used observation of coworkers' interactions with patients as a way to improve their skills. When the participants discussed observing others in the treatment setting, they did not discriminate based on education level or profession. In fact, many identified that the employees with the greatest skills in interacting with patients were the paraprofessionals who were out on the floor interacting with patients the entire shift. It is interesting to note that only one participant identified the hospital orientation as being helpful in developing therapeutic relationships.

The final theme related to utilizing student experiences as a means of recruiting nurses to the profession. The theme included using clinical experiences in the psychiatric setting as a means of recruiting to the specialty of psychiatric nursing. Several of the participants discussed the importance of having students on their units so that they could provide guidance to them and offer a positive image of psychiatric patients. Others pointed out the need to maintain psychiatric nursing and in particular, how to create a therapeutic relationship, as part of the basic curriculum for preparation of nurses. This is consistent with the findings in the literature. Several studies in Australia reviewed work shortage issues in mental health nursing and identified the need to add to curriculum in nursing programs at the entry level preparation (Chambers, Connor & Davren, 2006; Clinton & Hazelton, 2000; Scanlon, 2006).

Review of the Research Questions

The first research question asked "How do nurses perceive their role in developing therapeutic relationships?" The data from this study clearly indicate that nurses perceive the development of therapeutic relationships as correlated with their role as psychiatric nurses. The nurses identified four major responsibilities in their role, which impacted directly or indirectly the development of therapeutic relationships with patients. Trust emerged as a key component for nurses in developing therapeutic relationships and unanimously agreed that in order to develop trust the relationship had to be person-centered.

The second research question asked, "What are psychiatric nurses' perceptions of the adequacy of their education in preparing them to conduct one-to-one counseling?" The themes that emerged from the data did not focus on adequacy of preparation as much

as how the nurses developed their skills in interacting with patients over the life of their career. The participants all indicated they felt comfortable with their skills in therapeutic relationships at the time of the interviews, but most talked about how they participated in ongoing learning experiences to improve their skills. One factor might be that all the nurses had more than one and one-half years of experience in psychiatric nursing.

The final research question was "Are there differences in perceptions of psychiatric nurses with less than two years experience as compared to psychiatric nurses with more than five years experience in inpatient psychiatric nursing?" The data did not demonstrate significant differences in nurses with less than two years experience in nursing and this could be due to an inadequate sample because only one participant had less than two years experience in nursing. There seemed to be more differences related to the unit the nurses were assigned to and their particular job rather than years of experience.

Limitations of the Study

There are some limitations to the findings in this study. First, the participants were in the chain of command of the investigator and this could have limited the openness of the responses and limited the richness of the data. As noted previously, the participants presented mostly positive and compassionate responses about their role as psychiatric nurses. This differed from some of the studies in the literature related to the stressful working conditions of psychiatric nursing. The participants may have held back in talking about those issues because of a perception that it might not be acceptable to discuss with the investigator.

All the participants worked in the same hospital so the data may not be transferable to a different hospital or community and may not be able to be generalized to urban areas and other rural parts of the country. Sixty percent of the participants had three or more years experience so the findings may not be generalizable to new graduates or nurses with less than three years experience in the field of psychiatric nursing.

Recommendations for the Profession

The findings in this study raise some new perspectives not previously found in the literature related to what components are key in developing therapeutic relationships. The development of trust emerged so clearly as a major theme that it would be worth further research in other psychiatric hospitals and mental health settings to more clearly define how one develops trust. Further research on the relationship of patient safety and trust is recommended as this was another strong theme that emerged from this study.

There were several recommendations that may need to be considered by schools of nursing as curriculum revisions are made. There was overwhelming support to continue to have mental health/psychiatric nursing as a clinical rotation in schools of nursing with an emphasis on how to develop a therapeutic relationship. There might be a need to incorporate more of a focus on the development of trust in nurse-patient relationships as the underpinning for a therapeutic relationship. This concept could be a strand that would cross all areas of nursing, not just the mental health nursing component of the overall curriculum. Another recommendation for curriculum would be to address the issues around the professional relationship and boundaries that are much more important in the psychiatric setting versus other settings in nursing. And finally, the

concept of person-centered nursing resonated with all the participants and this should continue to be a key concept taught at the basic preparation level in nursing.

A final recommendation to the practice setting is to incorporate more content related to developing therapeutic relationships in hospital orientation and employee educational offerings. At the same time there needs to be opportunities for practice and observation of appropriate interactions with patients in the inpatient setting.

New Framework Proposed

As the data analysis progress, the strong connection between the development of trust and patient safety emerged. Both of these concepts seem to be closely related to patient-centeredness in relationships and appear to be the foundation for therapeutic relationships. The participants linked patient safety with trust development because patients need to feel safe in order to develop trust of the caregiver and if the caregiver uses a patient-centered approach it fosters a safe environment and promotes trust.

The data suggests a new model for therapeutic relationships be considered and is presented here for consideration by the profession in Figure 5 on page 54. The model suggests that safety and trust need to be in balance with each other and support a person-centered approach to patients. These three components are necessary for a therapeutic relationship to develop.

Figure 5. Taylor-Trujillo Model of Therapeutic Relationships

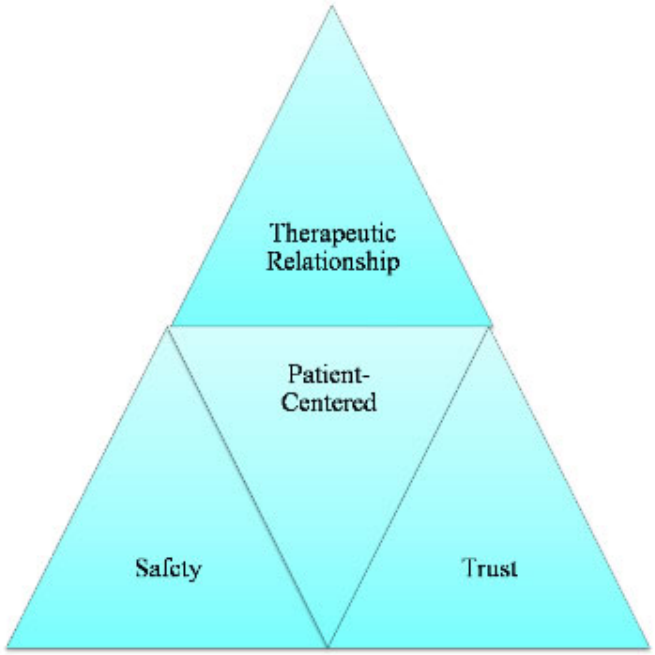


Figure 5. Proposed model for understanding the foundation of therapeutic relationships. Trust and safety balance each other and support a patient-centered approach to relationships. These three components are the foundation for therapeutic relationships to develop.

Appendix A

Institutional Review Board Approval

December 5, 2008

College of Saint Mary
7000 Mercy Road
Omaha, NE 68106

Dear Ms.Taylor-Trujillo:

The Institutional Review Board at College of Saint Mary has granted final approval of the Consent Form and Invitation for your study titled, *Psychiatric Nurses' Perceived Competence with Developing a Therapeutic Relationship.*

You will find the Consent Form with the approval stamp attached to this email. You will also find a copy of this approval letter attached for your convenience.

You may now make official copies of your consent forms directly from the attached document.

The Committee has assigned approval number CSM 08-72. The approval will expire in one calendar year, December 5th, 2009.

A copy of the "Rights of Research Participants" form is included below. Remember that you are required to make copies and give a copy to each research participants.

I would like to commend you, on behalf of the IRB, for your diligent work in making the required changes and receiving full approval of your research proposal. Best of luck with your research project!

Sincerely,

Melanie K. Felton, Ph.D.
Associate Professor
Chair, Institutional Review Board
mfelton@csm.edu

7000 Mercy Road • Omaha, NE 68106-2606 • 402.399.2400 • FAX 402.399.2341 • www.csm.edu

Appendix B

Invitation to Participate

You Are Invited To Be a Participant In Nursing Research....

I am a doctoral student at College of Saint Mary and am conducting a study on how Psychiatric Nurses perceive their role, particularly in the area of developing therapeutic relationships.

The study will involve at least one interview up to one hour in length with no more than three interviews total.

If you would like to be part of this exciting research and contribute to the body of knowledge about psychiatric nurses please contact me.

Ann Taylor-Trujillo

anntay17@hotmail.com

Appendix C

Letter of Consent

IRB # CSM 08- 72

PSYCHIATRIC NURSES' PERCEIVED COMPETENCE WITH DEVELOPING A THERAPEUTIC RELATIONSHIP-A RESEARCH PROPOSAL

Invitation
You are invited to take part in this research study. The information in this form is meant to help you decide whether or not to take part. If you have any questions, please ask.

Why are you being asked to be in this research study?
You are being asked to be in this study because you are a nurse employed in a psychiatric inpatient setting with experience in psychiatric nursing.

What is the reason for doing this research study?
It is important to understand the experiences of nurses in psychiatric inpatient units in developing therapeutic relationships with patients.

What will be done during this research study?

You will be asked a series of open-ended questions about your perceptions of the role of psychiatric nurses and the development of therapeutic relationships with patients from a prepared questionnaire during individual interviews conducted by one of the researchers.

The data will be audio taped for later transcription and recording of your verbal and non-verbal communication.

The initial interviews will last no more than one hour in length. Follow up interviews will be conducted if more information is needed at no more than one hour each. There will be no more than a total of three interviews.

The interviews will be conducted in a place of your choosing that is quiet and provides for confidentiality.

The audio tapes will be destroyed at the conclusion of the analysis of data.

Participants Initials_____

What are the possible risks of being in this study?

There are no known risks to you from being in this research study.

What are the possible benefits to you?

The information obtained from this study will be shared with you. However, you may not get any direct benefit from being in this research study

What are the possible benefits to other people?

The information obtained from this study is intended to provide a better understanding of psychiatric nurses' experience with therapeutic relationships.

What are the alternatives to being in this research study?
Instead of being in this research study you can choose not to participate.

What will being in this research study cost you?
There is no cost to you to be in this research study.

Will you be paid for being in this research study?
You will not be paid or compensated for being in this research study. However, refreshments will be provided during the interview.

What should you do if you have a problem during this research study?
Your welfare is the major concern of every member of the research team. If you have a problem as a direct result of being in this study, you should immediately contact one of the people listed at the end of this consent form.

How will information about you be protected?
Reasonable steps will be taken to protect your privacy and the confidentiality of your study data. The only persons who will have access to your research records are the study personnel. Your identity will be kept strictly confidential.

Participants Initials_____

What are your rights as a research participant?

You have rights as a research participant. These rights have been explained in this consent form and in *The Rights of Research Participants* form you have been given. If you have any questions concerning your rights, talk to Ann Taylor-Trujillo at 308-293-7147.

What will happen if you decide not to be in this research study or decide to stop participating once you start?

You can decide not to be in this research study, or you can stop being in this research study ("withdraw") at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator, or with College of Saint Mary.
You will not lose any benefits to which you are entitled.

If the research team gets any new information during this research study that may affect whether you would want to continue being in the study, you will be informed promptly.

Documentation of informed consent
You are freely making a decision whether to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study.

If you have any questions during the study, you should talk to one of the investigators listed below. You will be given a copy of this consent form to keep. If you are 19 years of age or older and agree with the above, please sign below.

Signature of Participant: _____Date_____Time_____

My signature certifies that all the elements of informed consent described on this consent form have been explained fully to the participant. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research and is voluntarily and knowingly giving informed consent to participate.

Signature of Investigator _____Date_____

Authorized Study Personnel

Principal Investigator: Ann Taylor-Trujillo, RN, MSN Phone No: 308-293-7147

Secondary Investigator: Peggy Hawkins, PhD, RN, BC, CNE Phone No: 402-399-2658

Appendix D

Participant Rights Document

THE RIGHTS OF RESEARCH PARTICIPANTS*

AS A RESEARCH PARTICIPANT ASSOCIATED WITH COLLEGE OF SAINT MARY YOU HAVE THE RIGHT:

1. TO BE TOLD EVERYHING YOU NEED TO KNOW ABOUT THE RESEARCH BEFORE YOU ARE ASKED TO DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH STUDY. The research will be explained to you in a way that assures you understand enough to decide whether or not to take part.

2. TO FREELY DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH.

3. TO DECIDE NOT TO BE IN THE RESEARCH, OR TO STOP PARTICIPATING IN THE RESEARCH AT ANY TIME. This will not affect your relationship with the investigator or College of Saint Mary.

4. TO ASK QUESTIONS ABOUT THE RESEARCH AT ANY TIME. The investigator will answer your questions honestly and completely.

5. TO KNOW THAT YOUR SAFETY AND WELFARE WILL ALWAYS COME FIRST. The investigator will display the highest possible degree of skill and care throughout this research. Any risks or discomforts will be minimized as much as possible.

6. TO PRIVACY AND CONFIDENTIALITY. The investigator will treat information about you carefully and will respect your privacy.

7. TO KEEP ALL THE LEGAL RIGHTS THAT YOU HAVE NOW. You are not giving up any of your legal rights by taking part in this research study.

8. TO BE TREATED WITH DIGNITY AND RESPECT AT ALL TIMES.

THE INSTITUTIONAL REVIEW BOARD IS RESPONSIBLE FOR ASSURING THAT YOUR RIGHTS AND WELFARE ARE PROTECTED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS, CONTACT THE INSTITUTIONAL REVIEW BOARD CHAIR AT (402) 399-2400.

***ADAPTED FROM THE UNIVERSITY OF NEBRASKA MEDICAL CENTER , IRB WITH PERMISSION**

7000 Mercy Road • Omaha, NE 68106-2606 • 402.399.2400 • FAX 402.399.2341 • www.csm.edu

Appendix E

Interview Schedule

Interview #_____ Date _____

1. **What is your educational preparation?**

2. **How many years of nursing practice do you have?**

3. **How many years in psychiatric nursing?**

4. **Describe your role as a psychiatric nurse?**

5. **How would you define a therapeutic relationship?**
   What are the key components?

6. **Tell me about your experience of developing therapeutic relationships.**

7. **How did you learn about forming therapeutic relationships?**

8. **How adequately prepared do you feel to develop a therapeutic relationship?**

9. **What might help you improve your skills in therapeutic relationships?**

10. **Is there anything else that I haven't asked you that you would like to share with me?**

11. **Additional encouraging statements will be used throughout the interview to assist the participant in expanding answers such as "Tell me more about that", "Interesting.**

Appendix F

Sample Member Check Letter

February 16, 2009

Dear :

Thank so much for participating in the research interview on 01-28-09. I greatly appreciate your willingness to share your insights on the study entitled Psychiatric Nurses Perceived Competence with Developing a Therapeutic Relationship.

Enclosed you will find a verbatim transcript of our conversation for you to review. As part of the research process, it is important that participants confirm the accuracy and completeness of our conversation. Please read the manuscript, make any changes or corrections, and place in my box or turn it into my office inside the pre-addressed envelope. If you do not need to make any changes please return this form in the pre-addressed. Your signature confirms the receipt of the transcript and acknowledges your belief that the transcript is a complete and accurate portrayal of our conversation. I would appreciate the return of the corrections or confirmation by February 27, 2009.

Again, thank you for your time and effort in participating in this research study. Your input is important. Please let me know if you have any questions or comments.

Sincerely,

Ann Taylor-Trujillo, RN, MSN
anntay17@hotmail.com
308-293-5122

I, _____, acknowledge receipt of the verbatim transcript of my
(please print your name)
interview with Ann Taylor-Trujillo for the research Psychiatric Nurses' Perceived Competence with Developing Therapeutic Relationships.

My signature indicates I believe the transcript to be an accurate and complete account of our conversation.

_____ _____

(Signature) (Date)

Appendix G

Audit Trail Letter

July 20, 2009

Elizabeth Ann Taylor-Trujillo has requested a qualitative research audit on Psychiatric Nurses' Perceived Competence with Developing Therapeutic Relationships. The purpose of this audit was to determine the degree to which the results of the study are trustworthy. The qualitative research audit was conducted in January through July 2009 and concluded on July 20, 2009.
An audit trail is conducted to provide accountability outlining the research process and the systematic thematic analysis (Miles & Huberman, 1984; Huberman & Miles in Deglin and Lincoln 1994; Lincoln and Guba 1985; Moustakas, 1994)

The audit was conducted by taking the following six steps:

1. Listened to audiotapes and examined verbatim transcripts.
    a. Listened to taped conversation and read transcriptions.
    b. Checked for added, omitted, or incorrect or inverted words.
    c. Findings: Transcription errors were negligible. There were no errors that affected or altered the meaning of data. Therefore, the effect of transcription error or data analysis is deemed non-existent.
2. Reviewed researcher's (s') notes and materials
    a. Institutional Review Board application and approval
    b. Coded transcriptions
    c. Researcher's notes
    d. Coding notes
    e. Dissertation draft
    f. Interview guide
    g. Findings: The files included the required information and approval forms.
3. Reviewed participants' consent forms
    a. Signed forms were consistent with approved forms by the Institutional Review Board
    b. Findings: All participants signed and gave consent to participate in the study.
4. Reviewed coding processes
    a. Researcher's notes indicated a transparent decision making trail of horizontilization and categorical aggregation.
    b. Findings: Data supported the identified theme.
5. Read draft dissertation
    a. Report was read in its entirety with careful review of purpose, design, verification of data quality, and use of theory.

   b. Findings: Theory and literature were described accurately. Ample description and direct quotes were consistent with the identified themes.
6. Reviewed purpose of this audit
   a. The overall product and process was reviewed.
   b. Findings: Appropriate procedures were utilized in producing the conclusions and findings. The data were accurately reported.

Based on the process outlined by Creswell (2007) the following conclusion is made:

Conclusion

In my opinion the study, Psychiatric Nurses' Perceived competence with Developing Therapeutic Relationships, followed established processes for qualitative studies. This study remained consistent with its intended purpose statement, Institutional Review Board approval, and proposal as approved by the Dissertation Committee. The researcher's steps were clearly transparent and documented. Data were logically analyzed and supported by quotes from informants. Procedures were followed as outlined. There was evidence of the following activities: prolong engagement, member check, thick and rich descriptions, and transparent audit trail. The utilization of Moustakas (1994) method of qualitative analysis lends credibility to the findings and conclusions.

In summary, the researcher satisfied the criteria for dependability and confirmability of findings.

Attested to this 20th day of July in the year 2009.

Sincerely,

Peggy L. Hawkins, PhD, RN, BC, CNE

Professor

College of Saint Mary

7000 Mercy Road

Omaha, NE 68106

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