

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

The therapeutic relationship
Perceptions of mental health nurses

A thesis presented in partial fulfilment of the requirements
for the degree of
Master of Philosophy in Nursing
at Massey University
Albany campus, New Zealand

Anthony John O'Brien

2000

ABSTRACT

The therapeutic relationship is a concept that has become central to the identity and practice of mental health nurses since it was formulated by nursing theorists in the 1930s. Most commonly associated with the work of the late Hildegard Peplau, the therapeutic relationship has been considered both fundamental to nursing generally and to capture the unique focus of mental health nursing: interpersonal engagement with consumers of mental health services. However this dual role, and the absorption of specialist mental health nursing education into generalist nursing education, has left the specialty in a problematic situation in identifying and articulating its unique contribution to mental health care. This problem is at its most acute in inpatient settings where, ironically, mental health nursing has its strongest historical roots.

In this study I have sought to describe mental health nurses' perceptions of the therapeutic relationship. Rather than ask, as many previous studies have done, whether mental health nurses interact therapeutically with consumers I have sought the views of mental health nurses themselves. A constructionist research paradigm has been used to develop the research. From within a constructionist paradigm, phenomena are seen as socially constructed rather than objectively available for observation. Language is regarded not as a transparent medium of description, but as theory-laden. Focus groups were used to gather data from experienced nurses in three different practice settings; inpatient care, community care and from nurse-therapists. By attending to the group as the focus of analysis it was possible to develop a broad view of the therapeutic relationship.

The themes reported here describe the therapeutic relationship as fundamental to mental health nursing, independent of theoretical accounts of mental health nursing and mental health care, and with a wide scope, from facilitative listening to involvement in coercive interventions. The therapeutic relationship in mental health nursing has emerged as a phenomenon socially constructed by its development as part of a therapeutic discourse in mental health care in the middle of the last century, and through the influence of current practice contexts. From the description developed in this study it has been possible to make recommendations for mental health nursing education, research and practice.

ACKNOWLEDGEMENTS

I would like to thank all those who helped in the process of developing this thesis. Without the help and support of family and colleagues writing the thesis would have been an impossible undertaking.

I would especially like to thank my partner Joan, for her patient support and encouragement. Also my children Clare, Gabrielle and Timothy for their tolerance of my absence and preoccupation during the long periods of writing.

Christine Palmer provided academic support and critique over a two year period. Christine's passion for mental health nursing, honest critique of the early drafts, and doggedness in the face of my persistent grammatical crimes has contributed immensely to the work. I received valuable critique on the section on constructionism from Ray Nairn, and on the themes chapters from Sharon Rydon. I am grateful for help received from Saira Khan and Toni Cathie who assisted by typing transcripts.

To the subscribers to the psychiatric nurses' and qualitative researchers' internet discussion lists who responded to questions and shared ideas that contributed to the ideas presented here, I am grateful for the interest, enthusiasm and generosity of colleagues I have yet to meet.

The many students and colleagues who discussed aspects of this work with me during the course of the study have helped in immeasurable ways to develop the ideas presented here. I owe a special debt of gratitude to the nine participants who gave freely of their time to participate in the interviews. I hope you feel that in the end the time was well spent, and that the thesis presented here is true to the views you expressed.

The study was conducted with ethics approval from the Massey University Human Ethics Committee and the Auckland Ethics Committee.

CONTENTS

Abstract	II
Acknowledgements	III
Contents	IV
List of Tables	VIII

Part One. Introduction and literature review

Chapter One. Introduction to the study	9
Background to the study	9
Research aims, purpose and questions	12
A note on terms	13
Organisation of the thesis	15
Part One. Literature review..	15
Part Two. Methodology and methods	15
Part Three. Description of the study and research themes	16
Part Four. Discussion and conclusions	16
Chapter Two. Literature review: The therapeutic relationship in mental health nursing	
Introduction	17
Interpersonal relationships in the early asylums	18
The influence of nursing theorists	19
Interpersonal influences in British mental health nursing	22
New Zealand nursing literature	24
Influence of medical interventions	25
The therapeutic relationship in mental health nursing texts	27
Nursing therapy and nurse-therapists	28
June Mellow: Nursing therapy	29
Claire Fagin: Psychotherapeutic nursing	30
Isaac Marks Nurse behaviour therapy	31
Therapy provided by mental health nurses	32
The nurse therapist in New Zealand	32
Critique of nurse-therapist roles	32
The therapeutic relationship in recent New Zealand literature	33
Constraints on the therapeutic relationship	36
Fundamental and special?	37
The therapeutic relationship: Critique and new directions	37
Consumerism and mental health nursing	38
Therapeutic relationships and coercive power	39
Theoretical critique	39
Responses to critiques of the therapeutic relationship o	40
Collaborative re-authoring	40
Therapeutic alliance	41
Recovery	41
The therapeutic relationship: An adequate basis for professional continuity?	42
Justification for the current study	43
Summary	43

Part Two. Methodology and methods	
Introduction to Part Two	45
Chapter One. Constructionist research	
Introduction	46
The language of constructionism	46
Constructionism, knowledge and reality	47
The nature of the constructionist research paradigm	49
Constructionism and nursing research	49
Criticisms of the constructionist research paradigm	50
Criteria	50
Critical purchase	51
Authority	51
Epistemological claims	52
Constructionism and mental health nurses perceptions of the therapeutic relationship	52
Summary	53
Chapter Two. Focus groups and nursing research	
Introduction	54
Group interaction	55
Generation of concepts	55
Numbers of participants and groups	56
Constitution of groups	56
Structure	57
Moderator influence and issues of power	57
Usefulness of focus group data	58
Analysis of focus group data	58
Appropriateness of focus groups for the current study	59
Summary	61
Chapter Three. Ethical issues	
Introduction	62
Informed consent	62
Confidentiality	63
Minimising of harm	63
Truthfulness	64
Social sensitivity	64
Chapter Four. Research methods	
Introduction	65
Sampling	65
Interview schedule	66
Data collection	66
Transcription of interviews	68
Analysis	68
Approaching the process of analysis	68
Literature	70
Preliminary analysis in the process of data collection.	72
Data display	73

Steps of the analytic process	73
Chapter Five. Soundness of the research	
Introduction	76
Soundness and reflexivity	76
Position adopted on reflexivity	77
Member checking and the creation of text	78
The decision trail	78
Part Three. Results	
Chapter One. Characteristics of participants and overview of themes	
Introduction	79
Characteristics of participants	79
The groups	80
The nurse-therapist group	80
The community nurses' group	82
The inpatient nurses' group	83
Themes	84
The therapeutic relationship as fundamental to mental health nursing.	84
Theory and the therapeutic relationship	84
The scope of the therapeutic relationship.	84
Chapter Two. Theme One. The therapeutic relationship as fundamental to mental health nursing.	
Introduction	86
Learning about the therapeutic relationship	87
The fundamental nature of the therapeutic relationship	90
Summary of theme one	93
Chapter Three. Theme two: Theory and the therapeutic relationship.	
Introduction	95
The therapeutic relationship as atheoretical	98
Use of other resources in developing therapeutic relationships	101
Theory use as unconscious / eclectic	105
Use of theoretical concepts	108
Relationship to the practice context	110
References to nursing theorists	113
Summary of theme two	114
Chapter Four. Theme three: The scope of the therapeutic relationship	
Introduction	115
The formative influence of inpatient experience	117
Dealing with difficult situations: The inpatient nurses.	120
Dealing with difficult situations: The nurse-therapists	122
Dealing with difficult situations: The community nurses	123
Summary of theme three	126
Part Four. Discussion and conclusions	

Chapter One. Discussion	
Introduction	127
The therapeutic relationship as fundamental	128
Theory and the therapeutic relationship	129
The scope of the therapeutic relationship	131
Nursing theory	134
The therapeutic relationship: contrast with medical literature	136
The social construction of the therapeutic relationship	136
Methodology	137
Strengths and limitations of the study	138
Inductive research	138
Partial perspective	139
Number of participants and groups	139
Focus	140
Mental health nursing literature	140
Characteristics of participants[140
 Chapter Two. Conclusions	
Introduction	141
Recommendations for education	142
Recommendations for research	143
Recommendations for practice	144
 Epilogue	147
 References	148
 Appendices	
Appendix A. Information for Research Participants	167
Appendix B. Consent Form for Research Participants	169
Appendix C. Transcriber's acknowledgement of confidentiality	170
Appendix D Notice announcing research and seeking participants	171
Appendix E Data Collection Form	172
Appendix F. Example of interview transcript showing column notes made in process of analysis	173
Appendix G Explanation of abbreviations used in transcripts	174
Appendix H Section of transcript from interview with community nurses	175

LIST OF TABLES

Table 1. Characteristics of participants	80
--	----

Part One. Introduction and literature review

Chapter One. Introduction to the study

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

T.S.Eliot. Little Gidding

Background to the study

My interest in the concept of the therapeutic relationship began as an attempt to clarify for myself the nature of mental health nursing. The therapeutic relationship has become fundamental to the identity of the profession (Olson, 1996) and yet does not in itself provide a secure or uncontested basis for professional continuity. It may seem somewhat ironic that after more than twenty years in mental health nursing I feel sufficiently unsure about the nature of my profession to devote a large amount of time and energy to investigating such a fundamental aspect of it. Yet inquiry into professional identity cannot be regarded as complete or final. Challenges thrown up by economic rationalism, consumerism and changes to the nature and scope of professional practice, make reflection on professional identity more, rather than less critical. In the urgency to respond to the challenges currently facing mental health nurses it is possible to overlook something that is easily taken for granted.

The rewards gleaned from the process of conceptualising the project, reviewing the literature and conducting the study have amply justified the effort involved. While I would hesitate to claim that I 'know' what the nature of the therapeutic relationship in mental health nursing is, I at least have a clearer idea of how it is constructed in the nursing literature and in the thinking of some practitioners. Although the nature of therapeutic relationship appears more, rather than less problematic, I am more confident that the concept has meanings which,

although they may not be specific to mental health nursing, are significant for the discipline, and which need to be recognised and nurtured.

As I immersed myself in the literature of mental health nursing and in the wider mental health nursing discourse, it seemed at times that the study was limited by its focus on a single construct with a relatively small group of nurses. However as the study progressed I became aware that by focusing sharply on a single construct, the therapeutic relationship, wider issues that impinge on mental health nursing became more apparent. The issue of the role of theoretical, as distinct from practical knowledge, was one of these issues. It is apparent from both the literature and from the accounts of participants, that theoretical knowledge plays a varying role in clinical practice. While the more structured nature of the work of the nurse-therapists lends itself to practice structured according to formal theories, the less structured nature of the work of inpatient nurses appears less amenable to such formal theorising. However, even for the nurse-therapist group, theory had its limitations and the group drew on both theoretical and experiential resources in their attempt to develop an account of the therapeutic relationship.

The concept of the therapeutic relationship was meaningful to all groups of nurses, albeit in different ways. While it is a concept located within the theoretical tradition of psychodynamic psychiatry it serves as an implicit, rather than formal theoretical understanding for the participants in this study.

It appears that as nurses move away from inpatient care it becomes easier to appropriate a range of theoretical resources with which to extend their practice. The concept of the therapeutic relationship has enabled mental health nurses to conceptualise their practice as beneficent and therapeutic rather than custodial. However, in inpatient care there has been minimal development of concepts of care which recognise the changeable and unpredictable nature of the inpatient context. Discussion of this problem in the literature was reflected in inpatient nurses' predominantly practical accounts of the therapeutic relationship.

A significant finding is that mental health nurses appear to have a distinct ethical orientation to mental health care, that allows assertive, even coercive interventions to be conceptualised as therapeutic. While the potential of this conceptualisation to lead to ethically unjustified

paternalism needs to be recognised, it also allows nurses to maintain a stance of therapeutic involvement in circumstances in which unqualified respect for autonomy might not be in consumers' wider interests.

Another issue that I became acutely aware of in the course of the study was the significance for mental health nurses in New Zealand of the dearth of indigenous mental health nursing literature. New Zealand like many other former colonies, is in the position of having imported a British system of psychiatric care (Sutch, 1966) and general education (Dakin, 1973), while, especially recently, having absorbed American influences in nursing education (Christensen, n.d.; Litchfield, n. d.). This might be expected to influence themes in accounts of mental health nursing. Because of the lack of literature, New Zealand mental health nurses are unable to locate their self understanding within their own history, but are obliged to see themselves in terms of the British history of mental health nursing. This thesis goes some way towards addressing this issue, but there still remains a significant lack of research and literature on mental health nursing in New Zealand. The historical background of mental health nursing in New Zealand is yet to be fully explored.

I am particularly interested in how the concept of the therapeutic relationship interacts with other theory, and with models of therapy and care that make up the diversity of mental health nursing practice. The construction of rational accounts of practical activities such as nursing is fraught with the difficulty that a theoretical account can never do justice to the complexity of skilled practice (Schon, 1992). The dilemma this creates for nurses is that their practice must nevertheless be explained, justified, defended, articulated and taught. At least part of this process requires the construction in language of accounts (Tilley, 1995). In turn the accounts created influence practice, either through the deliberative application of developed theories, or through the prereflective embedded knowledge of practice.

Previous literature has focused on the adequacy of nurses' theoretical accounts, sometimes finding that nurses are unable to articulate their practice in terms of either a theoretical perspective (Altschul 1971, Cormack 1976, Howard 1983) or a professional discourse (Morrall, 1998a). Other literature has provided inductively derived accounts of practice that suggest a coherent rationale for practice and the development of complex, yet sometimes invisible practical skills (McElroy 1990; O'Brien, 1999; Tilley 1995). The current study focuses on

nurses' perceptions of the therapeutic relationship and their integration of other theoretical frameworks with this central concept.

Constructionist theory has underpinned the research in terms of both the methods used and the conceptual lenses brought to bear on the data. By viewing the data within a constructionist framework, particularly through the work of Berger and Luckmann (1966), Gergen (1985) and Burr (1995), it has been possible to situate the therapeutic relationship within the therapeutic discourse of the mid-twentieth century, and to understand the therapeutic relationship as a socially constructed phenomenon.

Research aims, purpose and questions

The research aimed to document experienced mental health nurses' perceptions of the therapeutic relationship in their practice. The purpose was to develop an account of the meanings given to this concept which has contributed significantly to the development of the identity of mental health nurses. The therapeutic relationship has been described in formal theories of nursing (Orlando, 1961; Peplau 1952/1988; Travelbee, 1971) that form the basis of undergraduate curricula and text books (Keltner, Schwecke, & Bostrom, 1999; Stuart, & Laraia, 1998). Nurses are also expected to integrate a wide range of research and different theoretical frameworks into their practice. It was therefore thought useful to talk directly to practitioners about their perceptions of the therapeutic relationship and the theoretical resources underlying their practice.

Three specific questions structured the research. They were;

1. What are experienced mental health nurses' perceptions of therapeutic relationships in their practice?
2. Are there differences between inpatient, community based nurses and nurse-therapists in the way the therapeutic relationship is perceived?
3. How do nurses integrate other conceptual models of mental health care into their practice?

The research was intended to describe how participants perceive their practice, using the therapeutic relationship as a means of exploring those perceptions. Thus there are many important questions that this research does not address and cannot answer. Consumers' perceptions are not explored, and the effectiveness of nursing action is not considered. The

contribution of the study to the understanding of nursing practice must be seen in the light of its specific focus, the perceptions of practitioners.

A note on terms

In the nursing literature a number of terms have been used to refer to what I call in this study, the therapeutic relationship. My reason for using this, rather than a similar term (interpersonal relationship, nurse-patient relationship, human-to-human relationship, helping relationship, therapeutic alliance), is that the term was suggested by participants in an earlier study as central to their practice (O'Brien, 1999). I also found that the term had a ready resonance with practitioners in talking about their practice. This choice of term was confirmed in the process of data collection when participants readily engaged in discussion about it.

There are two other terms, and associated variants, that occur frequently in the mental health and mental health nursing literature, about which there is no consensus and which are freighted with meaning and ideology no matter which variant is used. They are; 'mental health nurse' and 'consumer'. In using these terms I have taken a position in relation to professional identity and within the discourse of mental health care. What follows is a brief explanation for these choices, although it is acknowledged that equally cogent reasons could have been advanced in support of some of the alternatives. I will also explain the reasons for a certain amount of variation in the use of these terms within the body of the thesis.

I have used the term 'mental health nurse' in preference to the alternatives of 'psychiatric nurse' or 'psychiatric/mental health nurse'. My reasons for this are partly pragmatic and partly ideological. Firstly, the term 'mental health nurse' is the preferred title used by the professional body, the Australian and New Zealand College of Mental Health Nurses which speaks on professional issues for nurses working in the areas of mental health and psychiatric care in New Zealand. While I do not wish to foreclose on valuable debate in this area I find it useful to use a consistent term that is widely understood and accepted by nurses, policy makers and other professionals. It is my observation, and I do not insist that it is irrefutable, that the term 'mental health nurse' most closely meets the first of my criteria, that of pragmatism. The second reason, based on ideological grounds, is that the term 'mental health nurse' enables me to focus on what my *raison d'être* as a nurse working in this area is; the improvement of mental health. I believe the term 'psychiatric nurse' is too narrow to serve this purpose and carries more than a

little ideological residue of the (successful) attempt by medicine to define and delimit the focus of mental health care to the treatment of illness. While there may be important and defensible reasons for favouring the term 'psychiatric nurse', I believe it is in the interests of nurses and consumers to offer, through the strategic use of language, an alternative to the psychiatric model of mental health care. In some instances, for reasons of ease of expression, the term 'nurse' is used to refer to the mental health nurse.

The choice of the term 'consumer' to refer to those who receive mental health services is more problematic, for the reason that professionals cannot claim an uncontested right to language in this area, and must be responsive to the wishes of those they serve. Many nurses and other professionals, and many consumers themselves use the term 'patient' because they believe it to be an accurate reflection of the nature of mental health services, and importantly, to clearly reference the ethical responsibilities of professionals in health care (Sharma, Whitney, Kazarian & Manchanda, 2000). There can be no final rebuttal of this argument. It might come down to the fact that some people prefer it, and I would not deny them that preference. What is more problematic is settling on an alternative. A bewildering array of options is on offer; client, consumer, user, person in care, service user, and in New Zealand 'tangata whaiora' (user of mental health services). I have opted for the term consumer, and as with the preceding discussion of the appropriate term for nurses, I make no claim to have established what the 'right' term is. 'Consumer' is a particularly problematic term in relation to mental health care, as the connotation of an individual making free choices in a fair market can hardly be said to fit the mental health context, where care is often legally coercive, and choice is severely constrained. However an existing lack of choice in the mental health system should not mean that the commitment to maximising choice should not be acknowledged. This is what I see as the strength of the term 'consumer'. It appropriates a market discourse with entitlements to autonomy and choice. Discourses both create and foreclose on claims to knowledge and power (Burr, 1995). In the discourse of consumerism a claim to choice is made without having to appeal to 'patient rights'. Consumers have rights that patients find difficult to assert.

There are significant philosophical and political issues involved in asserting an identity as a consumer, not least of which is that consumer ideology could be said to have constrained, rather than facilitated, fairness and choice in many areas of social life. However I believe that use of the term 'consumer' is a legitimate attempt to appropriate the dominant discourse of the

market in the interests of one group whom market ideology otherwise exploits. For this reason I am prepared to put up with apparent inconsistencies, in the hope that just as 'patient' has come to embody a set of moral responsibilities not apparent in predecessors, such as 'inmate', 'consumer' will come to acquire a valuable situated meaning referring to legitimate rights that other terms would not necessarily imply.

Throughout the text of this thesis there are some departures from this statement of preferences. At times the historical or other context of the discussion suggests that the use of different terms would make for clearer reading, and at those times, which are relatively few, other terms have been used. For the terms mentioned in this section I have also not followed the pedantic contrivance of using the term 'sic' to denote that a term is reproduced in its original context, where the original use is a matter of preference, rather than a grammatical error. All terms included in quotation marks are those in the original text.

Organisation of the thesis

The thesis is presented in four parts, Introduction and Literature review (Part One), Methodology and methods (Part Two), Results (Part Three), and Discussion and conclusions (Part Four). Each part is presented in separate chapters.

Part One. Literature Review

Part One comprises an introduction to, and overview of the study, and a second chapter that explores the literature around the concept of the therapeutic relationship. The historical development of the concept is discussed, and its contemporary forms are considered. While most of the available literature is either British or American, the small amount of New Zealand literature is also reviewed and shows that international trends have in most cases been mirrored by New Zealand developments. The exception is an absence of a New Zealand literature relating to nurse-therapists. The literature review provides a basis for some conclusions about the place of the therapeutic relationship in mental health nursing and the need for research in this area.

Part Two. Methodology and methods

Part Two outlines the research methodology and methods and is presented in five chapters. In Chapter One the nature of the constructionist approach to research used in this study is

outlined. Different approaches to constructionist research are reviewed and the location of the study within this literature is described. Chapter Two reviews the literature on focus groups, the method of data collection used in the study. Different approaches to focus group research are considered in Chapter Two, and the relationship of focus groups to the constructionist research paradigm is outlined. Chapter Three considers the ethical issues raised by the research, and outlines measures taken to conduct an ethical study. Chapter Four outlines the sampling, data collection and analytic processes used. Both focus group and general qualitative research literature informed the process of analysis, and the blending of these influences in the current study is discussed. In Chapter Five the issue of soundness is discussed and steps taken within the research process to promote soundness are outlined.

Part Three. Description of the study and research themes.

Part Three is presented in four chapters. Chapter One provides a description of the study participants' areas of employment, categories of registration, gender, length of clinical experience and educational background and a broad outline of the research themes. The three themes that were developed in the process of analysis are outlined individually in Chapters Two to Four.

Part Four. Discussion and conclusions.

In this part of the thesis the research themes are considered in relation to both the research methodology and the other mental health nursing literature. In Chapter One significant features of the themes are suggested, and the contribution of the study to the understanding of practitioners' perceptions of the therapeutic relationship is discussed. A discussion of medical literature on the therapeutic relationship provides a contrast with the views of participants described in this study. Chapter One also reviews the process of the research and reflects on the therapeutic relationship as a socially constructed phenomenon. Chapter Two reviews the implications of the study for mental health nursing practice, education and research.

Part One, Chapter Two

Literature review. The therapeutic relationship in mental health nursing

Introduction

This section reviews the literature on the therapeutic relationship in mental health nursing drawing on a range of material from early accounts of attendants' interpersonal practices, and formal theoretical formulations developed in the mid-twentieth century, to recent texts and policy documents. The review shows the emergence of a concept that has come to signify and define mental health nursing, although it is by no means unproblematic. Nor is it clear that in using the term 'therapeutic relationship' or its variants, mental health nurses are referring to a unique or consensual body of knowledge or set of practices. This is particularly clear in criticisms of use the term 'nurse-therapist', which some writers have taken to imply that mental health nursing is not generally therapeutic. Nevertheless, the concept of the therapeutic relationship continues to perform an important function in the consciousness of mental health nurses.

There are some difficulties involved in developing an adequate account of the development of ideas about the relationships between mental health nurses and consumers. One of the main difficulties encountered was the lack of historical material on mental health nursing. Most historical scholarship has focused on the work of medical superintendents, or the experience of consumers; there has been little work on the attendants' contribution to mental health care. This point is acknowledged by Smith (1988) and I have taken it up in a separate paper (O'Brien, 2000). A second difficulty was the lack of New Zealand material, both historical and contemporary. This has meant that the account provided here has drawn heavily on British and United States sources. The New Zealand pattern of asylum provision was modelled on that of Britain (Sutch, 1966), and latterly, nursing education and healthcare provision have been influenced by developments in the United States (Christensen, n. d.; Litchfield, n. d.). This means that there is some validity in drawing on these sources of literature. However the patterns of social organisation of New Zealand society are not an exact mirror of either Britain or the United States, meaning that comparisons should be made with caution.

The concept of the therapeutic relationship as a formalised account of mental health nursing developed out of a change, in the middle of this century, from a focus on the consumer as fundamentally flawed by disease and dysfunction, to a focus on the professional's behaviour and its effects on the treatment process (Smoyak, 1993). Institutional practices such as those described by Goffman (1961), were associated with exclusively intrapersonal and biological beliefs about mental illness, and were considered to contribute to, rather than alleviate the distress of mental illness. The concept of the therapeutic relationship grew out of the interpersonal relations theory of Peplau and others and was part of a general development of therapeutic discourse in Western psychiatry. It has been given different interpretations in different contexts, and its meaning is often implicit rather than explicit. This review will discuss the origins and development of the concept of the therapeutic relationship in mental health nursing, drawing on American and British sources, showing how those influences are reflected in New Zealand literature. The literature shows that while the therapeutic relationship has been a central concept since its introduction, it is not unproblematic. A number of critiques of the therapeutic relationship have developed, and alternative models of relationships between nurses and consumers have been proposed. The therapeutic relationship is not always reflected in theoretically informed practice, and serves rhetorical functions sometimes in defence of the very institutional practices it was developed to change (Porter, 1993). In the context of mental health care in the 21st century, present concepts of the therapeutic relationship are not by themselves theoretically or practically adequate to meet the multiple needs of nurses and consumers.

Interpersonal relationships in the early asylums

Recognition of the influence of relationships with caregivers on the course of mental illness has a long history, and was a feature of moral approaches to care developed as far back as the 18th century (Grob, 1966). Early examples are found in the asylums of France and England. Jean-Baptiste Pussin, an attendant, was the 'Governor' of Bicetre in France and implemented a regime of moral treatment prior to the appointment of the more well known Pinel who was appointed in 1793 (Walk, 1961). At around the same time Tuke, (1813/1964) initiated moral treatment at the Retreat at York in England. Attendants under the direction of Matron Catherine Allen and Head attendant George Jepson were encouraged to engage with their charges in order to distract them from their distress and restore their ability to maintain

relationships. Moral treatment such as that carried out at the Retreat at York has been described as based on interpersonal relationships (Weir, 1992), and the role of attendants in the success of this approach to care has been recognised by Russell (1988). However as Chung and Nolan (1994) make clear, the influence of medical dominance in the 19th century prevented the development of any account of attendants' care other than that dictated by the medical profession. The transformation from attendant to nurse saw no change in the formal conceptualisation of practice, which continued to follow the direction set by psychiatric medicine in the 19th century. Under medical domination nursing was socially constructed as subservient and acquiescent, and ethically as bound by duty (Gastmans, 1998). It was not until the middle of the 20th century that a formalised account of nursing was developed independently of medicine. It is perhaps ironic, therefore, that the first formal theory of nursing owed more to the abandoned interpersonal approach of moral treatment than the medical conceptualisation that had replaced it, with spectacular lack of therapeutic success, for almost 100 years.

The influence of nursing theorists

Nursing theorists, exclusively from the United States, developed a variety of theoretical conceptualisations of therapeutic relationships between consumers and nurses in the period between 1947 and 1971. Those considered here are Render, Peplau, Orlando, Leininger and Travelbee. Early accounts such as those of Render (1947, cited in Render & Weiss, 1959) and Peplau (1952/1988) were based on psychodynamic and humanistic theory and were considered to apply to nursing in all contexts. They were aimed at addressing the consumer as person or subject, rather than object, and were focused on provision of nursing care that addressed the consumers' psychological and social needs in the context of a relationship. Render published an interpersonal account of nursing in 1947 (Render & Weiss, 1959) in which the emphasis was on the contribution of nursing to mental health care, rather than on the role of the nurse in maintaining order and acting as a proxy for the psychiatrist. Render's account is the earliest available attempt to systematise nursing as a therapeutic interpersonal relationship, although Peplau's *Interpersonal relations in nursing* (Peplau, 1952/1988) is frequently credited as providing the earliest theoretical formulation of nursing as a therapeutic relationship. Peplau developed her theory for nursing in all contexts, although it has held its most enduring place in mental health nursing. Render and Peplau shared a psychodynamic orientation, and a conviction that

their interpersonal conceptualisations of nursing were at once foundational to nursing and a basis for the specialty of mental health nursing. The influence of interpersonal thinking on mental health nursing is evident in Gwen Tudor's landmark study of mutual withdrawal (Tudor, 1952).

Peplau's influence is also apparent in the work of some of her pupils such as Claire Fagin, who contributed to the development of the concept of mental health nursing as a therapeutic interpersonal relationship (Olson, 1996). A student of Peplau at Teacher's College, Columbia University, Fagin was originally trained in psychoanalytic approaches to mental illness. However her views on nursing practice were firmly interpersonal (Fagin, 1967), an apparent disparity she explained by reference to the inescapably interpersonal nature of mental health nursing (Fagin, 1996, p. 11). In this view the influence of Peplau is conspicuous.

Neither Render nor Peplau appear to have used the term 'therapeutic relationship' to refer to nursing in their major works, although both used the term 'therapeutic' in discussing the effect of nursing care, and the concept of relationship as the means of achieving a therapeutic effect. Render and Weiss (1959) provide a multitude of examples of nursing activities that they describe as therapeutic, although they appear to regard this 'therapeutic nursing' as supportive of the consumer's primary therapeutic work, which is with the doctor. Peplau (1952/1988, p. 16) is more confident of the primary therapeutic role of nursing, describing nursing as "... a significant, therapeutic, interpersonal process." Fagin (1967), perhaps reflecting the influence of her role in preparing graduate nurses for practice as therapists, describes nursing in terms of structured, scheduled, individual and group therapy, as well as therapeutic interpersonal involvement that develops as part of nursing involvement with consumers through day to day care.

It has been noted that the early nursing theorists discussed so far developed their theories for nursing in all contexts, not just psychiatric or mental health nursing. This is reflected in the work of Orlando who developed a psychodynamic theory of nursing (Orlando, 1961). Orlando's clinical background was in medical and surgical nursing, and the research that led to the development of her theory was carried out with undergraduate students in the medical and surgical nursing components of the basic curriculum, with the aim of integrating mental health concepts into that curriculum (Schumacher, Fisher, Tomey, Mills & Sauter, 1998). Orlando's

theory formed the basis of a graduate programme in mental health and psychiatric nursing (Schumacher et al., 1998). The theory shares with that of Peplau a focus on interpersonal relationships, and it might be assumed that Orlando was influenced in the development of her work by Peplau's publications. However Orlando's major work (Orlando, 1961) contains no bibliographic references. Forchuk (1991) notes theoretical similarities in the work of Peplau and Orlando. The relationship between nurse and consumer is the focus of both theorists' work. However where Peplau envisages a long term relationship, Orlando's focus is on immediate needs of the consumer (Forchuk, 1991). The difference in the scope each accords to the relationship between nurse and consumer, may be to do with the fact that Peplau developed her theory in a psychiatric nursing context, while Orlando developed a similar construct based on observations made in a medical and surgical context.

Another formulation of the therapeutic interpersonal relationship in nursing is provided by Hofling, Leininger, and Bregg (1967). Originally published in 1960 by Hofling and Leininger, this has been described as one of the first basic psychiatric nursing texts (Welch et al., 1998). Working within a psychodynamic framework, these authors emphasise the importance of the relationship between nurse and consumer to the consumer's well being. They provide a definition of the therapeutic relationship as "... an interaction process... in which the nurse offers a series of purposeful activities and practices that are useful to a particular patient." (Hofling, Leininger, & Bregg, 1967, p. 31).

Travelbee (1971) uses the terms "human-to-human" relationship and "nurse-patient interaction" to characterise nursing. A human-to-human relationship is distinguished from nurse-patient interaction by the fact that the human-to-human relationship is not qualified: "A human-to-human relationship *is* good, *is* helpful and the ill person's needs *are* met." (Travelbee, 1971, p. 121, italics original). By contrast, in nurse-patient interactions, nurse and patient encounter each other as stereotypes, rather than as unique human beings. Patients' needs are met inconsistently or may not be met at all. In Travelbee's theory, the therapeutic use of self is a characteristic of the nurse and incorporates the other distinguishing characteristic, a disciplined intellectual approach to problems to create the "educated heart and the educated mind" (Travelbee, 1971, p. 19). In the writing of Travelbee the humanistic focus of Peplau has shifted to an existential orientation to nursing, in which the human relationship is considered almost to transcend its original purpose in meeting the health needs of the consumer, and to be

an end in itself. It is notable in this context that Travelbee makes no reference to psychiatry or mental health, and it is apparent that the focus of nursing has become one of finding meaning rather than solving specific problems.

Interpersonal theoretical formulations of nursing originated in the 1940s as nurses began to define their distinctive contribution to mental health care and continued to develop over the next two decades. Inpatient psychiatric care, and in the case of Orlando, medical and surgical care, provided the basis for early theories influenced by psychodynamic and humanistic psychology, although these theories were considered to apply to nursing in all contexts. The theories discussed here focused on psychiatric and mental health care, either in clinical practice or in the integration of interpersonal concepts into basic nursing education. While they present different perspectives they all focus on the interpersonal relationship between nurse and consumer as the essential core of mental health nursing. The humanism of these theories is evident in the central place accorded the person of the nurse in the therapeutic process. This was in contrast to the centrality of Nature in the nursing philosophy of Nightingale (Nightingale, 1860/1992), and the place accorded biology in the psychiatry which dominated the institutional settings in the middle of the 20th century. While later theorists have also emphasised, and in some cases developed, interpersonal aspects of nursing (e.g. Benner & Wrubel, 1989; Parse, 1981; Watson, 1979, 1985) their work must be regarded as derivative on that of the theorists who defined nursing in terms of therapeutic interpersonal relationships.

Interpersonal influences in British mental health nursing

Developments in the United States were mirrored by changes in the conceptualisation of mental health nursing which occurred simultaneously, but apparently independently in Britain (Ritter, 1997a). Two major influences were apparent in postwar British psychiatry; the therapeutic community, and open-door asylums. Ritter (1997a) links development of interpersonal approaches in mental health nursing to the former, but not the latter. Nursing in therapeutic communities was psychodynamically oriented, requiring both self awareness and skill in dealing with interpersonal processes such as transference and countertransference (Jackson & Cawley, 1992). The influence of nursing theorists is not apparent in British literature in mental health nursing until it began to be used as a critique of practice in the 1970s. British mental health nursing author Barker (1993) states that he became acquainted with

Peplau's work late in his career, which began in the 1960's. However other interpersonal influences were apparent in British mental health nursing from the 1950s onwards.

Development of interpersonal approaches in British mental health nursing appears to have been uneven. A study of nurses employed in ten British psychiatric hospitals revealed that while those working in therapeutic communities learned to practice within the emergent psychodynamic framework, nurses in traditional settings continued to emphasise order and control (Caine & Smail, 1968). Nurses' training gave them little or no help in the understanding and management of human relationships, despite this being "... the most essential qualification of the modern mental nurse." (Martin, 1968 cited in Nolan, 1993a, p. 129).

Nursing theory provided a critical lens for Altschul's 1971 study of nurse-patient interaction (Altschul, 1971). This study focused on nurse-patient interactions in four inpatient wards in Scotland and found that there was a relatively low level of interaction. Altschul used the work of Orlando, Leininger and Peplau to justify her claim that therapeutic relationships should be built on interaction between nurse and patient. She found that there was a lack of acceptance by nurses and nursing administrators of the value of relationships between nurse and patient, and considered that they could not therefore become therapeutic.

Early developments in interpersonal relationships in nursing in Britain have been described by Reynolds and Cormack (1990, p. 4) as "unsystematic and random" with "no theoretical underpinnings". They regard pharmacological developments as having provided the basis for the development of interpersonal models of nursing, although they acknowledge that this view is contentious. It is interesting to speculate that it may have been the absence of an identifiable theory that led Reynolds and Cormack to conclude that pharmacological interventions provided the basis for interpersonal models of nursing. Theory has been considered essential to 'explain' nursing intervention, although very often accounts are provided in more 'common sense' terms (Tilley, 1995). However, Peplau's theory predated by a number of years the introduction of definitive pharmacological agents such as chlorpromazine, indicating that at least in the United States, interpersonal models of nursing developed prior to and independently of pharmacological agents. No British nursing theorist emerged at this time to develop a nursing theoretical framework to conceptualise the interpersonal practice of mental health nursing.

New Zealand nursing literature

Moves towards an interpersonal model of care are also evident in New Zealand nursing literature from the same period. The small amount of literature available reflects themes evident in the United States literature; that therapeutic relationships between nurse and consumer should replace custodial models of care, and that concepts of therapeutic relationships should inform general nursing education. In response to the question 'what is psychiatric nursing?' McEwan (1961) signals a change from a custodial to a therapeutic role. McEwan observes that "It used to be thought sufficient that the psychiatric nurse be a passive watcher and guardian..." (1961, p. 13) and goes on to describe the new interpersonal focus of education and practice of mental health nursing. In a later article the same author discusses the place of interpersonal relations in nursing generally, stating that "... these studies should be the basis of the student's introduction to nursing..." (Raboobi & McEwan, 1968, p. 7). Although the term 'therapeutic relationship' is not mentioned in either of these publications, the emphasis on an interpersonal model of nursing is a shift away from the institutional and custodial roles, which is clearly consistent with the concept of the therapeutic relationship as it is described in overseas literature.

In what appears to closely reflect changes in the United States and Britain, Bazley, Cakman, Kyle, & Thomas (1973) describe interpersonal relations as the basis of all nursing, elaborating on specific characteristics of the nurse-patient relationship in psychiatry. Referring to the nurse-patient relationship as a therapeutic relationship, Bazley, Cakman, Kyle, & Thomas (1973, p. 14) describe this relationship as a "human relationship with goals defined by patients' needs". Bazley (1973), writing specifically about the New Zealand context, considered the therapeutic relationship between nurse and consumer to be the basic skill of psychiatric nursing and maintained that it was expected that consumers receive benefit from the relationship. Some issues arising from the appropriation of 'human relations' as the basis for a generic nursing curriculum are discussed later in this chapter.

It is apparent that the conceptualisation of mental health nursing as a therapeutic relationship was part of an international trend, albeit one that was variable across different settings. Originating in the work of psychiatric nurses such as Render and Peplau, the concept was nevertheless considered from its beginnings to apply to nursing in all contexts. The dual purpose served by the therapeutic relationship in the clinical practice of mental health nursing

and in nursing education has continuing implications for the specialty of mental health nursing which will be discussed later. Attention now focuses on influences arising as a result of mental health nursing's direct relationship with medicine.

Influence of medical interventions

While the development of the therapeutic relationship has so far been explained by reference to theoretical conceptualisations reflected in the nursing and related literature, another set of influences can be discerned. These have less to do with the theoretical conceptualisation of mental health nursing and more to do with the impact of medical interventions on mental health nursing practice. This view was alluded to by the observation of Reynolds and Cormack (1990, p. 4) that pharmacological interventions provided the basis for the development of interpersonal models of nursing. It has already been pointed out that Peplau's interpersonal theory predated the availability of effective medications. Moreover, Smoyak and Skiba-King (1997) note that even when early antipsychotic medication became available, Peplau did not include psychopharmacology in her lectures. According to these authors "...students in training were given the clear message that the appropriate focus of study was interpersonal relationships" (Smoyak & Skiba-King, 1997, p. 17).

While pharmacological developments may not have contributed directly to the evolution of interpersonal approaches to mental health nursing, other physical interventions may have played a part. The discussion on this aspect of the development of the therapeutic relationship draws on Truman's (1984) account of the development of mental health services in the Wellington region between 1945 and 1978. Throughout the 1940's a range of physical treatments were introduced into psychiatric care. Cardiazol, electroconvulsive therapy, insulin coma therapy and leucotomy were interventions introduced in order to treat conditions previously regarded as untreatable. These treatments had the effect of diverting nurses from the roles they had occupied in supervising consumers in farming, laundry and other activities. Nurses' new involvement in medical treatment contributed to a reconceptualisation of their role as contributing to treatment. While perhaps not 'therapeutic' in the interpersonal sense defined by Peplau, it was a significant shift in that the new role was not primarily custodial. Peplau's work had not been published at this time, and its influence in New Zealand was more than a decade away. Truman (1984) has used psychiatric nurses' registration examination papers to illustrate how this change in focus came to gain official recognition by nursing's

governing body. Questions in the registration examinations began to focus less on maintaining order, and more on the new physical interventions. Similar changes have been noted to have occurred in Britain during the same period (Nolan, 1993a; 1993b). Truman (1984) notes that a number of nurses responded to this change by resigning their nursing positions and taking employment as hospital gardeners and farm workers. A similar trend away from supervisory roles was noted at Kingseat Hospital in the early 1960's (Kingseat Hospital, 1982, p.15) although there is no indication of staff changing employment. It is apparent that this redefinition marked a break with a role based on custodial care in favour of medical interventions. This change may have laid a foundation for nursing care based on the new concept of the therapeutic relationship by casting nursing in a therapeutic rather than custodial role. It is perhaps a moot point whether the 'therapeutic relationship' offered more benefit to consumers than supervision of farm and other work, and it is not insignificant that occupational therapy, a theorised practice of organising activity as therapy (Ludwig, 1993) developed steadily in New Zealand at this time (Skilton, 1981). There is a significant historical and conceptual relationship between mental health nursing and occupational therapy in New Zealand that has not yet been fully explored.

The therapeutic relationship in mental health nursing can be understood as part of a general development of a therapeutic discourse in mental health care. An increase in the use of medical therapeutics legitimised a shift in the focus of nursing from work supervision and management of consumers' activities of daily living, to providing the necessary care of patients receiving dangerous medical treatments. This therapeutic role may have created the conditions that enabled mental health nursing to be conceptualised as a therapeutic relationship. The therapeutic relationship challenged existing nursing practices because, unlike therapeutic relationships, work supervision and management of activities of daily living could not be justified by a recourse to theory. The actions of some nurses in resigning their positions to work as farm labourers reflect a pragmatic rather than theoretical approach to the care of people with mental illness. The conflict between these two approaches is as relevant now as it was then and this is reflected in contemporary debates about the relative value of practical and theoretical knowledge (Benner, Tanner & Chesla, 1996; McElroy, 1990).

The therapeutic relationship in recent mental health nursing texts

A review of selected contemporary psychiatric-mental health nursing texts reveals that the therapeutic relationship continues to feature as a theme in the theoretical preparation of nurses for clinical practice. Reynolds and Cormack (1990, p. 11) state that "...the primary function of the psychiatric nurse is a psychotherapeutic one". Although they also mention custodial and medically-supportive roles, these are seen in terms of their potential for therapeutic work between nurse and consumer. Reynolds and Cormack's text outlines a variety of models of therapeutic intervention used by nurses. Some models describe therapist roles while others are developed to inform more routine nursing practice. In Keltner, Schwecke and Bostrom's (1999) *Psychiatric nursing*, Schwecke (1999) contrasts "therapy" with "therapeutic nursing". While the former is structured, formalised and planned, the latter is "part of an overall therapeutic picture" (p. 125) and assists the consumer to process feelings and thoughts as they occur. Schwecke explains that many consumers cannot tolerate therapy but can benefit from "therapeutic encounters" (p. 125) which may be informal and spontaneous. Therapeutic relationships vary between brief encounters embedded in the day to day activities of the inpatient unit and long term contact, and may involve multiple nurses. This also seems consistent with Fagin's (1967) view that mental health nursing involves both structured therapy and 'therapeutic involvement' in day to day care. Schwecke urges nurses to distinguish social from therapeutic relationships, calling to mind Peplau's distinction between 'meaningful communication' and 'social chit chat' (Peplau, 1960). Peplau's interpersonal theory provides the basis for much of the discussion of the therapeutic relationship in this text.

Stuart and Laraia's *Stuart and Sundeen's principles and practice of psychiatric nursing* (1998) contains a chapter titled "The therapeutic nurse-patient relationship." In this chapter the therapeutic relationship is defined as "... a mutual learning experience and a corrective emotional experience for the patient." (Stuart, 1998, p. 18). The basis of a therapeutic relationship is explained in terms of Rogerian helping relationship theory, and nurses are described as helpers who "must be therapeutic" (p. 18). Although she does not explicitly state as much, Stuart discusses nursing as therapeutic, but not as therapy. The theoretical influences of the chapter are those of writers such as Berne, Carkoff and Rogers, whose work might in other contexts be regarded as describing models of psychotherapy or counselling. Discussion of the phases of the nurse-patient relationship is noticeably derived from Peplau, and although research based on

Peplau's theory is referred to, Peplau's work is a surprising omission from the acknowledged influences of this chapter. However, in another chapter of this text Stuart states that Peplau's work on the psychotherapeutic role of the nurse in the interpersonal relationship as a "milestone in the field". (Stuart, 1998, p. 56).

It is noteworthy that the texts discussed above also contain extensive sections on conceptual models of mental illness and mental health care. Practitioners are encouraged to develop their understanding of multiple theoretical perspectives. However, the therapeutic nurse-patient relationship, a concept that carries distinct theoretical commitments to a psychodynamic understanding of mental health nursing, appears to occupy a primary position in relation to other approaches.

Nursing therapy and nurse-therapists

As the preceding discussion has shown, various authors have distinguished between 'therapy' and 'therapeutic nursing'. The following section will outline some developments in the area of nurse-therapists. It is difficult to identify a single pattern in the development of nurse-therapists beyond noting that few nurse-therapists have claimed to provide nursing as a therapeutic intervention; almost all have practised a form of psychological or behavioural therapy that does not arise from a nursing theoretical perspective. This raises the question of whether nurse-therapists are practising nursing, or are nurses practising a therapy that could equally be practised by another practitioner. It also raises the question of whether nursing provides consumers with something significantly different to therapy, what that something might be, and what role it plays in the care of mental health consumers.

Nurse-therapist models have been described by a variety of nursing and other authors. The following discussion considers the work of Fagin (1967); Mellow (1968, 1986); (Mellow's work is also reviewed by Colliton, 1965); Marks (1985); Barker (1982, 1989) and Barker and Fraser (1985). Other authors who have contributed to this development are Montgomery and Webster (1994); Webster, Vaughn, Webb and Playeter (1995); Vaughn, Webster, Orahood and Young (1995); and Winship (1997).

June Mellow and nursing therapy

Colliton (1965) reviews the work of June Mellow who used a psychodynamic and psychoanalytic model of individual therapy to work with consumers with schizophrenia beginning in the 1950's. Mellow's nursing therapy was a specialised intensive outgrowth of the nurse-patient relationship that saw nurses using their generic background to become specialist therapists. Colliton (1965) explicates Mellow's thought on nursing therapy in a series of case studies, in which the boundaries of nursing therapy are explored. Beginning with intensive involvement in the acute phase of illness, nursing therapy was then extended to the post-acute phase, focusing on the personality structure, and mastery over intrapersonal and interpersonal conflicts. The phases of the nursing therapy relationship are similar to those described by Peplau (1952/1988), although Mellow's model is restricted to individuals with schizophrenia. Mellow saw individual therapy in the acute phase of illness as "... built into the fabric of [the consumer's] everyday experiences" (Colliton, 1965), and not as something separate. There is an unstated assumption in Colliton's review that the acute phase of illness is synonymous with hospitalisation. The nurse-therapist is considered to be a specialist, and although she works on the inpatient unit, she is not a member of the inpatient nursing staff. The significance of Mellow's account of nursing therapy is less that it articulates a genuinely new theory, which it probably doesn't, and more its claim that nurses could function in an autonomous therapeutic role, and with a consumer group generally regarded as not accessible to psychotherapy. It is also significant that the nurse-therapist is considered to extend the role of the inpatient nurse.

Mellow's own writing on her model of nursing therapy is limited. The two articles reviewed here are an initial explanation of the model and a later reflective account on its limited application in practice. Mellow (1968) regards the physical and emotional proximity of nurse and consumer in the acute phase of illness as the basis for experiential engagement in the context of co-participation in ordinary activities of living. In this form of therapy, the nurse does not attempt to verbally engage the consumer in exploration of issues believed to contribute to psychosis. Mellow (1968, p. 2365) warns against "... understanding of pathology for its own sake" and emphasises that nursing involves "*genuine human caring*" (original emphasis) aroused by the nurse's distress at the "potential waste of a human life" (p. 2365). Recalling Peplau's concept of "surrogate parent", Mellow argues that the nurse as therapist creates the possibility for development of a symbiotic relationship in which a corrective

emotional experience can occur. Mellow is careful in this and a later article (Mellow, 1985) to emphasise that nursing therapy in the acute phase of schizophrenia takes preeminence over the psychotherapy offered by the psychiatrist, as the consumer is not emotionally able to cope with insight and exploration of problems. The later stage of nursing therapy is the more conventional psychoanalytically-oriented therapy in which management of transference is a major issue, and which involves in-depth exploration of problems. Mellow sees the nurse as continuing the relationship established during the acute phase once the consumer is discharged from hospital.

Mellow's model of nursing therapy may be the only existing formulation of the ordinary activities of nursing as therapy, rather than as therapeutic. In the later of the two articles reviewed here, Mellow (1985) laments the lack of attention given to the therapeutic potential of nursing by both nursing and medicine. Mellow ascribes this neglect to the "mundane" nature of the activities involved and their association with women's sphere of work. The therapeutic potential of nursing is contained in the "unstructured, unpredictable flow of these activities" (Mellow, 1985, p. 183). Research into the nursing sphere of work could, according to Mellow, contribute to greater definition of the contribution of nursing to the care and treatment of people with mental illness.

Claire Fagin: Psychotherapeutic nursing

Fagin (1967) referred to the nurse as a therapist by virtue of the many therapeutic activities that made up the nursing role. Fagin notes that the structured therapeutic activities of nurses and others are well described theoretically, but that the less structured activities of nurses are not so well described. Although Fagin claims that nursing can occur in environments other than the hospital, the conceptual framework she seeks to develop is clearly based on nursing as it occurs in hospital inpatient settings. The result is a very broad concept of nursing as a therapeutic activity. Within this broad concept the nurse is seen as providing individual therapy, using a one-to-one relationship that develops in an unstructured way as the basis for therapy that continues on an appointment basis. Thus Fagin appears to hold a dual concept of nursing as therapy; on the one hand nurses are therapists because of the range of therapeutic activities they undertake, and yet 'therapy' is also given a more traditional meaning when the 'unstructured' interactions of nurse and consumer assume the nature of a formalised relationship based on appointments. The distinction discussed by Fagin (1967) between

therapeutic interpersonal involvement and scheduled therapy provides a further example of development of a specific therapist role compared to the general therapeutic role described by early theorists. Since these developments, the nurse-therapist, in various guises, has become an established aspect of mental health nursing.

Isaac Marks: Nurse behaviour therapy

Behaviour therapy was the basis of development of nurse-therapist roles in Britain with the initiation of behavioural nurse-therapist training at the Maudsley Hospital in 1972 (Lambert & Gournay, 1999; Marks, 1985). In these programmes there was no thought of 'nursing as therapy' but the nurse learned and practised a specific therapeutic modality. Nurses were (and are) trained to provide interventions for people with phobias and anxiety disorders. The title 'nurse-therapist' in this context referred to the professional background of the therapist, not specifically to a theoretical orientation they were expected to bring to their therapist roles. An early report signalled that graduates of this 18 month programme were providing effective interventions for this group of patients (Marks, Hallam, Philpott & Connolly, 1975), with a more recent clinical audit showing that health improvements continued to be provided, although with less intervention than for previous groups of trainees (Duggan, Marks & Richards, 1993).

Therapy provided by mental health nurses

In addition to practices identified in the nursing literature as those of 'nurse-therapists' there are other reports of nurses using specific intervention models to provide therapeutic interventions for specific groups of consumers. For example, in a study of cognitive therapy for chronic fatigue syndrome (Deale, Chalder, Marks, & Wessely, 1997), the therapists providing treatment were nurses, although this is not apparent in the research title or report. Other studies in which nurses provided therapy but did not identify as nurse-therapists include Krawitz (1997), and Marks, Lovell, Noshirvani, Livanou and Thrasher, (1998). Studies of this sort are difficult to identify because they do not show up on electronic database searches, and the disciplinary identity of the therapists is noted only incidentally or not at all in the reports. The prevalence of these studies is difficult to estimate and it is even more problematic to know what they contribute to an understanding of the therapeutic relationship in mental health nursing.

The nurse-therapist in New Zealand

There is no New Zealand literature on the nurse-therapist role, although Harraway (n. d.) mentions the development of nurse-therapists at Sunnyside Hospital in the 1970's. Through personal contacts I am aware that there are a number of nurses practising various forms of therapy within a nursing role, and who see themselves as both nurses and therapists. Some of these nurses contributed to the current study. The lack of documentation of this means that the extent of nurse-therapist practice in New Zealand can only be estimated. I am also aware anecdotally of New Zealand mental health nurses leaving their profession to pursue careers in family therapy, counselling and individual therapy, apparently because they felt unable to fulfill their therapeutic potential while maintaining a nursing identity. Again, there is no documented evidence of this trend.

Critique of nurse-therapist roles

Barker (1989) is sharply critical of the behaviour therapy programmes developed by Marks, stating that "... nurse-therapists can only cater for a very small proportion of the mentally disordered" (Barker, 1989, p. 133). Barker also contends that many graduates of Marks' training programmes "... appear to have rejected his outlook..." (1989, p. 133). However a 20 year follow-up of nurse behaviour therapists trained in Marks' programmes found that although many had moved into primary care and teaching, and have broadened the remit of their work, "They continue to treat the categories which it was envisaged they should..." (Newell & Gournay, 1994). What cannot be claimed, and is not claimed in the literature reviewed here, is that nurse behaviour therapy offers a model generalisable to all of mental health nursing.

The nurse-therapist role has been described as beyond the basic training of the nurse (Faugier, 1985) and to extend what were regarded as inadequate skills. This concept of nurse-therapist appears to recognise as 'therapeutic' only those skills that conform to a developed model of therapy. By exclusion, the skills of inpatient nurses and those providing support to consumers in community settings are not those of a therapist. Barker (1989) has expressed reservations about the nurse-therapist role, arguing that "the concept of the 'nurse-therapist' (sic) arose from the assumption that nursing care was not therapeutic" (p. 134), although in the writing of Fagin (1967), Mellow (1968, 1985), and more recently Schwecke (1999), a distinction is made between "therapy" and "therapeutic nursing".

Although other programmes of behaviour therapy developed (Barker, 1982; Barker & Fraser, 1985), there are reservations, even amongst their original proponents about this development, particularly its behavioural orientation and focus on a specific population of consumers (Barker, 1989). These reservations are to some extent shared by Mellow (1985) who distinguishes between nursing therapy provided in the context of day-to-day care in which the nurse enjoys close proximity to the consumer, and analytic therapy which, in Mellow's (1985) account, more closely resembles the appointment-based psychotherapy provided by a range of health professionals. Mellow (1985, p. 183) contends that the "unstructured, unpredictable flow of [mundane] activities..." occurring in inpatient care can be "transposed and shaped into a therapeutic modality for the very sick patient" (p. 183). This development would, according to Mellow (1986, p. 183), arrest the move "... away from psychotic patients into private practice with more healthy clients."

While himself a practitioner of cognitively oriented psychotherapy (Barker, 1990), Barker also regards the assumption of 'therapist' roles as a retreat from the difficulties of nursing people in mental distress (Barker & Whitehall, 1997, p. 26). There is doubt about whether the nurse-therapist represents a development within or away from a nursing role (Barker, 1989). It is therefore not always clear whether the activities of nurse-therapists contribute to the development of an understanding of the nurse-patient relationship, or simply demonstrate that the nurse-patient relationship, while therapeutic in itself, also provides a basis for individual nurses to develop specialist intervention roles.

The therapeutic relationship in recent New Zealand literature

Mention has already been made of New Zealand literature recognising the therapeutic relationship as the basic skill of mental health nursing. The modest amount of New Zealand literature available precludes identification of any definitive pattern of use of the concept. However commitment to the concept of the therapeutic nurse-patient relationship is shown in a number of sources. Those considered here are; official documents of nursing bodies, accounts of the concept in practice, prominence in research, and critiques of changes in the practice context.

The most unequivocal commitment to the therapeutic relationship in New Zealand literature can be found in the *Standards of practice for mental health nursing in New Zealand*

(ANZCMHN, 1995). The *Standards* reflect the influence of the concept of the therapeutic relationship throughout their wording. The definition of mental health nursing contains the phrase “[mental health nursing] is a specialised interpersonal process embodying a concept of caring which has a therapeutic impact on the consumer...” (p. 1). Standard II states that “The mental health nurse establishes partnerships as a basis for a therapeutic relationship with consumers” (p. 8). This Standard requires that nurses are familiar with the theoretical assumptions of therapeutic relationships. The Standards reflect a commitment to the distinctiveness and contribution of mental health nursing and to the therapeutic relationship as a partnership in which that contribution is enacted. A second document, the *Guidelines for mental health nursing education* (Nursing Council of New Zealand, 1998) was developed for schools teaching the undergraduate nursing curriculum. This document also reflects the influence of the commitment of mental health nursing to the therapeutic nurse-patient relationship. The commitment to the therapeutic relationship distinguishes mental health nursing within the broader discipline of nursing. Two of the *Guidelines’* six competencies refer specifically to the therapeutic relationship. Competency Two states that the graduate “Demonstrates a focus on partnership as the basis for developing a therapeutic relationship with clients”. Competency Three requires that the graduate “Demonstrates an understanding of the therapeutic use of self as an agent for change”. These competencies represent an extension of the generic competencies for entry to nursing practice, which contain no reference to the therapeutic relationship (Nursing Council of New Zealand, 1997).

A small number of New Zealand research studies confirm the place of the nurse-patient relationship in conceptualising mental health nursing care. Conclusions from such a small study base must be tentative, but the consistency with overseas studies previously discussed is of note. Two unpublished studies have documented aspects of mental health nurses’ relationships with consumers. A social learning perspective provided the theoretical basis for a naturalistic study of mental health nurses undertaken by Howard (1983). The level of interaction between nurses and consumers in a traditional hospital ward was compared with the level of interaction in a community outpatient centre. Howard found that in the hospital ward nurses interacted more with each other than with consumers. However in their responses to a questionnaire they indicated that they would prefer to interact more with consumers. The community unit nurses showed a higher level of interaction with consumers, leading Howard to conclude that the

community unit was more able to utilise its therapeutic potential than the inpatient ward. Although it is unlikely that the nurses in Howard's study shared her social learning perspective, the study is significant in its assumption that interaction between nurses and consumers is the basis for achieving an improvement in the outcome for consumers. Consistent with British studies (Altschul, 1971; Gijbels, 1995), the level of interaction was low in the inpatient unit, and in Howard's opinion, this limited the potential for exploitation of its therapeutic potential. The second study, by Truman (1984) has been discussed previously. That study documented a change in the mental health nursing role in the period 1945 to 1978 from a care-taking and management role to a therapeutically-based role. Truman describes this change as reactive rather than nursing-initiated, occurring mainly because of changes in consumer status. It is nevertheless significant that Truman characterised the change as towards a therapeutic role.

In two further studies mental health nurses were asked to describe their practice. The interpersonal relationship was a prominent theme in both. In Ryan's (1997) research, which sought to articulate the practice base of mental health nursing, participants described their practice in terms of their relationships with consumers. The relationship was also found to be "central to the practice" of the mental health nurses in a study carried out by O'Brien (1999). Components of the relationship identified in this study, such as 'minimising visibility' and 'individualising care', suggest that while the original psychodynamic basis of the therapeutic relationship has been retained, the concept takes on new aspects in the practice of experienced practitioners.

The effect on the therapeutic relationship of changes in the context of mental health care has been a source of critique of those changes from mental health nurses. Sangarran (1993) has stated that the manner of implementation of community mental health care policies has challenged the therapeutic relationship which is at the heart of mental health nursing. Similarly, critique of the Duly Authorised Officer (DAO) role for mental health nurses has focused on its implications for the therapeutic relationship (Street & Walsh, 1994, 1995). These authors found that this legislated role threatened the therapeutic relationship nurses had with consumers. Street and Walsh's work is supported by Foster (1998), who argues that the DAO role presents challenges to the nurse-patient relationship. The significance of the therapeutic relationship is also evident in developing a concept of advanced practice in mental health nursing in New Zealand. Crowe (1998a) has described the therapeutic use of self in the nurse-patient

relationship as “...the distinguishing feature of advanced mental health nursing practice”, noting that this realm of practice needs to be defined and articulated in order to challenge the economic rationalism of current changes in mental health care.

Constraints on the therapeutic relationship

An apparent widespread acceptance of the concept of the nurse-patient relationship as central to nursing care has not always translated into a therapeutic relationship in practice. Some recent studies add weight to the view that the therapeutic relationship is an ideal of mental health nurses, but one that is frequently not realised in practice (Cleary, Edwards & Meehan, 1999; Gijbels, 1995; Morrall, 1998a; Sullivan, 1998). This issue is taken up later in the discussion.

Sociological analysis of mental health nursing identifies institutional practices and the attitudes and beliefs of nurses as two differing constraints on the development of therapeutic relationships (Porter, 1993). Porter’s observation that a therapeutic rationale acts as a rhetorical device justifying the existence of psychiatric institutions, while institutional demands constrain therapeutic practices, has relevance for the New Zealand situation. A New Zealand reference to structural constraints on therapeutic relationships is found in the report of the 1971 Commission of Inquiry into psychiatric services at Oakley Hospital (Hutchison, Barlow & Hutchings, 1971). In expressing concern over the large number of admissions to Oakley, the Commission found that “The inevitable result [was] a swing back to the custodial pattern of care... at the expense of the modern therapeutic approach requiring relations between patient and nurse which take account of the individual patient’s needs.” (p. 55). In another example, a handbook given to staff of psychiatric hospitals as late as the 1980’s supports Porter’s observation that rules to do with order predominate over recognition of the need for a therapeutic relationship between nurse and consumer (Auckland Hospital Board, n. d.). Guidelines under the heading of “The relationship of nurse to patient” reflect a perspective that the purpose of this relationship is the maintenance of order. For example page 13 of the handbook states; “Courtesy, consideration and common sense, if practised, will ensure the observation of most rules without the need for stating them explicitly”. The dominant focus of this section of the handbook is on rules that emphasise order. The theory and rhetoric that supported and developed the concept of the therapeutic relationship as fundamental to mental

health nursing appears to have been structurally constrained by this institutional dictate for order.

Fundamental and special?

It was observed earlier that Render and Peplau saw interpersonally therapeutic nursing as fundamental to the practice of nursing generally, rather than something unique to mental health nursing. This was also reflected in New Zealand literature of the same period. At the same time these authors and others have asserted the special nature of mental health nursing through its use of the therapeutic relationship. Olson (1996, p. 4) has described this dichotomy as 'the dilemma of psychiatric-mental health nursing', arguing that exclusive focus on the therapeutic relationship has militated against articulating the distinctiveness of the specialty with the result of the real possibility of its demise through integration with general nursing. Taylor (1994) cited in Olson (1996, p. 8), goes further to argue that mental health nursing has not demonstrated either the efficacy or cost-effectiveness of its interventions in the era of deinstitutionalisation. The suggestion is that the focus on the therapeutic relationship has had a role to play in inhibiting the development of the discipline, a consequence of which is a threat to its continuity. Morse, Havens and Wilson (1997) have noted that Altschul's 1971 study has not been replicated, lending support to the suggestion that the therapeutic relationship in mental health nursing has been inadequately researched and theorised.

The therapeutic relationship: critique and new directions

Earlier in this chapter it was argued that the concept of the therapeutic relationship arose because of dissatisfaction with models of care and treatment that located pathology solely within individuals (Smoyak, 1993). Interpersonal models extended the range of phenomena of interest to mental health nurses to the person in the context of interpersonal relationships. This enabled the development of a concept of nursing that assigned to the nurse and to nursing, a therapeutic role based on the relationship between the nurse and consumers. Peplau's theory sought to systematise the nature of this relationship, and to describe its constituent parts (Peplau, 1952/1988). In this section some of the critiques of the concept of the therapeutic relationship, of mental health nursing, and of mental health care are discussed. Some new directions evident in the literature are considered.

As the preceding discussion shows, the therapeutic relationship has been, and continues to be, a central concept in mental health nursing, and one that is germane to the professional identity of mental health nurses. However the concept has not been immune to critique and attempts at reconstruction. Many current models of relationships between consumers and professionals do not assume that 'therapy' is unproblematically good (Masson, 1993). They also do not accept that a model of mental health nursing based solely on an individual relationship is adequate to account for the power differentials inherent in professional relationships, or the contextual factors that influence mental health and mental health care. At a theoretical level, a concept such as the therapeutic relationship is, by itself, inadequate to account for the phenomena of interest to mental health nursing (Johnston & Fitzpatrick, 1982), constituting another source of critique. Reflecting on the history of mental health nursing over the past 150 years, Stuart (1999) urges that mental health nurses review concepts such as the therapeutic relationship which have become a deeply embedded feature of mental health nursing identity. What follows is a discussion of some of the critiques of mental health nursing, and their implications for the concept of the therapeutic relationship.

Consumerism and mental health nursing

Recent New Zealand mental health policy and advisory documents signal a move towards a more consumer oriented mental health service, which demands that nurses re-evaluate the concept of the therapeutic relationship (Mental Health Commission, 1998a; 1998b, Ministry of Health, 1997a). Similarly the Australian and New Zealand College of Mental Health Nurses acknowledges in its *Standards of Practice* (ANZCMHN, 1995) the significance of "partnership", emphasising the need to focus on the consumer's experience and perspective of services provided. Consumer focused views of mental health care are not without their contradictions. Hazelton (1997) has pointed out the conflicting discourses inherent in different notions of consumerism. There is a contradiction between discourses of consumer rights and those of risk and community rights. At a micro level nurses are encouraged to respect consumer rights and encourage collaboration in care, while at a macro level risk discourse prefigures both who will come to receive services, and what the nature of the clinical relationship will be. Nevertheless consumerism provides an alternative discourse of mental health care that has implications for nurses' concept of the therapeutic relationship.

Therapeutic relationships and coercive power

Since the development of the concept of mental health nursing as a therapeutic relationship there has been substantial critique of mental health nursing as coercive, paternalistic and disempowering (Glenister, 1997; Hopton, 1997; Playle & Keeley, 1998; Porter, 1993; Sines, 1994). Moreover, a plethora of studies have shown that the ideals of the therapeutic relationship are frequently not realised in practice (Altschul, 1971; Cleary, et al., 1999; Gijbels, 1995; Gournay & Brooking, 1994; Howard, 1983; Morrall, 1998a; Sullivan, 1998). It is interesting to note that despite mental health nurses' apparent commitment to sociological critique of prevailing medical models of mental illness (Ritter, 1997b), there has until recently been little fundamental criticism of the part played by the highly individualistic concept of the therapeutic relationship, in perpetuating power structures thought by their critics to be responsible for psychiatric oppression. The acceptance by many nurses of the reality of the coercive power of mental health services has, according to Ritter (1997b), left mental health nurses ambivalent about their part in this process, and unwilling to embrace models of intervention that are seen to support what are considered to be the dominant interests of psychiatry. One result of this, in Britain at least, has been the shift by community psychiatric nurses away from working with the seriously mentally ill in favour of working with individuals with less severe mental illness (Gournay, 1995; Morrall, 1998a). A similar trend has been noted in the United States (Mellow, 1986; Pelletier, 1984). Nurses are understandably reticent about embracing models and practices that are perceived as coercive and disempowering. And yet they are faced with a dilemma that an illness model of mental distress can provide a conveniently parsimonious explanation for troubling experiences (Ritter, 1997b), and constitutes a powerful cultural resource that can be harnessed to beneficial effect. The adoption of the therapeutic relationship as a fundamental concept in mental health nursing has not ended the coercive practices that led to its development. Development of an alternative model is, however, problematic.

Theoretical critique

In a theoretically sophisticated analysis of the concept of nurse-patient relationships, May and Purkis (1995) draw on social theory to describe nurse-patient relationships as a discursive production that enables a common sense appreciation of events and practices. Their critique has important implications both for traditional conceptualisations of the therapeutic

relationship and for the alternatives discussed later in this section. While it must be acknowledged that May and Purkis' critique is grounded in 'general' nursing, it does not take too close a reading to see that the subtly coercive practices discussed invite ready comparisons with mental health nursing. The general point that professional education prefigures the nurse-consumer encounter such that certain responses to questions are legitimised while others are discounted seems wholly applicable, for example to Peplau's theory. That nurses construct their encounters with consumers according to available theoretical and cultural resources seems a straightforward observation which is consistent with what is generally known about learning and socialisation. What much of the critique of mental health care has identified is the hegemonic influence of psychiatry in this process (Hall, 1996). However it is by no means clear that alternative accounts are free of such influences. In fact the amorphous boundaries of concepts such as collaboration, partnership and alliance pose similar problems to that identified by May and Purkis (1995) with the concept of 'transcendence' in Parse's theory. Another issue raised by May and Purkis' critique is that of the extension of the clinical gaze over areas of consumers' lives that has occurred as a result of nursing's adoption of 'human relations' as the basis of the nursing curriculum. Mental health nursing arguably has a more legitimate role in exploring with consumers deeply personal issues affecting their lives. But the boundaries and purpose of this exploration are problematic if there is not some definition of what the reason for nurses' involvement in consumers' lives is.

Responses to critiques of the therapeutic relationship

In response to the criticisms of the paternalism of mental health care, and recognising the professional ideology inherent in the concept of the therapeutic relationship, several alternative conceptualisations of relationships between nurses and consumers have been advanced.

Collaboration and re-authoring

Barker, Reynolds and Stevenson (1997) have used the concept of collaboration to reconstruct the therapeutic relationship, arguing that the function of nursing is "collaborative reauthoring" of a person's life, particularly experiences of mental distress and illness. The concept is further elaborated by Barker and Whitehall (1997) who make a distinction between mental illness and a person's experience of it, noting that the latter, but not the former, is the focus of nursing practice (Barker, 1996). While the reality of mental illness is not explicitly denied, it is accorded a limited place in Barker's concept of mental health nursing. Significantly,

Barker acknowledges Peplau as a major, if belated influence on his own thinking (Barker, 1993), in some cases invoking Peplau's name in support of what is identifiably a more modern concept of the therapeutic relationship (Barker, 1996; Barker, Reynolds & Stevenson, 1997; Barker & Whitehall, 1997). The concept of collaboration attempts to address the paternalistic professionalism of earlier models of the therapeutic relationship, and to re-establish the focus of mental health nursing on the experience of the consumer.

Therapeutic alliance

Speedy (1999) discusses the concept of 'therapeutic alliance' as an alternative to 'therapeutic relationship' and argues that the concept of therapeutic alliance meets the criticism that 'therapy' has in the past been thrust on consumers with little negotiation. It is interesting that some of the arguments advanced by Speedy for the concept of therapeutic alliance are similar to those previously advanced for the therapeutic relationship. For example, Speedy argues that the concept of alliance, with its emphasis on the experience of the consumer, is necessary if nursing is to move beyond a purely custodial role. This is almost exactly the argument advanced from the 1950's onwards for interpersonal relationships as the basis of mental health nursing (Altschul 1971; Bazley, 1973; McEwan, 1961; Peplau, 1952/1988). However the concept advanced by Speedy also emphasises attending to the experience of the consumer, and although this might also be argued to be a feature of Peplau's and others' conceptualisations of the therapeutic relationship, there is a sense in Speedy's discussion that a new attentiveness is required. Previous concepts have too readily attributed explanatory power to mental illness, whether conceived in biological, intrapersonal or interpersonal terms, as an objectified phenomenon, rather than to the person experiencing it.

Recovery

One singular response to calls for involvement of consumers in mental health policy and service is the use of the concept of recovery as a guiding principle of mental health care (Anthony, 1993). This is apparent in the policy and advisory documents discussed above. Recovery seeks to politicise relationships between consumers and caregivers, and this has implications for nurses' concepts of therapeutic relationships. Recovery is the focus of an analysis of mental health nursing as a discursive product framed by its historical location as either custodial, therapeutic or, more recently in the recovery discourse, as empowering (Clinton & Redmond, 1999). This is not considered an "evolutionary development" (p. 260),

but a “layered and contingent structuring of practice” (p. 260). However it is apparent that there is at least some element of progression towards a more subtle and less direct form of involvement, although Clinton and Redmond’s analysis would maintain that the shifting forms of the professional relationship enable maintenance of control rather than, necessarily, movement towards self determination. Thus attempts at reconstructing the relationship between nurse and patient need to be examined in light of the historical and contemporary social control function of psychiatry and mental health nursing.

Clinton and Redmond’s (1999, p. 260) conceptualisation of mental health nursing as representing “... a complex and multiple, as opposed to unitary social form.” is helpful in considering the many constructions of mental health nursing to be found in the literature. It is apparent that the therapeutic relationship should be similarly regarded not as a defined and determined entity, but as a discursive product which, from its origins in the theories of Rendo and Peplau, has assumed different meanings and forms in different historical circumstances. Any future concept of the therapeutic relationship must also be understood as historically and socially situated, and evaluated for its role in supporting consumers in their experience of mental distress and illness. This requires an awareness of the social context that may contribute to that distress, and within which meaning and recovery is sought. The place of mental health nursing within the social order must necessarily be part of practising nurses’ understanding of their relationships with consumers. Under such a definition the therapeutic relationship is both a technology of personal change and a process of developing awareness of the social context within which any change must occur.

The therapeutic relationship: an adequate basis for professional continuity?

The influence of Peplau in developing an interpersonal theoretical framework for nursing is apparent in continued interest from nurses in interpersonal relationships in nursing (Gastmans, 1998). However the future place of mental health nursing in the care of people with psychological distress and mental illness cannot be assumed on the basis of tradition. Perhaps more than any other discipline in mental health, nurses are being challenged to articulate their distinctive contribution to mental health care. Recent developments in the context of mental health care require that nurses re-evaluate concepts that influence their practice. Some examples are; the renaissance of biological models of illness (Lego, 1992), case management (Forchuk et al., 1989), prescribing rights (Ministry of Health, 1997b), evidence-based care

(Farrell, 1997), calls to respond to the needs of the severely mentally ill (Gournay, 1995), and the need to form collaborative relationships with consumers (Parkes, 1997). These diverse influences each challenge mental health nurses to consider the role of concepts like the therapeutic relationship in their practice, and their contribution to the care of consumers. While each of the above influences represents an approach to achieving improved mental health care, the therapeutic relationship may be the core concept by which nurses define involvement with consumers.

Justification for the current study

The therapeutic relationship has become fundamental to the identity of mental health nursing, and in official and educational discourse has assumed a central place in the articulation of the focus of the discipline. Most research has approached relationships between nurses and consumers seeking to establish whether these relationships are consistent with existing theory. Many studies have concluded that more explicit use of theory would lead to relationships that are more therapeutic. There are few studies that seek nurses' perception of their relationships with consumers, yet understanding 'what is going on' in these relationships requires understanding of the perceptions of participants, from the perspective of participants. The current study seeks to improve that understanding by asking nurses for their perceptions of the therapeutic relationship in their practice. On the basis of the results it is intended that education and practice can be informed by greater understanding of nurses' perceptions of this central concept.

Summary

The concept of the therapeutic relationship gave formal expression to interpersonal caring practices that can be traced to the early asylums. This review has shown that the concept of mental health nursing as a therapeutic interpersonal relationship arose in response to perceived inadequacies in intrapersonal theories and institutional practices in the middle of this century, and came to be regarded as both foundational to nursing and special to mental health nursing. Various models of therapeutic intervention are used by nurses, building on the therapeutic relationship, which is fundamental to mental health nursing identity and practice. Arguably the concept of the therapeutic relationship has not been adequately articulated and explicated within mental health nursing. A number of research studies suggest that the ideals of the nurse-

patient relationship as therapeutic are not always realised in practice although from qualitative studies it is apparent that the therapeutic relationship plays a significant role in mental health nurses' perceptions of their practice. Although a multitude of conceptual frameworks and models are available to inform mental health nursing practice, the concept of the therapeutic relationship continues to hold a firm place in the views mental health nurses hold of their practice.

Part Two. Methodology and methods

Introduction to Part Two

In Part Two the theoretical and philosophical framework, and steps of the research process are outlined. The discussion considers the relationship of the methods of data collection and analysis to the theoretical and philosophical framework of the study. The constructionist research paradigm is discussed, and the language of constructionism is discussed in relation to the relevant literature. The constructionist research paradigm offers a means of studying perceptions of the therapeutic relationship that considers their social location and discursive production. The relationship between the research question and the methodology is also explored. Epistemological and ontological assumptions of the research are considered. The method of data collection, focus groups, is discussed, and the reasons for using that method are explained. Focus groups are an interactive form of data collection, in which both researcher and participants contribute to the production of meaning. The relationship between focus groups as a method of data collection, and the assumptions of the constructionist research paradigm are explored. Ethical issues identified as relevant to the study are discussed. The methods of sampling, purposive sampling and snowballing, are described, and the process of data collection is outlined. The methods of analysis have been developed from a range of qualitative research literature, and this literature is identified and the analytic process is outlined. The process of analysis is related to the research paradigm of constructionism and its theoretical and philosophical commitments. Part Two concludes with a consideration of criteria for evaluating the soundness of qualitative research, and a discussion of how these criteria have been addressed in this study.

Part Two, Chapter One.

Constructionist research

Introduction

The philosophical framework for the study is that described by Gergen (1985), Burr (1995) and Crotty (1998) as social constructionism. Burr traces the origins of social constructionism to the symbolic interactionism of Mead (1934, cited in Burr, 1995). Another major influence on the development of social constructionist thought is the work of Berger and Luckmann (1966). Those authors' work provides an exposition of the sociology of knowledge that underpins constructionist research agendas and which I have used in analysing the transcripts produced in this study to explore the social construction of the therapeutic relationship. This section outlines the development of the constructionist agenda for research. Broadly, social constructionism refers to the idea that identity and what we take to be reality, are constructed in social interaction. Observation and analysis do not reveal a stable reality; neither fixed social structures nor essential truth are available for discovery.

The language of constructionism

Multiple uses of the term 'constructionism' require that those who claim to hold to a constructionist position define that position and acknowledge the assumptions and beliefs they wish to imply (Crotty, 1998). The terms 'constructivism' and 'constructionism' both appear in the literature. Gergen (1985) spoke of the 'social constructionist movement' and emphasised this choice of term to distinguish between his view of the social construction of knowledge and the individualist constructivism of cognitive psychology. Guba and Lincoln (1994) and Schwandt (1994) subsume Gergen's social constructionism under the general rubric of constructivism which they define as including both individual and social constructivism. By contrast, Appleton and King (1997) in discussing 'constructivist' research reject the term 'constructionism' and with it any concept of knowledge as socially constructed. This view appears to be inconsistent with what these authors describe as the 'transactional' epistemology of constructivism.

This study will observe the distinction noted by Burr (1994) and Crotty (1998) between the social constructionism of Gergen (1985) and the cognitive concept of constructivism attributed by Burr (1995) and Guba and Lincoln (1994) to Piaget. For the purposes of convenience the term 'constructionism' will be used in this thesis to refer to social constructionism, drawing on the work of Gergen (1985), Guba and Lincoln (1994), Schwandt (1994), Burr (1995) and Crotty (1998). The philosophical assumptions of constructionism will be outlined, and the place of constructionist inquiry in the investigation of nurses' relationships with clients will be explored. Social constructionism, because of its emphasis on the dialogical nature of reality, has been chosen as the framework for the study, and the reasons for this choice are explained.

Constructionism, knowledge and reality

In their foundational treatment of the sociology of knowledge Berger and Luckmann (1966) state that what we come to experience as taken for granted reality develops through processes of social interaction:

... in so far as all human 'knowledge' is developed, transmitted and maintained in social situations, the sociology of knowledge must seek to understand the processes by which this is done in such a way that a taken for granted 'reality' congeals for the man in the street. (p. 15)

More recently the socially constructed nature of knowledge and reality has been the focus of a constructionist perspective that seeks an intermediate position between the individualism of behaviourist and cognitivist perspectives, and the determinism of structural theories.

The common sense view that the world is not given, but is interpreted on the basis of individuals' perceptions is consistent with the constructionist worldview, but is only the most elementary form of constructionist thinking (Schwandt, 1994). Constructionism is not merely concerned with the psychology of knowledge, but proposes an alternative to the positivist and empiricist commitments of traditional natural science (Gergen, 1985). According to Schwandt (1994), radical constructivists (sic) suggest that not only do perceptions influence what we understand to be reality, but that reality is no more than our constructions of it, and not an independently existing facticity. This leads to a subjectivism that denies the reality of nature or culture as a preexisting 'objective facticity' (Berger & Luckmann, 1966). The individualism of this position places it beyond the social constructionist perspective used in this research.

While cognitive constructionism might be considered individualistic because it is concerned with constructions within individual minds, Gergen (1985) stresses the social nature of knowledge construction. Gergen's social constructionism is thus less concerned with the individual production of meaning than the influence of human interaction in the form of language on the generation of meaning. In Gergen's social constructionism, knowledge is seen as dialogical, and thus socially rather than individually constructed. This position brings into play the role of interests in influencing the construction of knowledge, an issue taken up by feminist and other critical constructionists. Critical constructionism positions the knower in a social and political context that constructs the knower, and most importantly from the point of view of research, constructs the research encounter in terms of the perceptions and interests of both researcher and informants (Schwandt, 1994).

Burr (1995) offers four criteria, any one of which identifies a social constructionist position. Firstly, constructionism assumes a critical stance towards taken-for-granted knowledge. Observations of the world are not considered to reveal, by simple correspondence, what is there. What we see is considered to be a result of perspective. Burr's second criterion is the cultural and historic specificity of knowledge. Knowledge is considered to be a cultural product, dependent on the social and economic arrangements of a specific place and time. Knowledge as socially constructed and maintained is Burr's third criterion. This brings into focus the role of language both as a repository of knowledge and the means of its construction and transformation. Burr's fourth criterion relates knowledge and social action. Knowledge is socially constructed, creating some possibilities for action while closing off others.

The relationship between knowledge, language and action, and its historical and cultural location have implications for both the subject and process of this research. The therapeutic relationship is enacted in language and is a site of dispute over how language should be used. Peplau's (1960) distinction between 'social chit-chat' and 'responsible use of words' is an example of this, and nurses use of every day rather than theoretical language has similarly brought the criticism that their interactions are 'untherapeutic' (Altschul, 1971). A brief sketch of the constructionist research paradigm will provide a background against which the position of the current project will be outlined.

The nature of the constructionist research paradigm

According to Schwandt (1994), the roots of constructionism reach back to the earliest philosophical arguments over a rational foundation for knowledge. However, constructionism as a research paradigm has been articulated only recently, through the work of authors such as Gergen (1985); Guba and Lincoln (1994); Schwandt (1994); Burr (1995); and Crotty (1998). In proposing constructionism as an emergent research paradigm, those writers are working within a tradition of philosophical discourse extending back to classical Greek philosophy. Schwandt (1994) regards the constructionist research paradigm as a 'persuasion' rather than a model and one that shares the philosophical commitments of interpretivist approaches to research. The broad framework of constructionism does not offer details of method, but direction as to the philosophical commitments of the research.

The constructionist view of knowledge and reality rejects the positivist view that research is a matter of seeking an objective point of reference from which reality can objectively be viewed and veridically interpreted. In constructionist research the version of reality we create is a product of both the world we seek to understand and of the interpretive systems we apply to it. From this perspective perceptions of the therapeutic relationship do not await discovery or uncovering, they are constructed in the process of inquiry. The resulting construction of the therapeutic relationship is not considered to be 'truth' in some sort of objectively valid sense, but a construct that is congruent with the perceptions of the research participants.

The view arising from these philosophical commitments is that a participatory research process, in which a construction of reality is co-created in a dialectic between researcher and participants, was an appropriate process for this study. The social position of the researcher as mental health nurse provides a common perspective between researcher and participants. Commonality of perspective is considered to enhance the quality of constructionist inquiry (Guba & Lincoln, 1994).

Constructionism and nursing research

Although nursing research has embraced qualitative methods of inquiry there has as yet been little nursing research conducted within a specifically constructionist paradigm. Burr (1995) comments that much social science that is consistent with the philosophical assumptions of constructionism is not specifically described as constructionist, and this would

appear to be the case with nursing. A related issue is nursing's individualism (Purkis, 1994), especially the concept of the nurse-patient relationship (May & Purkis, 1995), which is the focus of this study. The only major paper from within the nursing literature that addresses constructionism is that of Appleton and King (1997) which adopts an individualist constructivist (sic) perspective. These authors argue that constructivism offers nurses "... a highly robust and practical framework for undertaking research inquiry" (1997, p. 21). They regard constructivism as an emerging paradigm that is set to assume a significant role in nursing research, and look to constructivism to provide an understanding, through hermeneutic interpretation, of "essential meaning of constructions" (p. 15). Appleton and King (1997) believe that essential meanings exist independently of their construction in language. They also attribute a structuralist perspective to constructionism that they contrast with their preferred individualist perspective: "Unlike constructivism, [constructionism] holds the view that understanding is not shaped by the individual, but *purely* by collective endeavours and social processes" (emphasis added) (Appleton & King, 1997, p. 16). This view is at variance with the position on constructionism outlined by Burr (1995), which sees individuals in interaction as constructing reality, but not in the structurally determined manner suggested by Appleton and King. Interaction involves dialogue between individuals who retain some agency in the process rather than acting merely as predetermined entities. It is hoped that this study will show the discursive nature of the therapeutic relationship and thus the value of a social constructionist research paradigm for nursing.

Criticisms of the constructionist research paradigm

Guba and Lincoln (1994) discuss four criticisms of constructionist inquiry. They are the problems of criteria, critical purchase, authority and epistemology. Criteria for evaluation of soundness of this study are further discussed in Part Two, Chapter Two.

Criteria.

This problem has to do with the adequacy of the basis of conclusions in constructionist inquiry. Because constructionism denies an essential foundation for interpretation it is open to criticisms of relativism and solipsism. In part the root of this criticism is a lingering commitment to an idea of truth established by appeal to correspondence with the 'real' world. A more pragmatic perspective on truth is required for constructionist inquiry. However although the constructionist view is that knowledge is developed in a dialogical process,

knowledge is not regarded as arbitrary. Science represents a disciplined construction of knowledge that is systematic and extensively shared. Similarly, knowledge as construction is not accepted as right in an arbitrary or relativistic way. Constructions, like inadequate scientific accounts, can be incomplete, simplistic, uninformed, inconsistent and inadequate. According to Guba and Lincoln (1994), criteria for making judgements of the adequacy of conclusions are given by the paradigm out of which the individual operates. In the case of constructionist research, judgements of adequacy have to do with the coherence of conclusions with the worldview of participants.

Critical purchase

This criticism is to do with the willingness or ability of constructionist accounts to be self critical, and a tendency to privilege the views of actors. A more general comment of this nature has been made of qualitative research in nursing (Crowe, 1998b). This criticism has been said to apply to constructivism, rather than constructionism (Crotty, 1998), as constructivism "... suggests that each one's way of making sense of the world is as valid and worthy of respect as any other, thereby tending to scotch any hint of a critical spirit" (p. 58). Identification of the researcher's position, a reflexive approach to the research (Koch & Harrington, 1998), and comparison of the findings with existing literature, provide some protections against producing a naïve account.

Authority

This is almost the opposite of the problem of lack of critical purchase, and is to do with the potential of the researcher as interpreter to exert a dominant perspective that suppresses the dialogic nature of the emerging account. This issue has been taken up in regard to nursing research by Cheek (1996) who describes qualitative research as creating a viewing position based on the perspective of the researcher. This position is then used to represent what is 'real' or 'authentic'. Cheek (1996) suggests attending to *how* research texts represent, rather than exclusively on *what* they represent. Returning the interpretations to the participants for confirmation is one response to this criticism. Researcher reflexivity can also assist by providing a check on any tendency to take over the participants' accounts.

Epistemological claims.

Generalising from a psychological to an epistemological claim requires an account of how individually constructed knowledge can be shared and modified. This criticism is directed at cognitive and individualist constructionism, and is one of the reasons that a social constructionist approach has been adopted for this research. Social constructionism emphasises a dialogically evolving knowledge that is never wholly individual, as the language that forms it is a shared resource of intersubjective meanings.

Constructionism and mental health nurses' perceptions of the therapeutic relationships.

Mental health nursing is an irreducibly social process. The therapeutic relationship as an interpersonal transaction between nurse and patient is widely held to be essential to mental health nursing (Olson, 1996; Orlando, 1961; Peplau, 1952/88). Social constructionism is a useful paradigm of inquiry for such a fundamentally dialogic activity as mental health nursing. The philosophical commitments of constructionism assume that the therapeutic relationship is not a self evident truth but a product of complex discursive practices.

The discursive construction of mental health nurses' interactions with patients diagnosed as neurotic has been given extensive treatment by Tilley (1995). The usefulness of the constructionist paradigm in exploring mental health nursing is well demonstrated in Tilley's work. Using the concept of "accounts", Tilley was able to describe the use of practical, rather than theoretical knowledge by inpatient mental health nurses, and the construction of reality by the consumers they cared for. This study explores the perceptions of nurses from three different practice settings, and does not seek to compare or contrast their perceptions with those of the consumers they care for. Also, the context of care is not specifically examined in the current study, another point of distinction with Tilley's work.

Tilley (1995) contrasted the accounts of interactions provided by nurses and consumers that the theories which purport to explain them. This contrast between 'lived' and 'intellectual' ideologies supports the constructionist proposition that there is no 'real' or 'true' account of the therapeutic relationship awaiting explication through research. Rather, research should aim to describe how nurses (and others) construct and modify their accounts of the therapeutic relationship. The use of a constructionist paradigm should allow an account of the therapeutic

relationship, as it is perceived by the participants, to develop through the exchange of meanings occurring in the process of the research.

Summary

Crotty (1998) cautions qualitative researchers to reflect deeply on the claim to engage in constructionist research, because such a claim has crucial implications for the research process. This chapter has attempted to outline the constructionist framework of the study in a way that addresses the concerns raised by Crotty's admonition. Constructionism offers a range of perspectives from the everyday observation that individuals play an active role in developing their knowledge of the world to claims that what we take to be the external world is no more than our constructions of it. Those constructions are considered to be a product of the positions we hold. Social constructionism adopts a definite perspective that makes a commitment to knowledge as a social production shaped by the conventions of language and other social processes. The reality of an external world is not denied, but it is considered to be understood through the medium of socially negotiated understandings.

Within the social constructionist view, inquiry is regarded as a social activity in which understandings emerge dialogically (Gergen, 1985). Reality is considered to exist as "multiple, sometimes conflicting mental constructions of everyday life experiences that are situation and context dependent" (Ford-Gilboe, Campbell & Berman, 1995, p. 16). These assumptions provide both an epistemological and ontological foundation for the research that is consistent with the study of perceptions as social constructions rather than the private experiences of individuals.

In the following section the nature of focus group research is outlined. There has been some criticism that focus group research can objectify participants' perceptions and experiences and can privilege researcher's interpretations over the views of participants (Barbour, 1999). The use of a constructionist research paradigm acknowledges that the researcher adopts a "viewing position" (Cheek, 1996) and is not disinterested in the process of knowledge construction. As a method of data collection, focus groups are consistent with the constructionist notion that reality is socially negotiated through the medium of language.

Part Two, Chapter Two

Focus groups and nursing research

Introduction

This chapter discusses the use of focus groups in research, outlining the major issues to be considered in designing a focus group study. The use of focus groups to study perceptions of the therapeutic relationship is discussed. Focus group research uses group discussions to identify and explore thoughts and perceptions about a specific area of interest. Originally developed within social science, focus groups are now widely used in market research (Johnson, 1996; Morgan, 1988). Interest in the use of focus groups in social science research has grown in the last decade (Morgan 1996). The potential utility of focus groups in health and nursing research has been recognised by Basch (1987), and Kingry, Tiedje and Friedman (1990), and they have been used in a variety of nursing research studies. Focus groups have been described as “a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive non-threatening environment” (Krueger 1994, p.18). The role of group processes in focus groups is emphasised by Morgan (1996, p. 129) who defines focus groups as “... a research technique that collects data through group interaction on a topic determined by the researcher.” Morgan (1996) also notes the divergence in definitions of what constitutes focus group research and recommends that focus groups be regarded as “... a set of central tendencies with many useful variations that can be matched to a variety of research purposes” (p. 131). This view is apparently shared by Kitzinger and Barbour (1999, p. 4) who state that “... any group discussion may be called a focus group as long as the researcher is actively encouraging of an attending to the group interaction.” Although focus group research is often thought to be preliminary to larger qualitative or quantitative studies, Morgan (1988) argues that they can also be used as a ‘stand alone’ method.

Focus groups have been described as useful, but underutilised in mental health nursing research (Happell 1996). Mental health practitioners’ longstanding interest in group processes (Basch 1987) further suggests the usefulness of focus groups in mental health nursing research. Focus groups were used by Street and Walsh (1996) in their research into community mental

health nursing, and by O'Brien (1999) in exploring mental health nurses' perceptions of their practice. Carson, Leary, de Villiers, Fagin and Radmall (1995) used focus groups to explore stress in mental health nurses. The only other example from mental health nursing was that of Breeze and Repper (1998) who conducted one focus group interview as part of a study of the care experience of clients labelled as difficult.

Group interaction

Focus groups generate data through group interaction between participants, a characteristic that distinguishes the method from group interviews, and is considered the "hallmark of focus groups" (Morgan, 1988, p.12). Interaction is considered to be crucial to the method, but frequently overlooked by researchers (Kitzinger, 1994). Review of a number of nursing research studies supports Kitzinger's claim that the role of interaction in focus group research is frequently overlooked. Studies by Thomas, MacMillan, McColl, Hale and Bond (1995), Kelly, Shoemaker, and Steele (1996) and Torn and McNicol (1998) show little evidence of attention to interaction in the process of conducting interviews, in analysis of the data or in reporting the results.

Generation of concepts

There is evidence supporting the belief that focus groups generate more concepts than individual interviews (Thomas et al., 1995). These authors consider that focus groups are a more efficient means of gathering data about perceptions than individual interviews, with no difference in the depth of concepts generated. However Morgan (1996) reports that focus groups are less efficient than individual interviews at generating responses from participants, but that the responses generated provide greater insight into the sources of complex behaviour and motivation. One disadvantage of focus groups is that it can be difficult for the researcher to follow new leads as the interest is in the ideas generated within the group, rather than in those of the researcher (Morgan, 1988, p. 19). In attending to the ideas generated in focus group discussions, Basch (1987) and Kitzinger (1994) argue that noting distinctions and contradictions is an important part of the methodology of focus groups. Kitzinger recommends exploring differences and encouraging participants to theorise about the reasons for diversity.

Numbers of participants and groups

Opinion varies about the numbers of participants who can be involved in a single focus group discussion. Basch (1987) sets the number at between four and twelve, however Kitzinger and Barbour (1999) state that focus groups can be conducted with groups of as few as three participants. The latter view is supported by Thomas et al.'s (1995) report of a focus group study involving three participants. By contrast, Linhorst (1995) reported a focus group of 22 participants. Between four and twelve participants are recommended by Morgan (1988, p. 44) to balance practical and methodological concerns. The number of groups used in a particular study is also variable. Examples of focus group research using just one group are those of Torn and McNichol's (1998) exploration of the concept of the nurse practitioner, and Butler's (1996) study of Irish public health nurses' responses to changes in child care legislation and policy. By contrast Thomas et al. (1995) conducted 15 focus groups, each with new participants, as part of a project aimed at generating items for a patient satisfaction survey. Morgan (1988, p. 43) provides the general guideline of conducting "... as many groups as are required to provide an adequate answer to the research question." Morgan cites Calder (1977) as recommending three to four groups, with the proviso that when the researcher can anticipate the participants' responses, the data gathering is complete. Another consideration is the number of population subgroups to be sampled. According to Basch (1987) the number of groups to be conducted, and the number of participants in each group depends on the goal of the research, in particular whether depth or breadth of data is sought.

Constitution of groups

Familiarity between participants is considered by Torn and McNichol, (1998) to be beneficial in focus group research. This is supported by Krueger (1994) and Carey (1994), who give homogeneity as a key principle in group formation. Morgan (1988) however, recommends that participants are strangers to prevent existing alliances inhibiting the discussions. Kingry et al. (1990) also argue that participants should be unfamiliar with each other. Market researchers have traditionally recruited participants not known to each other, while health researchers sometimes make a point of recruiting participants who work together or who are known to each other (Basch, 1987). In her research into the impact of media messages about AIDS, Kitzinger (1994) used existing work groups to form some of her focus groups, reasoning that such groups would naturalise the process of discussion. Although she acknowledges that focus

groups do not produce 'natural' data, Kitzinger (1994) likens focus groups to participant observation, as the participants, if they are drawn from a naturally occurring social group, represent the range of knowledge resources available to individuals from that group. Members are also considered likely to communicate in natural language, rather than in language supplied by the researcher. This partly addresses the a problem identified by Morgan (1988, p. 20), that focus groups are an unnatural setting. Groups members are normally selected to produce a theoretically chosen, purposive sample (Morgan, 1988). The goal is not representativeness, but to learn about a range of perceptions (Kitzinger, 1994). Morgan (1996) uses the term 'segmentation' to refer to the practice of sampling different population subgroups, noting that constructing groups from different subpopulations builds a comparative dimension into the research design, and facilitates discussion through the participants' familiarity with each other.

Structure

The amount of structure to a focus group discussion depends on the research goals and the skills of the moderator. In market research, when the goal is often to construct a survey for wider distribution, groups are likely to be highly structured. In health and social science research it may be more important to encourage groups to explore topics at some length so that depth of data is obtained. Reports consulted for this review referred to lists of key questions that were used to initiate and guide discussion (Kelly et al., 1996; Thomas et al., 1995; Torn & McNichol, 1998). Morgan (1988) describes guides to focus groups as important in structuring the discussion, but warns against rigid adherence to set questions as this may prevent worthwhile emergent issues from being explored.

Moderator influence and issues of power

While there are issues about power in focus groups that might influence what is said and by whom (Happell, 1996), the researcher, as group moderator, plays an important role in managing the discussion so that power issues do not impede discussion. Morgan (1988) warns that a high level of moderator involvement can bias the discussion towards the moderator's views, and prefers a low level of involvement so that the views of participants are emphasised. However Morgan considers that moderator involvement is useful in managing potential problems of loss of direction, and provides guidelines to assist groups to self-manage these problems. Agar and McDonald (1995) and Safarstein (1995, cited in Morgan, 1996) have used discourse analysis to highlight the focus group moderator's influence over the direction of the

discussion, noting that disruption of interaction can occur with a directive moderating style. Although Morgan (1996) notes that the problem of researcher influence is not limited to focus group research, it must be considered a threat to soundness of this form of research as interaction is the prime source of data in focus group research.

Usefulness of focus group data

The role of group interaction in providing data in focus group research is regarded as a crucial characteristic to this form of research (Happell 1996; Kingry et al., 1990; Kitzinger 1994; Morgan 1988, 1996; Thomas et al., 1995). However group processes are not without their problems and concern has been expressed that group dynamics, while having the potential to generate ideas not found in individual interviews (Kingry et al., 1990; Morgan 1988, 1996) may also inhibit or distort discussion as participants compete with each other or acquiesce to the perceived wishes of the researcher (Thomas et al. 1995). While the potential for the group to inhibit the production of ideas should not be minimised, Carey (1994) and Kitzinger (1994) maintain that it is the contextual nature of the data provided that constitutes their greatest significance. Carey (1994) refers to 'censoring and conforming' as two ways in which individual members of groups may tailor their contributions in accordance with their perceptions of other members or of the group moderator. Carey (1994) gives examples to show how other group members provide a moderating influence over 'exaggerations' of individuals. Cogent examples of the moderating influence of groups are also provided by Kitzinger (1994), who argues that the contextualising influence of a group provides a contrast between what might be expressed in the 'private' arena of an individual interview and the 'public' arena of the group. If groups act to censor or elicit conformity, this may provide important information on a group discourse that gains in significance from its contrast with the perspective of individuals.

Analysis of focus group data

Many of the issues of analysis of focus group data are common to other qualitative methods (Kitzinger 1994; Morgan 1996). However Sim (1998) considers that there are issues that present problems specific to focus group research. Review of a number of focus group studies shows that a wide variety of inductive and deductive analytic processes are used. Morgan (1988) suggests that if a schedule of interview questions is used, the topics should structure the analysis, suggesting that the data are read deductively to answer specific questions. However

focus group researchers also describe a range of inductive analytic processes which can be used to identify themes in the data. Morgan (1988, p. 68) states that "...the issue is always the question that motivates the analysis."

Analysis of focus group data involves the researcher in an iterative process which may be regarded as continuous with the process of data collection. Morgan (1988) describes both qualitative and quantitative approaches as useful for data analysis, arguing that a qualitative means of data collection does not preclude analysis by quantitative means, provided that in the analysis allowance is made for the research design.

It is in the process of analysis that the significance of interaction between participants and its influence on the data is frequently overlooked. Many descriptions of focus group research make no reference to capturing in the analysis, the dialectic nature of the data (e.g. Basch 1987; Happell 1996; Kingry, Tiedje & Friedman 1990) while focus group reports similarly neglect in their analysis, the role played by interaction (e.g. Kelly et al., 1996; Thomas et al. 1995; Torn & McNichol, 1998). By contrast, the process described by Morgan (1988) analyses data for the effect of interaction on knowledge formation, including the influence of the researcher's questioning. Similarly, Kitzinger (1994) considers that focus groups should examine how ideas develop within a specific context. The focus group provides or simulates that context, and analysis of the data should record the nature of the interactions that produce the data, not merely the themes abstracted from their context.

Focus groups produce context-specific data in the form of public accounts (Sim, 1998), which may contrast with the perceptions of participants taken individually. Although this difference has been used to cast doubt on the validity of group data, such data is valuable in its own right (Kitzinger, 1994), and as Sim (1998, p. 350) remarks "...it is not clear that any process of analysis can meaningfully separate out from the data the social factors which operate within the context of a focus group - indeed, the very idea of a context neutral perspective may not even make sense within this sort of epistemological framework."

Appropriateness of focus groups for the current study

Focus groups have been chosen as the method of data collection for the current research because the lack of existing research warrants research of an exploratory nature. Although

focus group methodology is not restricted to exploratory research, the interactive nature of focus groups enhances the possibility that tentative ideas will be put forward and discussed, and that contrasting perspectives and new perceptions will emerge as part of the focus group dialogue. There is a further practical reason supporting the use of focus groups: that more participants can be involved using group interviews than can be reached in the same number of individual interviews. Focus groups have been found to be useful in exploring perceptions of nursing. The previously cited studies by Street and Walsh (1996), Butler, (1996) and Torn and McNichol (1998) were planned around a similar objective to the current study: exploring nurses' perceptions of their role. My own previous experience with the method (O'Brien, 1999) confirms the usefulness of focus groups for exploring nurses' perceptions of their practice. That experience was also useful in planning an interview guide for the current study.

Focus group methodology is congruent with the constructionist framework that underpins this research. Focus groups are consistent with a view of reality as socially negotiated and of knowledge as constructed in a dialogical process. The interactive nature of focus group discussion and the absence of emphasis on consensus (Carey, 1994), mean that multiple perspectives can be acknowledged. Protagonists of contrasting views can identify points of conflict and agreement that can form part of the data. These have been discussed as "complementary" and "argumentative" interactions (Kitzinger, 1994). These features of focus group methodology support a constructionist view that the therapeutic relationship does not constitute a fixed entity that can be represented by a single objectively valid account.

The literature on the therapeutic relationship has been developed within a variety of health disciplines, most notably psychology, psychoanalysis and counselling. Peplau's (1952/1988) theoretical formulation of nursing, with its focus on the therapeutic relationship, is itself derived from those disciplines. Despite the existence of these theoretical traditions, mental health nursing practice has been considered to lack theoretical foundation (Reynolds & Cormack, 1990), and to elude formal theoretical formulation (Tilley, 1995). The concept of the therapeutic relationship, however, plays a central role in mental health nursing discourse as reflected in policy documents and mental health nursing texts. It can be expected, therefore, that focus group research would reveal both consensus and divergence in perceptions of the therapeutic relationship. Of further interest is how the discursive practices of groups of nurses are managed within groups, given the likely divergence of views.

Summary

Focus groups are a useful means of collecting qualitative research data. When the commitment to interaction is followed through to the process of analysis, focus groups allow socially constructed realities to emerge. A growing literature on focus group methodology shows a divergence of practices in their utilisation. Focus groups offer the opportunity to explore phenomena such as perceptions of the therapeutic relationship without predetermining what those perceptions might be. The interactive process of focus groups provides for a multiplicity of perspectives to be represented, and for contrasting views to form part of the data. These characteristics make focus groups an ideal method of data collection for the current study.

Part Two, Chapter Three

Ethical issues

Introduction

The research received ethical approval from the Auckland Ethics Committee and the Massey University Human Ethics Committee. In addition, approval to approach staff was obtained from the Hospital and Health Services from which participants were recruited. The Massey University *Code of ethical conduct for research and teaching involving human subjects* (Massey University, n. d.) guided the research process. The code sets out five principles for research, discussed below, and emphasises that they need to be “... interpreted before being applied in a context” (p. 1). Discussions of research ethics provided by LoBiondo-Wood and Haber (1994) and Morse and Field (1995) have been used to assist in the process of interpretation.

All participants were nurses with whom I had no current professional relationship in either a clinical or academic sense. Most were recruited from a Hospital and Health Service outside the area from which my teaching institution normally enrolls students. In the case of three participants who were recruited from within the Hospital and Health Service served by my teaching institution, specific consent was sought from this Service, and issues of potential conflict of interest in relation to my teaching role were avoided.

Informed consent

Informed consent in research involves providing understandable information, with time to decide about participation, in circumstances that are free from coercion (LoBiondo-Wood & Haber, 1994). Informed consent is based on the ethical principle of respect for persons. Potential participants were sent an Information Sheet outlining the research and what commitment was required of participants (Appendix A). The Information Sheet explained processes of maintaining confidentiality and anonymity. Participants were also sent a copy of the Consent Form (Appendix B). At an initial meeting to discuss the research, the Information

Sheet was discussed. Participants were given the opportunity to discuss the research, and their rights as research participants were outlined.

Confidentiality

Confidentiality and privacy are also based on the ethical principle of respect for persons. Confidentiality requires that the individual identities of participants will not be publicly linked to the information they provide, while privacy involves that participants maintain control over the disclosure of personal information (LoBiondo-Wood & Haber, 1994). Privacy is important in the data collection process, and was provided by ensuring that group and individual interviews were conducted discretely and without unwanted intrusion. For this purpose, a separate room at the participants' places of work or, in the case of the nurse-therapist group, at my own place of work, was used. Transcripts were rendered anonymous by the use of alphabetical codes. The typists who helped with the transcription were asked to sign a confidentiality form (Appendix C). Audiotapes were stored in a locked cabinet throughout the course of the study and destroyed on completion of the study. Transcripts will be securely retained for a period of ten years for possible secondary analysis.

Minimising of harm

The right to protection from harm is based on the ethical principle of beneficence (LoBiondo-Wood & Haber, 1994). Potential harm due to lack of informed consent or breach of confidentiality or privacy was avoided as described above. LoBiondo-Wood and Haber (1994, p. 326) categorise research according to five levels of potential for harm. This study would be rated at Level One (no anticipated effects) or Two (temporary discomfort). There is some evidence that participants in qualitative research can benefit from their involvement (Hutchinson, Wilson, & Wilson, 1994). Discomfort in this study could result from the researcher's manner or the content of questions. Some protection from this was provided by the researcher's previous experience, and by the process of supervision. The literature on focus groups (Morgan, 1988) and interviews (Morse & Field, 1995) provided guidance in the methods that help to promote the wellbeing of participants.

Truthfulness

This principle is not specifically referred to in either of the references cited so far. However it would seem to be implicit in gaining informed consent that the researcher is truthful in providing information. Johnstone (1994) relates truth to the ethical principle of autonomy, which she considers to be a moral obligation of health professionals. Truthfulness in this study was ensured by providing a full explanation of the conduct, purposes and use of the research. Participants were encouraged, especially during initial briefings, to seek clarification of any points that were unclear. The researcher provided candid responses to these questions, and continued to provide information as needed throughout the process of the research. Transcripts were discussed with participants whose views were sought, and the final report will be made available to participants.

Social sensitivity

Like truthfulness, this principle is not specifically addressed by either references consulted for this study. It perhaps arises because of the focus in New Zealand on Maori rights as provided in the Treaty of Waitangi. For this reason the Health Research Council's *Guidelines for researchers on health research involving Maori* (Health Research Council, 1998) has been used as a basis for discussing social sensitivity. Although the proposed study does not specifically seek to involve Maori, the issues raised in the *Guidelines* are considered analogously applicable to other cultures and vulnerable groups. Maori or any of these other groups could have been involved in the research. The purpose of the guidelines is to "...establish research practices which ensure that the research outcomes contribute as much as possible to improving Maori health and well-being, while the research process maintains or enhances mana Maori" (Health Research Council, 1998, p. 3). Lack of respect for Maori cultural values is considered a threat to the validity of research, and the same might be said for other vulnerable groups.

To promote social sensitivity the researcher needed to acknowledge his social position as a middle class pakeha male researcher who might be considered to enjoy a favoured social position in terms of those aspects of his identity. Experience as a nurse in mental health provides some personal insight into practices of marginalisation. Reflection on this experience, and acknowledgement of known sources of discrimination; age, gender, religion, social class (Massey University, n.d., p. 1), helped to promote social sensitivity in the research process.

Part Two, Chapter Four

Research methods

Introduction

This chapter describes the steps of the research process used in this study. The methods were determined by the methodological commitments outlined in Part Two. They include methods of sampling, data collection, data display and analysis.

Sampling

Participants were identified by purposive sampling and snowballing (Miles & Huberman, 1994; Polit & Hungler, 1995). An initial purposive sample was sought by placing an advertisement in a staff newsletter and on notice boards explaining the nature of the research and asking interested individuals to contact the researcher for further details (see Appendix D). Nurses who expressed interest were asked to contact others who they thought might also be interested. Potential participants were sent the Information Sheet explaining the research in more detail and copies of the Data Collection Form (Appendix E). They were invited to attend a briefing at which the nature and conduct of the research was explained. In some cases a telephone explanation was sufficient, with further explanation provided at the initial interview. Issues of confidentiality and anonymity and the right to withdraw were explained.

Purposive sampling was considered to be consistent with the research aim to identify the perceptions of a specific group of people about a specific topic (Miles & Huberman, 1994). Within the study population of mental health nurses, theory driven sampling (Miles & Huberman, 1994) was used to identify three sub-groups of participants; inpatient nurses, community based nurses, and nurse-therapists. This process is consistent with the practice of “segmentation” in focus group research, described by Morgan (1996) and referred to in Part Two, Chapter Two. Reading and anecdotal evidence suggested that the focus of employment might be a source of divergent ideas amongst the study population. The sampling process was designed to recruit a sample that showed both overall variation (seen in the differing areas of clinical practice) and homogeneity within the individual focus groups (which were constituted

of nurses from the same practice areas). The focus of sampling was to answer conceptual questions about the therapeutic relationship rather than to achieve representativeness. The aim was to achieve analytic, rather than sample to population generalisation (Firestone, 1993). The data collection form was completed prior to or at the first interview, and details were checked to ensure that volunteers met criteria for inclusion in the study. No volunteers were excluded at this stage.

All participants were recruited prior to the first interview, and no further sampling was attempted once the initial sample had been recruited. No attempt was made to recruit participants who held particular views such as typical, deviant, confirming or disconfirming cases (Miles & Huberman, 1994). Self-identification of participants may have contributed a bias in favour of nurses holding positive views about the therapeutic relationship.

Interview schedule

Four questions were developed to make up an interview schedule. The schedule attempted to strike a balance between what was known about the likely focus of discussion and the need to limit the amount of data generated. The questions which comprised the interview schedule were:

- “What does the therapeutic relationship mean for you in your practice?”
- “How do you know if you have achieved a therapeutic relationship?”
- “Do you have a specific theoretical model that guides your practice?”
- “Do you think it is possible to achieve a therapeutic relationship without using a specific theoretical model?”

The interview schedule was designed to facilitate and focus discussion rather than control it. The perceptions of the participants were not seen as data to be collected, but rather as accounts co-authored in the process of the focus group discussions (Kvale, 1988, cited in Miles & Huberman, 1994).

Data collection

Data were collected in the form of audiotaped focus group discussions which were transcribed for analysis, field notes made during or on the day the interviews were conducted, a

journal in which issues related to the research process were recorded, and self reported summary data which were recorded on the Data Collection Form. Interviews were conducted at the participants' place of work in the case of the inpatient and community nurses, and in the researcher's place of work in the case of the nurse-therapists.

In total eight interviews were recorded, three with the community nurses and nurse-therapists, and two with the inpatient nurses. The decision on how many interviews to conduct was based on the guideline provided by Morgan (1988) and referred to in Part Two, Chapter Two, that data collection should continue until sufficient data is collected to answer the research questions. Problems encountered in the interviews were a fire alarm leading to vacating the building in the first interview, the intrusion of an unidentified person in a later interview, and an audiotape that jammed during recording.

The interviews proceeded at a different pace with each group, and the questions on the interview schedule lead to differing issues being raised within the groups. At the second interview with each group a brief review of the previous discussion was presented before proceeding to discussion of the next unanswered question on the interview schedule. Discussion was encouraged by the researcher's use of probes and clarifying questions and through the use of examples to demonstrate points under discussion.

For the final interviews with all groups, participants had been provided with copies of the transcripts and the researcher's initial summary of the data. In the interviews the researcher's tentative summary of the themes of the research were discussed. No intergroup comparisons were made at that time. Participants were encouraged to reflect on and contribute to the process of analysis by offering their observations about the content of the transcripts. At this stage confirmation of the tentative analysis was not specifically sought, although participants were invited to comment and note any points of disagreement with the researcher's version of the discussion.

Although data analysis is discussed in the next section, it will be apparent that data collection and analysis were continuous rather than separate processes. The researcher's responses to issues raised in the interviews helped shape the construction of perceptions, as did the responses of group members to each other. Interaction has been noted to be one of the

strengths of focus group research (Kitzinger, 1994; Morgan, 1988) and in the researcher's field notes and journal, interaction became further data for analysis.

Transcription of interviews

The first five interviews were transcribed by the researcher as soon after recording as possible. Those transcribed by typists were read alongside the tapes soon after transcription. The aim was to avoid the natural decay in memory that might diminish the accuracy of recall of observations not recorded on tapes or in field notes (Krueger, 1994). The maximum delay between an interview and preparing the transcriptions was seven days. The remaining interviews were transcribed by a typist. In two cases, the first two nurse-therapist interviews, technical problems with the recording made full transcription of the interviews impossible. The sound quality was so poor that the interview had to be reconstructed with the help of field notes. In the case of the second nurse-therapist interview the field notes were provided to the participants with a letter from the researcher explaining the nature of the recording problem, and the subsequent interview focused on the original questions from the interview schedule and the content of the researcher's field notes. In this way the issues which had previously been discussed were reviewed and new data about them was generated. This interview was successfully recorded and transcribed in full. Following transcription, the tapes were reviewed again and the transcriptions checked for accuracy.

Analysis

This section describes the process of analysis. Sources of literature that informed the analysis are identified. A discussion of theoretical issues arising in the analytic process of constructionist research is followed by description of the processes of data display and the steps used in the analytic process of the study.

Approaching the process of analysis

The process of analysis was approached with a cautionary awareness provided by Wolcott (1994) that the term 'analysis' is grounded in natural science and lends an aura of respectable certainty even to a qualitative study. There is always a provisional quality to the meanings derived from the process of qualitative research. In constructionist research, meaning is not regarded as inhering in objects or dialogue awaiting discovery. Meaning is regarded as a co-created product, and not fixed or final (Crotty, 1998). Therefore while the term 'analysis' is

used to describe the reduction, organisation, presentation and interpretation of the data, the 'findings' (meanings) are regarded as constructions that are theory laden, rather than transparent accounts.

Not the least of the problems in this regard is that I am a product of the same educational influences as the research participants and a member of the same discursive community of mental health nurses. It was apparent during the process of conducting the interviews, and in the process of analysis, that I was more involved in the focus group discussions than some of the focus group literature recommends. Krueger (1994, p. 121) describes focus group moderators as "... visitors in the world of participants...". However, in my case, I was a co-participant in the world of the participants through our common professional identity as mental health nurses. While as noted in Part Two, Chapter One, commonality of perspective is considered to enhance the quality of constructionist inquiry (Guba & Lincoln, 1994), there is also the possibility that research can simply 'validate' existing beliefs, rather than reconstruct those views. Continued reading, discussion and reflection assisted in developing the reflexivity necessary to avoid uncritically accepting my own or participants' views (Koch & Harrington, 1998; Lamb & Huttlinger, 1989).

Much of the focus group literature does not explicitly state the theoretical perspective that informs the process of analysis (Cunningham-Burley, Kerr & Pavis, 1999) and I have previously commented (see Part Two Chapter Two) on the objectivist nature of many focus group studies. The influence of market research on the development of focus group methodology is such that some descriptions of the process of analysis describe an objectified process in which verifiability is emphasised at the expense of coherence or in which a simplistic form of quantification suffices for analysis (Johnson, 1996). Krueger (1994, p. 129-130) states that analysis must be verifiable, and gives as his criterion for verifiability, that another researcher, given the same data, should be able to arrive at similar conclusions. Krueger's criterion seems consistent with what other literature describes as auditability (e.g. Koch, 1994). However Sim (1998, p. 349) considers that focus group data should be regarded as "... firmly contextualised within a specific social situation", which is likely to be an unnatural one for the research participants, limiting any concept of verifiability.

The focus group texts consulted for this study provided useful guidelines and principles of analysis, although additional reading of constructionist literature was necessary to bring a constructionist perspective to the process of analysis. If the strength of focus groups in generating data through interaction is to be exploited, then analysis must attend to interaction as data (Kitzinger, 1994) and to the theoretical commitments that underpin the analysis.

The constructionist theoretical basis of this research required that the process of analysis allow the dialogical nature of participants' perceptions of the therapeutic relationship to emerge. Prior to and throughout the study, I read around the concept of constructionism as I sought a theoretical framework for the research that was consistent with the philosophical commitments of the study to a transactional epistemology and a social ontology (Guba & Lincoln, 1994). In reporting the themes, I have endeavoured to provide some of the context of the interviews by providing not just key statements, but sections of interviews in which they occurred. Something of the interactive nature of the developing perceptions of participants is apparent in these sections, and in several instances conflicting views are presented in the same interview segment.

For this study a process of analysis was sought that was both consistent with the assumptions of constructionist research and with the nature of focus groups as a method of data collection. Miles and Huberman (1994, p. 56) remind researchers "...to be explicitly mindful of the purposes of your study and of the conceptual lenses you are training on it..." This required that the analysis enabled the description of perceptions as they were constructed in the participants' language and interactions, acknowledging the position of the researcher in this process. Part of the process of analysis involved reflection on the research process, especially on my own involvement as a researcher and as a mental health nurse. In this I found that much of the focus group literature did not address issues that arose as a result of my being a researcher investigating my own discipline. This involved a degree of reflexivity that is not normally a part of either market oriented or social science focus group research, although its importance in social science research has been noted (Cheek, 1996).

Literature

The analytic process for this study was informed by two sources of literature; the focus group literature and the more general literature on analysis of qualitative data and

constructionism. The methods of analysis are common to a number of different forms of qualitative research (Miles & Huberman, 1994). Texts that served as key references were Morgan's (1988) and Krueger's (1994) guides to focus group research, Miles and Huberman's (1994) reference work on qualitative data analysis, and the work of Wolcott (1994) already referred to. In addition, Berger and Luckmann (1966), Burr (1994), and Crotty (1998) provided guidance in terms of the constitutive role played by language and interaction in producing meaning. This was previously discussed in Part Two, Chapter One.

Krueger (1994) discusses steps of the analytic process and principles of analysis, and this discussion was helpful with conducting an orderly, systematic, replicable analysis. Both Morgan (1988) and Krueger (1994) stress that the analysis is guided by the research question and by the principles of focus group research: that it is the group that is the focus of analysis and the interactive process of the group that leads to the formation of the concepts that will emerge from it. Consistent with the view that focus groups should avoid seeking only consensus (Morgan, 1988), and instead allow 'argumentative' and 'contradictory' voices to be heard (Kitzinger, 1994), the analysis sought to identify divergence of opinion both within and between groups, as well as agreement within and between groups. Data from individual groups are presented, and contrasts and commonalities between the groups are outlined.

Morgan (1988) signals that focus groups as a means of data collection do not presuppose a particular method of analysis. As an example, Morgan argues that the use of ethnographic qualitative analysis, which seeks broad themes illustrated by relatively long passages of text, or quantitative content analysis by counting occurrences or 'mentions' of words, concepts or ideas, should both be considered and where possible used in tandem. Krueger (1994), referring to the twin traditions of social science and market research in focus group research, emphasises a need to balance the social science emphasis on systematic and verifiable procedures with the emphasis of market research on practicality, which is explained as avoiding undue attention to detail.

According to Miles and Huberman (1994, p. 2), qualitative research lacks a "bank of explicit methods of analysis to draw on." This problem is compounded for researchers working within a constructionist framework because for constructionist researchers there is "...no unambiguous social reality "out there" to be accounted for and hence no need to develop

methodological canons to explicate its laws" (Miles & Huberman, 1994, p. 2). In relation to focus groups, Frankland and Bloor (1999) suggest that focus group data, while often poorly analysed, does not demand distinctive analytic techniques. From Wolcott's (1994) work I have taken the distinction proposed between description, analysis and interpretation as a guiding framework for data transformation, although I have not rigorously followed Wolcott's restricted use of the term 'analysis'. I have been concerned to provide an account that uses participants' terms and language in discussing the therapeutic relationship, the more descriptive task in Wolcott's terms. However I have also used "systematic coding" (Miles & Huberman, 1994, p. 56-7) through which some generalities have been suggested, a process Wolcott refers to as 'analysis' in a more restrictive sense than that generally used in the research literature. Any move to interpretation, asking "what does it all mean?" (Wolcott, 1994, p. 12) is quite limited, with attention focused mainly on producing a systematic descriptive account. However by applying a social constructionist lens to the process of analysis it has been possible to provide an account of the therapeutic relationship as it is constructed through participants' engagement with the therapeutic discourse of mental health nursing. With further rounds of interviews it would have been possible to test any speculations about meanings but I considered that beyond the scope of this study.

Preliminary analysis in the process of data collection.

Although some patterns were apparent in the early interviews, no attempt was made to isolate patterns from their original context until the formal stage of the analysis, as the constructionist commitment to interaction amongst participants required that segments of the data be maintained in their discursive context. Impressions arising from initial interviews were discussed at subsequent interviews and confirmation of these impressions was sought from participants. Krueger (1994) recommends member checking to verify the researcher's descriptions although Sandelowski (1993) cautions against seeking verification through member checking, as too rigid an adherence to this process can threaten the validity of qualitative research. Initial impressions were treated as a provisional view of the data and as a stimulus for further discussion. This iterative process enabled patterns that emerged early in the research process to be discussed by participants, ensuring that they were not 'captured' prematurely, that is, before the dialogical process had either developed into a consensus or it was clear that there was a difference of views amongst participants.

Data display

Data were initially displayed in a five column WORD¹ table in landscape format. The first column was used to record the identity of the speaker (using alphabetical codes to maintain anonymity), and the second for notes made in the process of analysis. The notes in column two recorded my impressions of the significance of comments and interactive processes. An open attitude was maintained towards these notes to avoid premature closure in the process of analysis. The field notes were read at the same time as the interview transcripts to enable comments recorded at the time of the interviews to be integrated into the data displayed in this column. This added details and nuances to the transcriptions. The third column was headed 'codes' (Miles & Huberman, 1994, p. 56) and in this column verbal labels assigning meaning to participants' accounts were made, where possible using their own language and verbatim quotes. The fourth column focused specifically on interactive processes between participants and between myself and participants. Points of convergence and consensus were noted. The fifth column was used for text. Each statement was entered into a separate cell of this column. Pages were numbered for ease of reference. An example of a page of transcript, illustrating the use of the columns described above is included (see Appendix F). A total of 163 formatted pages of transcript were produced. Continued reading and reflection on methodological and substantive literature informed the process of data collection and analysis.

Steps of the analytic process

Analytic strategies were drawn from a variety of qualitative research literature. The research questions provided the basis for that part of the analysis that served to explore tacitly hypothesised positions about nurses' perceptions of the therapeutic relationship. Analysis also sought themes that were not hypothesised but which emerged from the data. Analysis was both continuous and staged, occurring throughout the research process and in the formal stage of reading the transcripts. As Miles and Huberman (1994) have commented, analysis begins with data reduction, and the process of reduction begins with formulating the research questions which limit and shape the data to be generated. Field notes collected during and following interviews provided initial speculative analysis and began a process of immersion in the data which continued until the results were written up. Labels recorded in column three

¹ Using Microsoft Word® Version 7

were used to establish the basis for initial thematic categories (Miles & Huberman, 1994), referred to as 'codes' at this stage of the analysis, as they referred to what Miles and Huberman (1994, p. 56) describe as "chunks of data". Codes were assigned terms (verbal labels) that were thought to most closely approximate their meaning, in order to facilitate recall, by both the researcher and the research supervisor, of the concept to which it referred (Miles & Huberman, 1994, p. 64). Transcripts and field notes were read for suggestive codes, which were the basis of rereading in an attempt to confirm their descriptive power (Miles & Huberman, 1994, p. 58). The codes were initial speculative categories which provided the basis for the themes developed in analysis and described in Part Three. There was no return to the field to collect further data once the formal stage of analysis had commenced.

In successive readings initial codes shaped the analysis as I sought either confirmation or contradiction (Miles & Huberman, 1994, p. 61). During this process some codes were dropped from the developing thematic account; others were collapsed into broader categories to develop the eventual structure of the findings. Initial codes expanded to become the organising framework for further analysis. The transcripts were read for similar phrases or ideas, and for conflicting expressions (Miles & Huberman, 1994). In supervision, discussion of the data and apparent patterns helped clarify the process of analysis and review impressions arising early in the research process. Miles and Huberman (1994, p. 62) suggest that coding and recoding continue until a sufficient number of regularities emerge. They caution that the saturation sought through exhaustive analysis can become a "vanishing horizon" (Miles & Huberman, 1994, p. 62) and suggest that pragmatic considerations may determine when a halt is called to this part of the process of analysis.

As generalisations elaborated from the initial codes began to develop, comparisons were made with the nursing and related literature (Miles & Huberman, 1994), allowing the research findings to be positioned within this body of knowledge. At this stage the codes were regarded as 'themes' indicating that they represented patterns of similarity within the data. However, no assumption was made that the themes represented a theory (Creswell, 1994), but rather they are regarded as providing an account that was partly descriptive and partly analytic (Wolcott, 1994). As the analysis progressed it became apparent that the codes were clustered into the three themes that became the organising framework for the study. At this point numerical

codes were assigned to codes which contributed to each theme, so that the sections of transcript could be easily located in the process of writing up.

In parallel with the process of identifying codes and themes, the data were read for processes of interaction between participants and between researcher and participants. This is consistent with the commitment of focus group research to attending to processes of interaction (Kitzinger, 1994) and to the basis of the study in the constructionist research paradigm (Crotty, 1998; Schwandt, 1994). Interaction between participants in generating data is not included in either of the “accounting schemes” outlined by Miles and Huberman (1994, p. 61). Reading of the constructionist and focus group literature was crucial to developing this part of the analysis. Notes recording evidence suggestive of consensus and difference were made in column four of the transcript (see Appendix F). Findings describing the themes established in analysis have been merged with observations about interaction so that the process of construction of knowledge could be described. Similarly, reflective notes made in the first column of the transcript, and field notes, were read alongside the developing descriptive and analytic account, so that my own engagement with the data and ‘viewing position’ (Cheek, 1996) could be made transparent. In Part Three, which outlines the findings of the study, I have attempted to provide an account which reflects these parallel processes of analysis. In developing the written account of the three themes, the themes were ‘read’ in terms of social constructionist literature. This allowed the themes to be positioned within this body of theory and enabled a social constructionist account of the therapeutic relationship to be developed.

Part Two, Chapter Five

Soundness of the research

Introduction

Qualitative research has struggled to establish criteria by which readers of research can evaluate the quality of studies, and decide on their credibility (Sandelowski, 1986). Sandelowski conceptualised this issue as one of “rigour”, arguing that qualitative research had not demonstrated the rigour of its methods to a standard of scientific adequacy. In an attempt to establish rigorous evaluation criteria, some researchers have borrowed criteria from natural science, a practice regarded by Koch and Harrington (1998) as problematic, and one that has lead to a fruitless search for objective criteria of reliability and validity. A set of criteria that seek to overcome the preoccupation with reliability and validity has been proposed by Lincoln and Guba (1985). Within a general concept of trustworthiness, Lincoln and Guba offer criteria of credibility, transferability, dependability and confirmability. Koch and Harrington (1998) argue that Lincoln and Guba’s criteria have been adopted uncritically, and applied universally to nursing research, although they may not fit some studies. The tendency to adopt a rule-governed approach arises out of a desire to establish final criteria that will insulate the researcher against criticism. This form of objectivism prevents researchers from engaging with the social and political realities of research, and of locating themselves within the research process as an active agent in the production of knowledge.

Soundness and reflexivity

This study proceeds from a constructionist theoretical and philosophical position, and so commits the researcher to acknowledging his (in this case) identity and commitments and how they may have influenced the research process and outcome. In exploring the constructionist research paradigm it was noted that criteria for evaluation of the adequacy of the research arise from the research paradigm (Guba & Lincoln, 1994). In this chapter I will outline a position on what I have called soundness of the research, by which I mean the extent to which the research meets criteria for adequacy arising from the constructionist research paradigm. I have used the concept of reflexivity described by Lamb and Huttlinger (1989) and Koch and Harrington

(1998). Lamb and Huttlinger (1989) suggest that reflexivity involves awareness of the influence of the researcher on the research environment, and on the research findings. They commend Lincoln and Guba's (1985) suggestion of the "reflexive journal" which logs the research process in terms of the researcher's engagement with it. Koch and Harrington see reflexivity as moving beyond the actuarial concept of audit, to involve a "critical reading of [the] constructions... that inform our research practice" (1998, p. 887). Both positions are consistent with the constructionist view that "... the process of understanding is not automatically driven by the forces of nature, but is the result of an active, cooperative enterprise of persons in relationship" (Gergen, 1985, p. 267). A constructionist perspective has informed the process of reflexivity used in this study.

Position adopted on reflexivity.

Koch and Harrington (1998) outline four forms of reflexivity and discuss their application to nursing research. For the purposes of this study I have taken from Koch and Harrington the position that identification and location of my own interests in the therapeutic relationship, and my identity as a mental health nurse are crucial to the research process. I have outlined my interest in the area of study in the Introduction to the study (Part One, Chapter One). Location of the researcher within the study has been addressed in the discussion of the process of analysis, where it was noted that my shared educational background and identity as a mental health nurse has meant that I have not been able to adopt the position recommended by Krueger (1994, p. 121) of a "visitor in the world of participants." Furthermore, Sim (1998) notes that within the epistemological framework of focus group research, it is not possible to adopt the neutral position suggested by positivist frameworks of both qualitative and quantitative research. This is especially so for a study that is committed to constructionist methodology.

At various points in reporting the themes I have included my own voice, rather than assume the neutral voice of the researcher. This has enabled me to identify myself as a co-participant in the process of constructing an account of the therapeutic relationship. I was, in Tilley's (1995) words, a "sense maker making sense of sense makers" (p. 120). Sections of interview transcript have been included in the reporting of results in order to render visible my involvement in directing and managing the focus group discussions. The results reflect the interests I brought to the study as a student, an academic and a mental health nurse.

Member checking and the creation of text

Tentative views on the data as it developed were presented to the participants in the second and third rounds of interviews, although not all findings have been presented for confirmation by participants. Sandelowski (1993) modified her original position on rigour, cautioning that too rigid an approach to member checking posed a threat to the validity of qualitative research. The results presented in this thesis represent a “viewing position” (Cheek, 1996) which does not claim to simply reproduce views of participants, but to reflect my engagement with the views expressed and the relevant literature.

The decision trail

In order to provide as transparent an account as possible I have endeavoured to outline the steps of the research process and details of methods adopted. Details of sampling, data collection, transcription and display, and analysis are given, and the reader is invited to engage in the process of following the trail of the research as described in this report. Through explication of social constructionist underpinnings of the study I have endeavored to make the theoretical and philosophical commitments of the study available to readers. Whether the result is a credible report can in part be judged by readers on the basis of information provided in it, by explanations of details of method, and in the reflexive comments threaded through the report.

Part Three. Results

Chapter One. Characteristics of participants and overview of themes

Introduction

This chapter presents characteristics of the study participants, a discussion of the process of interaction in the groups and its influence on the construction of the accounts in the language of participants, and an outline of the themes identified in the analysis. An explanation of abbreviations used in sections of the transcripts is given in Appendix G.

Characteristics of participants

A total of nine participants was recruited to the three groups. There were three participants in each group, the minimum number for a successful focus group. Characteristics of the participants are shown in Table One. For participants holding overseas qualifications, their category of registration has been converted to its New Zealand equivalent. There were 3 male and 6 female participants. Their areas of clinical practice were; inpatient care (three), community care (three) and nurse-therapist (three). The community nurses worked in an intensive intervention team (two) and in early intervention (one). All members of the nurse-therapist group were involved in community based care and practised as family therapists. All participants held Comprehensive or Psychiatric nursing registration or its New Zealand equivalent. Three participants had undertaken New Zealand polytechnic based diploma courses leading to registration. The remainder had begun practice in mental health nursing through an apprentice-style hospital based programme, three in New Zealand and three overseas. A limited amount of discussion in the first interview with each group indicated that hospital based courses were similar in different parts of the world, and provided a similar introduction to the concept of the therapeutic relationship. All participants had been involved in uncredited postregistration education (inservice training, workshops, and seminars). Two had obtained undergraduate degrees after gaining registration. Four either had, or were working towards a postgraduate qualification. None held Master's degrees. The average length of clinical experience was 14.2 years. The average for each group was 14 (inpatient nurses), 16

(community based nurses) and 13 (nurse-therapists). On the basis of this data, any differences noted are unlikely to be related to length of clinical experience.

Table 1. Characteristics of participants.

	Inpatient group (n=3)	Community group (n=3)	Nurse therapists (n=3)
Male	2	0	1
Female	1	3	2
Polytechnic diploma (R Comp N) ¹	1	1	1
Hospital based course (RPN) ²	2	2	2
Postregistration inservice education	3	3	3
Postregistration degree	1	0	1
Postgraduate education	1	1	2
Clinical experience (years, averaged)	14	16	13

¹ Registered Comprehensive Nurse

² Registered Psychiatric Nurse

The groups

The three groups functioned quite differently in the way they responded to the questions and interacted in the process of discussion. Whether these characteristics are typical of nurses working in the areas the participants were drawn from cannot be definitively answered as the numbers were very small. However it is worth noting the main patterns of interaction that occurred, as it helps to create a context within which the themes identified can be better understood. It is also consistent with the constructionist methodology of the research which sees knowledge as socially constructed (Crotty, 1998; Gergen, 1985) and with the literature on focus groups, which emphasises attending to the patterns of interaction in the groups (Carey, 1994; Kitzinger, 1994).

The nurse-therapist group

This group comprised three nurses who practised family therapy, and who identified themselves as practising as nurses. It should be noted that none were employed as 'nurse-therapists' under any of the definitions found in the nursing literature and referred to in Part

One, Chapter Two. However their clinical practice as therapists provides an identity that distinguishes them from the other groups of nurses. The three members of this group were well known to each other through professional contacts, and had some common background in terms of their training in family therapy. In the first interview they discussed a clinical case in which they had all had some involvement in their professional capacities, despite working for different agencies. The nurse-therapists were by far the most articulate of the three groups. I could think of two possible reasons for this. One was that their work as family therapists required a high level of verbal skills, and considerable experience and training in working with group processes. Thus they were nurses whose professional culture was one of careful verbal exchange requiring conscious, explicit clarification of meanings, challenging received views and explicitly acknowledging differences of opinion. Secondly, this group may have had more experience in employing the skills required of focus group participants with each other than either of the other two groups. The nurse-therapists thus constituted an homogenous focus group (Carey, 1994; Krueger, 1988) with little indication of the potential problem identified by Morgan (1988) that familiarity and existing alliances can inhibit discussion. Although the participants were known to each other and shared broadly similar views, they had no difficulty expressing differences of opinion. Some of the differences expressed are referred to in the presentation of themes.

The nurse-therapists were keenly aware of issues surrounding the use of theoretical models in clinical practice, and could readily articulate the contribution and limitations of models of the therapeutic relationship to their clinical practice. In reviewing the interview transcripts it was apparent that this group generated the most discussion amongst its members, and also demonstrated the most explicit consensus and conflict in their discussions. Like the other two groups, the nurse-therapists' discussions were marked by a high overall degree of consensus, perhaps reflecting their common clinical backgrounds as nurses and family therapists, and yet they provided the clearest examples of conflicting views of all three groups.

Of the three groups, the nurse-therapist seemed the most at ease in discussing what might be considered theoretical questions about their clinical practice. On many issues they had more than one formed view, and readily problematised the issues as they discussed them. While the language of 'therapy', 'therapeutic' and 'relationship' seemed familiar territory, they also volunteered the most informed discussion of nursing theory and theorists, despite seeing these

theories as more useful for beginning practitioners than experienced clinicians like themselves. While there were significant similarities in the views of the three groups on theory and the therapeutic relationship, the nurse-therapist group appeared to have the most developed views on both nursing and therapy. This sometimes lead them to a profound questioning of mental health nursing identity, informed by a theoretically developed perspective and a broad view of practical clinical issues.

The community nurses' group

This group comprised three nurses, two of whom had recently worked together in another clinical area, and were now working in the same specialty community team, and a third who worked for a different specialty community team, but from the same mental health centre. The interaction in this group was characterised by a high level of consensus. As with the nurse-therapist group, an account of the therapeutic relationship, and responses to other questions, were developed in their discussion in response to the interview questions. The community nurses were all familiar with the concept of recovery in mental health care, and this provided the main focus of discussion around theory related to the therapeutic relationship. In theme two I discuss similarities between the way the therapeutic relationship and the recovery model were seen. This particularly had to do with the perception of recovery as a broad approach to care, and not one that could be used selectively, a view that was also held of the therapeutic relationship.

The role of the community nurses in responding to crises and in monitoring individuals at risk for deterioration in their mental state led them to reflect on the meaning of the therapeutic relationship in potentially coercive roles such as medication management and admission to hospital. The community nurses were adamant that these roles were enacted within the framework of therapeutic relationships. While they readily agreed on what constituted a therapeutic relationship, the community nurses held divergent views about how other theories and models built on that concept. There were examples of overt conflicts of opinion in the community nurses' group, especially around whether recovery represented a new and different approach to care, or was a development of the concept of a therapeutic relationship. Some of the dialogue in which this difference was discussed is contained in Appendix H.

The inpatient nurses' group

The striking feature of the inpatient nurses' group was its tendency to allow one articulate member take most of the speaking time, although in the responses of other members it was evident that they shared the perceptions being expressed. While all members contributed responses to the questions, for the two non-dominant members these frequently took the form of elaborations or confirmation of the views of the more outspoken member. As a group, the inpatient nurses made most use of 'common sense' explanations of the therapeutic relationship and of the integration of other theoretical concepts in their practice. The notion of using theory without being consciously aware of it was most frequently and clearly expressed in this group. This was consistent with the idea that arose in this group, that nurses were more likely to make explicit use of theory as their practice moved further away from the hospital environment.

Another feature of this group was that of the three groups involved in this study, the inpatient nurses had the most difficulty in negotiating and keeping appointments for interviews. On two occasions I attended appointments for interviews to find that events had interceded and it was no longer possible to conduct the interview. It was also difficult to agree on times when all three would be available. No doubt a contributing factor was that interviews were held at the participants' place of work. However even if an alternative venue had been arranged, the participants would have had to arrange to attend in their own time, while other participants, with the exception of one who attended while on leave, were able to schedule interviews within their hours of work. While these difficulties were frustrating for me as a researcher, they gave me cause to reflect on what it meant in terms of opportunities available for inpatient nurses to withdraw from the coalface of practice and reflect on the issues that confront them on a day to day basis. It seems that the difficulties I experienced as a researcher attempting to arrange interviews reflected a reality of inpatient work; that constant presence and availability constrains and constructs the perception of what it is to be a mental health nurse. This idea was discussed in one of the interviews (not with the inpatient nurses) and is discussed further in Part Four, Chapter One.

Themes

Analysis resulted in the identification of three themes. There was little residual data following the analysis, indicating that most of the recorded material contributed directly to the generation of the themes. Three themes were:

The therapeutic relationship as fundamental to mental health nursing

This theme describes the perception that the therapeutic relationship is a basic, perhaps *the* most fundamental concept of mental health nursing. The theme of the therapeutic relationship as fundamental was expressed in a variety of language, and applied across different practice areas, clinical roles and clinical situations.

Theory and the therapeutic relationship

This theme describes the relationship of the therapeutic relationship to other theoretical models. While all groups saw the therapeutic relationship as not dependent on theory, there was a range in the use of other theoretical concepts across the three groups. While the inpatient nurses and community nurses saw the therapeutic relationship as being part of whatever other model they assumed, (although there was some divergence of opinion in the community nurses' group), the nurse-therapists saw distinct limitations on the therapeutic relationship as a model for their practice as therapists.

The scope of the therapeutic relationship.

The scope of the therapeutic relationship extends from forming facilitative empathic relationships to overtly coercive practices. All groups discussed how dealing with difficult situations was part of the therapeutic relationships they developed with consumers, and this aspect of therapeutic relationship was developed through contrasts with other professionals. While this seemed to be taken for granted by the inpatient nurses, it was identified as an issue in the community nurses' group where it was felt that 'being there' for consumers during times of high need, strengthened rather than threatened the therapeutic relationship between nurse and consumer. With the nurse-therapist group there was doubt about whether accepting a role of dealing with difficult issues was something that was seen as positive. However, there was a sense that formative experiences in inpatient care generalised to develop a 'wider sense of awareness' that characterised therapeutic relationships between nurse-therapists and consumers.

The first theme seems to represent a deeply entrenched ideology, but the other two represent a range of positions for which the term 'theme' seems inadequate. Themes two and three are constant only in the broadest sense and cover a shifting set of realities which, in my perception as a researcher, do not pre-exist the research, but were constructions resulting from the research process. Participants drew on a range of common resources and experiences to develop these accounts, and it was my own participation in the discussion and later analysis that led to their explication as themes. This is consistent with the constructionist methodology of the research, and with the observations of Tilley (1995) that social interaction produces and reproduces valued discourses as to what mental health nursing and the therapeutic relationship 'is'.

With all three themes there was a sense that in putting forward the various views that contributed to their development, participants were confirming, and in some instances questioning received views of the therapeutic relationship. The focus of discussions ranged widely within and across groups. It seemed that the therapeutic relationship is a concept so embedded in the ideology of what it is to be a mental health nurse that at times it was mental health nursing, rather than the therapeutic relationship that was being discussed. In the following three chapters each theme is described in detail. Data from the transcripts are cited to support the analysis, and a social constructionist commentary is provided to illustrate the socially constructed nature of the therapeutic relationship in mental health nursing.

Part Three, Chapter Two

Theme One. The therapeutic relationship as fundamental to mental health nursing

Introduction

Of the three themes identified in this research the theme of the therapeutic relationship as a fundamental aspect of mental health nursing was the clearest and least ambiguous. This theme was expressed in each of the three groups and although there were differences, it was one of the strong similarities between them. The theme was expressed in a variety of language ('underpins', 'basic', 'fundamental', 'always there', 'core', 'underlines', 'forefront'). It overlapped with the other two themes in that the therapeutic relationship was considered fundamental to the use of other theoretical frameworks, and to underpin nurses' interactions with consumers throughout a range of involvement, from listening and supporting to the most coercive of interventions. There was a sense that the therapeutic relationship formed a taken for granted reality of clinical practice and was part of mental health nursing in whatever context it took place. It was also apparent that the implicit or explicit use of a range of theoretical constructs was considered to rest on the basis of a therapeutic relationship which for all groups was a core construct of their everyday practice. All groups expressed the view that the therapeutic relationship was not by itself a sufficient theoretical basis for mental health nursing practice, but for each it was seen as a necessary prerequisite for utilising other theory or models of practice.

The extent of consensus on the fundamental nature of the therapeutic relationship in mental health nursing suggests that participants draw on a pool of shared understanding in considering this concept. Apart from a view expressed in the nurse therapist group that the therapeutic relationship had limitations that brought it into conflict with some models of family therapy, there was little need for dialogue in considering the fundamental nature of the therapeutic relationship. The finding that participants saw the therapeutic relationship as 'fundamental' to their practice, besides confirming Olson's (1996) views of the therapeutic relationship in mental health nursing, indicates that the concept has become a part of their taken for granted world. A concept that once had to be invented has become, in Berger and

Luckmann's (1966, p. 85) words, an "intersubjective sedimentation". Berger and Luckmann (1966) describe a three stage process by which "Language becomes the depository of a large aggregate of collective sedimentations, which can be acquired monothetically, that is, as cohesive wholes and without reconstructing their original process of construction" (p. 87). Language allows experiences to be "externalised" (expressed as narrative), "objectivated" (perceived as pre-existing their social construction), and "internalised" (learned as 'truth').

The nurses in this study came from a variety of training backgrounds in three different countries and had a differing levels of postgraduate education and experience. Yet there was a consensus within and between groups that the therapeutic relationship was 'basic' to their practice. Although some told of how they acquired this knowledge in their preregistration training, it was apparent that what was acquired was now perceived as an existing reality, rendering invisible the process of its historical and current social construction. Berger and Luckmann (1966, p. 87) stress that the transmission of sedimented meanings is based on the recognition that they provide a permanent solution to a permanent problem that must be "...impressed powerfully and unforgettably on the consciousness of the individual." The ready recall of the learning processes, and adherence to the place of the therapeutic relationship in mental health nursing, suggests that the transmission of knowledge through education has had the expected effect of creating a lasting impression on the consciousness of the participants.

Learning about the therapeutic relationship

The background to the perception of the therapeutic relationship as fundamental could be seen in the learning experiences through which participants had been introduced to the concept. Experience as students learning about the therapeutic relationship was discussed in each group. For some the concept was an explicit part of their introduction to nursing; for others it was part of a structured introduction to 'the nurse-patient relationship' or a similar construct.

K: I mean for me /.../ it started in the first year of nursing when you had to go and make and break a relationship, and it, and there was a lot of... sort of... hot conversation about... the ethics of all of that. (NT1/15).

Learning experiences were readily recalled suggesting that they had formed a significant part of participants' introduction to nursing. One participant recalled that the term 'therapeutic relationship' had been used to describe a specific component of the curriculum:

B: Yeah, my first was... during my training days that was part... it was you know... a subject that was put on the curriculum... actually it was... yeah... labelled you know 'therapeutic relationship'. It was actually a subject that was... started round the time of training... a new component into the psych programme... (IN1/2).

Another participant in this group recalled the introduction of interpersonal skills in terms of counselling skills:

S: When I started training in the seventies that process came through in what was basic microcounselling skills. /... /... we had a separate microcounselling component /... /... to all the other sort of psyche-type nursing-type things... (IN1/1).

The learning of labels, which is the focus of these recollections, can be seen as a process of externalising in language, processes that could otherwise be understood only in terms of common sense notions of social communication. The acquisition of this new language is an important strategy in creating a therapeutic discourse of mental health nursing. Through participation in this discourse nurses are urged to move, from "social chit chat to therapeutic communication" (Peplau, 1960), an injunction repeated in later introductory mental health nursing texts in terms of a distinction between social and therapeutic communication (e.g. Schewecke, 1999).

A number of participants recounted assignments they had completed on nurse-patient relationships. This experience was common to participants from different nursing programmes, and to participants who had completed undergraduate programmes in different countries. The assignments focused on maintaining and analysing a record of interaction with a consumer, and included an aspect of reflective self-discovery:

B: I remember doing an assignment on 'therapeutic relationships' because, you know, like... /... /... we had to look at... a relationship with a friend first... do an assignment on that, you know, why you entered this relationship /... / some self disclosure stuff. (IN1/3).

M: Similar to B, actually in the training, but it went through /... / more the self-discovery type stuff first ... (IN1/3).

Significant in these accounts is the emphasis on 'self-discovery'. Although not explored further in the interviews it is apparent that the self as it currently existed was seen as inadequate for carrying out the work of mental health nursing. It needed 'discovery', a process mediated in the language of the therapeutic relationship, resulting in the careful development of a 'therapeutic self' adequate to the task of mental health nursing. This 'therapeutic self' could not be expected to emerge naturally, but needed careful development through a process of socialisation. One of the key components of this process was the education which is the subject of these recollections. This experience was common across different groups. The following excerpt was related by a participant with a comprehensive nursing background:

K: Well in the first year /.../ the therapeutic relationship was an assignment just before we did our clinical block /.../ and it was definitely Travelbee that we were taught about and it was, you know, the three phases of making the relationship, forming the alliance, establishing the relationship, and then the second phase was the working phase... of the relationship, doing whatever needed to be done, in terms of, yeah, helping that person and, and then terminating the relationship and /.../ writing your report, trying to fit it around the, the theoretical framework that we had been given, so that was our introduction to it. (NT2/3).

A graduate from a hospital based psychiatric nursing programme had undertaken a similar assignment:

D:... one of the things that we had to do was find a client... find a patient who you could develop a therapeutic relationship with. That was our task, and there was some guides for that, and we had to, I think one of the conversations we had to /.../. I don't remember using a tape recorder, but we almost had to write down verbatim that conversation, and then there was, sort of two columns of analysis, your own self analysis of what you are trying to do, like what aspects of... I suppose active listening, clarifying, questioning, paraphrasing those kind of things, what aspects of those you were using, and the column that was client-centered was, I think, what you were thinking about them and what you thought they were trying to convey, that's what I remember about that. (NT3/1).

Common introductory experiences, then, helped create the conditions for the therapeutic relationship to be experienced by participants as fundamental. This experience was recalled easily and was a common strand of shared experience in participants' introduction to relationships between nurses and consumers. It is apparent that the nurse herself is subject to observation and analysis, as much as the consumer who is the focus of these interactions. "Fitting it around the theoretical framework" (NT2/3) suggests that common sense understandings need to be supplanted with the new therapeutic discourse. The second of the

two participants quoted above talks of recording, for a teacher's assessment, "what you (i.e. she, the nursing student) *thought* they were trying to convey" (emphasis added), showing how the knowledge of the nurse is not accepted at face value, but is subjected to scrutiny in terms of the official therapeutic discourse.

The fundamental nature of the therapeutic relationship

The social construction of knowledge is concerned with how "... a taken for granted reality congeals for the man on the street" (Berger & Luckmann, 1966, p. 15). The success of the strategies discussed above in facilitating a process whereby knowledge of the therapeutic relationship became a taken for granted reality for the nurses in this study is apparent in the shared perception of the therapeutic relationship as 'fundamental', and in the primarily atheoretical nature ascribed to it.

The fundamental nature of the therapeutic relationship was expressed in a variety of statements by participants. There was strong agreement about this both within and across groups. Several participants used the terms 'foundation' or 'fundamental' in describing the place of the therapeutic relationship in mental health nursing. A variety of other terms with similar connotations were also used, each suggesting that the therapeutic relationship was a fundamental aspect of participants' perceptions of mental health nursing:

N: I think it means the foundation of how I practice. (CN1/2).

S: I mean it's still fundamental, I mean... that basic counselling... technique it's still there. I mean it hasn't changed./ ... / ... that basic fundamental... therapeutic contact is still there, it hasn't changed. (IN1/3).

E:... it underlines the whole... whatever you're actually trying to achieve or work with a client, because very much what you need to use... the relationship... it's certainly the core of... what we're doing... (CN1/7).

K: I think the therapeutic relationship is, is basic... to what you're doing; if you can't, if you're not connecting with people... on a human... level then you may as well not bother, really... (NT1/14).

What had been described earlier in this chapter as a carefully structured learning experience, subject to the discipline of self analysis, writing and assessment was now a "ready-to-hand" skill (Benner & Wrubel, 1989) experienced as independent of its social construction in language.

In addition to the similarities in terms used to express the fundamental nature of the therapeutic relationship, the therapeutic relationship was also seen as a constant feature of clinical practice. This applied over time, across different areas of clinical practice, across the range of situations that might occur with individual consumers, and as the basis of other theoretical influences. There was a sense that the therapeutic relationship permeated the whole of mental health nursing practice. Some qualifications to this observation are noted in theme three, but there was a clear convergence of views on this point.

In the inpatient nurses' group the therapeutic relationship was seen as a feature of clinical practice that was constant across time:

B:..it's like... forefront in your nursing and all the time there... (IN1/4).

The relationship of the therapeutic relationship to time was further illustrated in the following exchange which took place in another interview with the same group. Participants agreed that the therapeutic relationship was 'always there', although the mention of 'different degrees' suggests that not all references to the therapeutic relationship should be treated as referring to the same quality of relationship:

M: [The therapeutic relationship is] there all the time but in different degrees... .

R: Yeah, so it's a general agreement about that? It is there all the time?

S: Absolutely... I mean... you can have a professional therapeutic [relationship] all the time... there's the odd client that you... I guess it comes back to the transference and countertransference thing... (IN2/2).

In response to my question about whether nurses in different practice settings might give different meanings to the therapeutic relationship one participant said:

N: Even in the same areas like, like I'm doing special practice and I guess it's like you know, with the people you actually work with you need to have that therapeutic relationship. (CN1/3).

Another participant in the same group took this issue up even more emphatically:

A: You have to be able to take that with you... It's not something that you can actually say, 'well okay, in the community setting my care will be... can have a therapeutic relationship' and if I'm working in an inpatient setting, acute ward, 'oh, it's a different game there, I can't actually be... I can't have a therapeutic relationship'. I think you've got to be able to take it

with you everywhere you go no matter what area of practice you are in. /.../ it's not something you can just... ah pick up and leave behind, you know. (CN1/4).

The therapeutic relationship was considered to pervade all aspects of clinical practice and to be a constant feature regardless of the area of clinical practice:

A: I mean if you look at it in terms of everything we do we could see aspect (sic) of that... therapeutic relationship. (CN1/20).

The therapeutic relationship was seen as foundational not only to different areas of clinical practice, but also to the use of other theoretical influences:

E: It's how you practice the therapeutic relationship and I mean it's like then how you use... other tools, on top of that... /.../. Like for me, the relationship would come first, I might have an idea of the model I'm using in my head, but I wouldn't necessarily go out with that if that wasn't what the client was interested in. (CN1/10).

For the nurse-therapist group, recognition that the therapeutic relationship was 'basic' to mental health nursing was an important issue in recognising its limitations, especially in contrast with other theory and models:

L: Like because, the therapeutic relationship, kind of how we talked about how we learnt it, ah, you know on the coat-tails of a Rogerian approach to psychotherapy... um, but then you know other models of psychotherapy, um... you know, are very very distinct from that, like a strategic model you know is in many ways opposite... /.../... some of the interventions would be really frowned upon within a Rogerian approach. (NT2/14).

Although the therapeutic relationship was seen as foundational within the nurse-therapist group, there were differences within that group about the implications of its fundamental nature. When, as in the example given above, one participant had challenged whether the concept could be applied to other models of intervention, there were differences apparent in how broadly the term 'therapeutic' could be applied:

D: You are trying to be therapeutic aren't you?

L: Well, trying to be helpful, yeah. (NT2/14).

In the nurse-therapist group there was also a more explicit recognition that other skills may need to be built on the 'foundation' of the therapeutic relationship:

D: So your therapeutic relationship, although as we move into different areas like the three of us have you know /.../ without kind of that mainstream core psychiatric nursing that none of us are doing /.../ it is totally, um, it's necessitated the development of other skills and calling, like the example I just gave, the therapeutic relationship by another name... as per whatever the model is, it still happens and I think it's a bit more sophistication. (NT2/15).

It is apparent that for this participant, building on the therapeutic relationship does not involve leaving it behind. This contrasts with the view expressed in the exchange immediately above, in which the therapeutic relationship was seen as possibly at odds with other models.

Summary of theme one

Despite different educational backgrounds the participants in this research shared a common experience of having been introduced to the concept of the therapeutic relationship early in the course of their undergraduate education. No doubt this common experience helped to create the common perception of the therapeutic relationship as fundamental to their practice. Although there was strong agreement about the fundamental nature of the therapeutic relationship in mental health nursing, there were differences in the views expressed about how the concept of the therapeutic relationship articulated with other theoretical influences. This issue is taken up in the second theme of the research; theory and the therapeutic relationship. However it should be noted here that the different ways in which the therapeutic relationship serves as a foundation for the development of other knowledge and skills may represent different perceptions of what the foundational nature of the therapeutic relationship is. For some nurses 'foundational' may mean 'sufficient', while for others it may mean necessary (but not sufficient).

The concept of the therapeutic relationship as fundamental, while a clearly held perception of participants in this study, may in some ways be problematic. Such a broadly applicable concept, together with its taken-for-granted reality, appears to offer little in the way of boundaries as to when a relationship might have become untherapeutic. In responding to the research questions participants talked mainly about their own practice, and the research

situation may have created a tendency to idealise the concept of the therapeutic relationship. Participants were not explicitly asked to contrast therapeutic and non-therapeutic relationships.

Part Three, Chapter Three

Theme two: Theory and the therapeutic relationship

Introduction

While the theme of the therapeutic relationship as fundamental was characterised by a high degree of consensus within and between the groups, the second theme was characterised by both consensus and divergence of views. The theme of theory and the therapeutic relationship arose in response to one of the research questions that sought to explore the contribution of theory to the development of therapeutic relationships. For all groups there was a perception that the therapeutic relationship was not theory-dependent, but was more likely to be influenced by factors such as personality and experience. In considering this theme the three groups could be ranged on a continuum in terms of their integration of other theoretical concepts with the foundational concept of the therapeutic relationship. In order, the inpatient nurses, community nurses and nurse-therapists showed increasing integration of other theoretical concepts with the therapeutic relationship. There was a large area of consensus between the inpatient and community nurses in four areas. Both groups described the therapeutic relationship in atheoretical terms, spoke of their use of an eclectic theoretical approach, and of using theory without conscious awareness. They also described intrinsic qualities of the nurse and experience as contributing to their skills in developing therapeutic relationships. The nurse-therapist group discussed the therapeutic relationship, as a constraint on their practice, although did not reach a consensus about this. This tension was unresolved in the process of this study. The community nurses' use of the recovery model¹ extended their understanding beyond that provided by the concept of the therapeutic relationship, although as with the nurse-therapists there was a divergence of views about the place of the therapeutic relationship alongside other theoretical models. Despite these differences, all three groups expressed the idea that theory was limited in its capacity to inform practice, and a common

¹ It has been stated that 'recovery', an approach to mental health care associated with the work of Anthony (1993) and others is not a 'model' but an experience of a person who experiences mental illness (Burdett, personal communication, 1999). While accepting this as a valid perspective on recovery, in this report, consistent with the approach to using other terms whose meanings may be disputed, I have used the term in the sense suggested by the participants in order to render visible their views and perceptions.

thread within this theme was the role of experience in extending theory. Some implications of the different perceptions of theory are discussed in Part Four, Chapter One, where the views expressed by participants in this study are compared to literature on this issue.

In using the terms 'theory' and 'theoretical concept/s' I did not set parameters around what those terms meant to participants. I assumed that these terms form part of the everyday discourse of mental health nurses, notwithstanding that there may be significant differences between the meanings given these terms by practising nurses and those preferred by nursing theoreticians. In some discussions the term 'model' substituted for 'theory'. This stance on terms was not problematic in conducting the interviews or in reading the transcripts. I did not ask participants to justify their references to use of theory, a practice of previous researchers in this area, and one noted by Tilley (1995) to be problematic. The assumed common meanings were evident in the participants' responses and use of terms. I have made no attempt to validate or critique participants' accounts of use of theory; a perception that theory is used has been regarded as the important data.

In the literature review it was noted that there is a tension between literature that critiques mental health nursing practice as atheoretical (e.g. Altschul, 1971; Howard, 1983; Reynolds & Cornack, 1990), and that which describes mental health nursing as a practical skill, without the pejorative connotation that such skill is inferior to that derived from theory (e.g. McElroy, 1990; Tilley, 1995). The effect of attempts to have nurses integrate theory into their practice could be seen in participants' references to theoretical concepts that extend the atheoretical notions of the therapeutic relationship shared by all three groups.

By interviewing nurses from three different practice contexts it was possible to get some sense of the relationship between practice context and perceptions of the therapeutic relationship. Focusing on the group as the unit of analysis (Kitzinger, 1994) allowed differences between the groups to be explicated. It seems that the further nurses move away from an inpatient context the more likely they are to integrate theoretical influences other than the therapeutic relationship into their practice. Put another way, inpatient nurses provided the most atheoretical account of their practice, with the community and inpatient nurses showing increasingly explicit adoption of other theoretical influences. I do not consider this observation

to be a criticism of any of the groups' accounts of the therapeutic relationship. It is however, an interesting observation in terms of the role of theory in practice.

Taken together, the three groups exemplified the process of sedimentation of knowledge (Berger & Luckmann, 1966). In all groups the anonymised tradition of the therapeutic relationship could be seen, reified in the sign system of nursing discourse. In nursing theory, and the less formal theory which guided the learning of the therapeutic relationship discussed in the previous section, the therapeutic relationship has become objectified in language and thus generally available (Berger & Luckmann, 1966, p. 85). What were once problematic concepts that conflicted with the dominant practice of detached observation (Altschul, 1971; Martin, 1968, cited in Nolan, 1993a; McEwan, 1961) have become the accepted mainstream of mental health nursing. The different positions on theory adopted by the three groups illustrates knowledge in the process of sedimentation (Berger & Luckmann, 1966). For all groups, although to varying extents, the therapeutic relationship represents an internalised truth which is perceived as natural. For the community nurses, the recovery model has not become an internalised truth. Divergence of views on the issue of the relationship of the recovery model to the therapeutic relationship suggests that the recovery model is still perceived as an external reality. However the view that the recovery model, once adopted, becomes a total approach to care, suggests that internalisation of the recovery model is seen as a goal of the community nurses. The nurse-therapists' brief discussions of strategic family therapy, and especially the unresolved conflict with the concept of the therapeutic relationship suggests that this concept is perceived very much as external to the fundamental reality of the therapeutic relationship. It has not been systematically organised into the body of what is recognisable as nursing knowledge. The title 'therapist' confers a disputed status on family therapy knowledge as nursing knowledge (Barker, 1989).

In the following account I will outline responses to the research questions that contributed to an understanding of participants' perceptions of the role played by theory in understanding the therapeutic relationship, and as an additional resource to inform and guide practice. I will outline the views of the different groups on whether their concept of the therapeutic relationship involves the integration of other theoretical concepts. The different positions developed within the groups will be illustrated with examples of each group's discussion of specific issues related to integration of theory. I will also describe resources other than theory

that were considered by participants to contribute to therapeutic relationships. Finally I will discuss participants' specific references to nursing theory.

Three elements within the theme of theory and the therapeutic relationship will be outlined, and the perceptions of the different groups of each of these elements will be described. The elements are:

1. The therapeutic relationship as atheoretical.
2. The contribution of resources other than theory to the therapeutic relationship.
3. The integration of theoretical concepts other than the therapeutic relationship into clinical practice.

These components are not separate. For example participants' perception of using resources such as personality and common sense to develop therapeutic relationships supports the perception of the therapeutic relationship as atheoretical. Similarly, the use of other theory, such as the recovery model by the community nurses does not challenge the therapeutic relationship as an atheoretical underpinning of their practice.

The therapeutic relationship as atheoretical

The idea of the therapeutic relationship as atheoretical is something that was immediately apparent in statements that specifically refuted the idea that therapeutic relationships needed theoretical understanding to develop. However this finding has also been inferred from other statements in which a range of non-theoretical resources were described as contributing to therapeutic relationships. Finally specific references to theory and theories, put forward to 'explain' theoretical influences on therapeutic relationships also support the finding that the therapeutic relationship is perceived in practical rather than theoretical terms. This is because these references appeared to be post hoc reconstructions of relationships that were primarily enacted and constructed in practice, rather than in theory. This last comment is particularly pertinent to the inpatient group, and less so for the community nurses and nurse-therapists. The community nurses and nurse-therapists, as will be shown in this section, made increasing use of theoretical resources instead of, or as well as, practical resources in developing therapeutic relationships.

As discussed earlier, the groups can be ranged along a continuum in terms of their perceptions of the relationship of theory to the therapeutic relationship. The inpatient nurses relied most heavily on atheoretical accounts of their practice, and subsumed most areas of practice under the concept of the therapeutic relationship. There was little explication of the therapeutic relationship in theoretical terms. The therapeutic relationship was considered to be something that became 'automatic' with experience, and hence not to rely on theoretical reflection:

B: I guess it... comes with experience, that you don't create... you automatically just get into it without really thinking about it... (IN1/4).

This view was shared by the group which expressed agreement non verbally. There was a sense in which the therapeutic relationship was not derived from theory, although day to day practice was seen as based on a therapeutic relationship. The knowledge involved was tacit rather than explicit, indicating that the theoretical roots of the therapeutic relationship were lost in history and yet continued to influence practice in the reified knowledge of the therapeutic relationship:

B: You're actually doing it, but when you look back at some of the things you've done you sort of review your day... put that all as part of the therapeutic, um relationship. (IN1/4).

In this view of clinical knowledge the participant shows the tacit understanding characteristic of practical skill. Practice is carried out with unselfconscious skill, and it is only when an opportunity, however brief, arises to reflect on practice that the practitioner can begin to lay bare its theoretical roots. However this reflection on action is not characteristic of practice. More commonly, reflection occurs *in* practice without prior deliberative reasoning (Schon (1992). Schon has used Ryle's (1949) distinction between "knowing how" and "knowing that" to identify the difference between skilled practice and theoretical knowledge. The practical nature of the therapeutic relationship is consistent with this distinction.

As with the inpatient nurses, the community nurses also saw the therapeutic relationship as atheoretical:

N: The question was... is, do you need a therapeutic (sic) model to have a therapeutic relationship?

R: yeah, that's it.

N: I don't really think you do... We talk about therapeutic use of self... that's not a theoretical model. (CN2/6).

The position of theory seemed ambiguous in the following quote, as if theory wasn't necessary, but therapeutic relationships were nevertheless consistent with what theory would prescribe:

E: Yeah I think you do, without necessarily... I don't necessarily think that you... that you need... always to base it on a model of a therapeutic theory... but you do, you carry out, (?) you know, the theories. (CN2/2).

In references to using theories, and to using an eclectic approach (discussed later) it is apparent that there is a commitment to the idea of using theory, even if participants did not explain which theories they use, or how they influence their relationships.

A clue as to how the therapeutic relationship comes to be seen as atheoretical despite being grounded in interpersonal theory comes in a comment from one of the community nurses:

E: I don't think I quite agree when you say that it doesn't matter if you don't have any models because I think... I think we wouldn't be here if we hadn't learnt about any of them, it actually becomes part of your practice. (CN2/8).

The process of sedimentation of knowledge is recognised in this comment which describes an increasing familiarity with a theoretical concept that becomes so closely integrated into nurses' ways of thinking about therapeutic relationships that it no longer stands out.

The nurse-therapists shared with the other two groups a perception that the therapeutic relationship was not dependent on a theoretical model to develop. A contrast was seen between the 'ways of engaging' that were prescribed by a model and the "qualities" of the therapeutic relationship, which were seen in atheoretical terms:

K: It's like you can be effective, you know, if your model is, if your model is an adjunct to the therapeutic kind of dealing with the person anyway. (NT3/3).

In this quote "models" are contrasted with "therapeutic dealing with the person", suggesting that the relationship exists *a priori* in relation to theory. The "qualities" referred to

“human interaction” that could occur regardless of the model used, and were seen as “normal” in an implicit contrast with theory

K: So much of the therapeutic relationship is in common with kind of normal human interaction. (NT3/2).

Across the three groups there was a consensus that therapeutic relationships were not dependent on theory to develop. Theories might contribute to an understanding of therapeutic relationships, but in practice therapeutic relationships did not proceed from theory so much as from an atheoretical basis involving practical skills such as therapeutic use of self and natural human interaction. As will be seen in the discussion later in this chapter, theory is seen to influence practice in varying ways. However the therapeutic relationship stands apart as something that is independent of theory.

Use of other resources in developing therapeutic relationships

In support of the atheoretical notion of the therapeutic relationship, a variety of resources were cited as contributing to its development. In response to a direct question about the theoretical basis of the therapeutic relationship, personality was seen as more influential:

R: Do you think it [is] possible to have, to achieve a therapeutic relationship, without having a specific theoretical model?

B: Absolutely, you use your personality... (IN2/7).

Nurses were seen as having been selected for training programmes on the basis of personal attributes which then had a dominant influence on their ability to enter into therapeutic relationships:

S: When I started in the seventies, a lot of... students... were naturally helping type, counselling type people and they were picked for that...

R: Right.

S: and I guess that comes through in their personality and in how you feel about the helping profession like we do... I guess that was a predominant feature of their personality.

R: Right.

S: We are altruistic, we *are* caring, to help those more needy. (IN1/12).

Other participants agreed with this observation. One extended the role of personality to the whole sphere of mental health nursing:

R: So, B and L, would you agree with that, about personality that it tends...

B: yeah.

R: that the way you... perhaps interact or, or, or practice...

M: It has to, because everything you do your personality comes through and is showed. (IN1/12).

Despite acknowledging a limited role for theory, the final determinant of what contributed to the development of therapeutic relationships was the person of the nurse:

S: Yeah it's about a relationship and I think that's your personality that you bring into that... but it relates to a lot of models or theories about who you are as a person.

R: yes.

S: Some people are good at this job, and some people aren't. (IN2/8).

Personal style was mentioned in the nurse-therapist group as an influence on integration of theoretical concepts, recalling the comments of the inpatient group about personality. A crucial difference was that the influence was not directly on practice, but on the sorts of theory that an individual might choose to work with:

K: ... and personal style means that you can accommodate some models.

D: that's true.

K: And a lot of us would feel really limited using a behaviourist model. (NT2/13).

Rather than theory, 'natural processes' were considered by the community nurses to contribute to therapeutic relationships.

N: Perhaps we, you know, we don't need a model or anything, or maybe it is just the fact that we are working with another human being... um... that's a natural process like you would form a therapeutic relationship with that person. (CN3/12).

This comment clearly exemplifies Berger and Luckmann's (1966) notion that knowledge becomes objectified and detached from its human construction. Perceived as 'natural', the therapeutic relationship takes on a status beyond its human authorship and is seen as a 'given' rather than a historically and culturally located product. The inpatient nurses, too, cited 'natural' skills as the basis of therapeutic relationships. One participant saw therapeutic relationship skills as 'natural' rather than theoretical, although a limited role for theory was also acknowledged:

S: And then I guess... people that went into that field naturally was (sic)... like that, they were natural counsellors but they needed that, um... academic, sort of theoretical base to fall back to as well... (IN1/5).

Where the inpatient and community nurses had described the therapeutic relationship as 'natural', the nurse-therapist group saw the theoretical framework underlying the therapeutic relationship as allowing the therapeutic relationship to 'become natural':

D: But it was a clear framework, that was accessible, practical um... and it just became a natural, a natural thing to do, I guess. I mean for me it just kind of, it gave me a framework for um... I suppose it gave some sort of purpose to some of the conversation. (NT2/3).

In this quote there is a recognition that the therapeutic relationship is not intrinsically 'natural', but needs to be learnt using a framework (theory). The concept of what is 'natural' can be seen to have changed as the therapeutic relationship comes to replace more spontaneous and enjoyable interactions, and in the process comes to be experienced as natural:

L: ... it was gonna be focused on a goal, in terms of a goal in relation to the stages of therapeutic relationship, and um, there was gonna be some focus around some issue or issues that were pertinent to the client, but... but nowhere near as far as ah... perhaps it wasn't gonna have the same level of spontaneity and you know or be as fun or as necessarily enjoyable as other kinds of encounters. (NT2/4).

In addition to personality, common sense was another resource cited as contributing to the development of therapeutic relationships.

S: A lot of it's common sense, I mean that micro course to do with paraphrasing, reflection, empathy, the body language, being up front, some self disclosure, appropriate self disclosure./.../. and that, I mean... a lot of that *was* common sense. (IN1/14).

It is interesting to note that the terms mentioned in the above quote (paraphrasing, reflection, empathy) were the subject of specific learning strategies referred to in theme one, but which were now experienced as common sense. In response to my question about whether this 'common sense' existed prior to the theories that gave it expression as the therapeutic relationship the participant quoted above saw theory as offering an explanation for what was understood firstly as common sense.

R: Did it *become* common sense? Or did it start out that way?... You know what I mean, like, was it common sense to start with?

S: not common *sense* but, it needed that... theoretical framework to fall back on to and make then make some sense of it...

R: Right.

S: to know that you were heading in the right direction. (IN1/5).

Something akin to "common sense" was mentioned in the nurse-therapists' group where it was clear that personal resources and knowledge rather than theory provided the basis for intervention:

K:... and I think alongside all of that another ... influence is... is I don't know if there's a model for it, I mean I sort of think... jokingly call it 'getting on with your life therapy' (laughs)...which is... which is kind of gleaned from what I've seen work and what hasn't worked... (NT1/3).

This has parallels with the process described by Tilley (1995) in one of the sites of his study, in which nurses created a "moral order". In the notion of "common sense", and in the example given above, there is an implicit idea that the knowledge that informs the development of therapeutic relationships overlaps significantly with ordinary moral knowledge of obligations and responsibilities. "Getting on with your life" expressed here as a nursing intervention could equally be a message from a parent to a child, amongst peers or in some other non-professional relationship. "Getting on with your life" and "common sense" signify the embeddedness of nursing knowledge in popular discourse, and suggest that what underlies theory and makes it comprehensible is the common resource of cultural knowledge that as members of the wider culture, nurses and consumers share.

Yet another resource cited by the inpatient nurses was that of learning from others. Rather than theory influencing the development of relationships, learning from observing others was considered to be important:

M: And you're learning off other staff...

B: yeah.

S: You do.

M: ... and they, um interact or interrelate with clients and so, especially as a new staff you, you know, look and learn type thing (laughs), you know, or what doctors, how doctors interact, whatever staff it is, and you think "Oow, that looks all right, I might try that." (IN1/11).

This resource was also cited as a significant source of knowledge in the nurse-therapist group. Although not explicitly contrasted with learning from theory, learning from observing others was identified as an influence on developing skills in therapeutic relationships:

K: I think a lot too, of how I learnt about therapeutic relationships came once um, once I started working in the area of mental health and observing other... you know, other clinicians from a variety of professions / ... / not only nurses, but... OTs and psychologists, social workers, psychiatrists, you know, other people working in the field of mental health were working therapeutically. So while I learnt the basics of, you know, a basic relationship, and you know, basic nursing in my training and had an understanding of some of those things that, a lot of, it was sort of learning by observation. (NT2/8).

Theory use as unconscious / eclectic

Amongst the three groups there were references to knowledge being used unconsciously, and to use of an eclectic theoretical approach. The inpatient nurses did not explicitly theorise their concept of the therapeutic relationship, instead making use of explanatory notions such as common sense and personality. However the *idea* that theory influenced their practice was important. References to numerous theories and the use of the concept of an eclectic approach suggest that the inpatient nurses felt obliged to provide a gloss of theory on what was otherwise seen as a natural, common sense skill originating in personality:

R: Right, yeah, what about for you, B?

B: The social theories, those were those models we, we tend to use a lot of that...

R: Right.

B: in our practice, um... I think from time to time we pick a little of, of different styles, different theories, sort of what suits us best / ... / so we can't really put it down to one, one theorist.

M: yeah.

S: The eclectic approach. (IN1/9).

The sense in which an eclectic approach is discussed suggests that the therapeutic relationship is compartmentalised as an atheoretical underpinning to other models of intervention. The concept of using an eclectic approach was combined with an idea that theory was used, but without conscious awareness:

M: I think [nurses] use them but they are not aware of it...

S: True.

R: yeah.

M: it's the same you're just not aware of them.

R: Not consciously aware of them?

M: yeah. (IN2/14).

The idea that theory is used without conscious awareness of its application was expressed in the same group in a later interview:

S: No, I mean we all practice it but we don't realise it in some ways. (IN2/8).

Explicit application of theory was seen as getting in the way of using the therapeutic relationship in practice:

S: You don't, you don't study, when you go down to ICU you don't think "I'll use a cognitive behavioural approach interspersed with some interpersonal..." You don't think that at all, I mean you just... (IN1/11).

However there was a perception that theory informed practice even if unconsciously:

S: We all use the social interpersonal model...

R: yeah...

S: but we don't ... have... use that social interpersonal model, but probably don't realise it... it's a model...but we don't say it to ourselves... "I've just used the social interpersonal model..." (IN2/8).

The idea that theory could influence the development of therapeutic relationships without conscious awareness was also expressed in the community nurses' group:

A: I guess it doesn't really matter which model you use, we still from a nursing perspective, I mean your relationship will be, is very much like an interactive process that's going on all the time, you know and hopefully out of that, will achieve their goal, you helping and the... um facilitating them I guess, achieving that goal. So... because I don't go out ah, every day and say 'well, today I'm actually, I'm using this model or now with this situation I'm using that model, ah it, it's an interactive thing I think. (CN2/7).

Theory appears to occupy a conflicted position: although it is not necessary for the development of therapeutic relationships, those relationships are compatible with 'the theories' (CN2/2). In common with the other two groups, the nurse-therapists saw theory as forming an implicit part of practice, rather than as being self consciously 'applied':

K: And I don't necessarily think that when I'm sitting in front of someone, with someone... that I'm superconscious of that, I think probably at times I am... but... um... I go with whatever they bring and whatever the difficulties are... (NT1/3).

For the community nurses, the eclectic approach was seen as necessary to maintain a broad approach to practice, but also served to minimise any commitment to a specific theoretical approach. The sense in which the term 'eclectic' is used here suggests that resources other than theory are more important to the development of therapeutic relationships:

N: I think in many ways you have to quite eclectic... um in terms of um, not so much models, but, um the sort of things that you use, you have in your tool bag, you know, to be able to use, to, to develop that sort of therapeutic relationship. It's not about just 'this model' because I think if you just use a specific model you become very tunnel visioned about, I think as nurses, we tend to... take a bit of everything. (CN1/8).

The ability to work with a range of theoretical approaches was also seen as a strength by the community nurses. This idea was developed through an implicit contrast with other mental health practitioners who limited themselves to a single 'way of working':

N: I think that's quite an emphasis, that we're all generalists.

E: yeah.

N: And in that way, we can fit in to working with almost anybody because we're not... we don't restrict ourselves to just one way of working with people, and we're willing to take good ideas from other areas.

E: And use them, in practice, where you don't actually believe that what we're doing is it.

N: yeah. (CN1/12).

It was important for the community nurses to have a range of theoretical resources in order to take a broad view of clients' problems:

N:... I think because of that whole idea of looking at all the areas in people's lives, not just what they've presented with, um... you tend to use different models depending on what fits. (CN2/5).

In these excerpts participants refer to theory as constraining their practice either by limiting them to a single way of working, or by inhibiting their spontaneity in developing relationships. This is interesting in light of the comment from the nurse-therapist group that in learning about the therapeutic relationship, the framework provided had the effect of limiting spontaneity and gave purpose to the relationship, (see quotes from D and L on page 107).

What was initially perceived as a helpful constraint on spontaneity in learners at an early stage of their education was seen as inhibiting the development of relationships by experienced practitioners.

Use of theoretical concepts

Both the community nurses and the nurse-therapists made use of specific theoretical resources in addition to the concept of the therapeutic relationship. The community nurses discussed the influence of the recovery model on their practice, and the nurse-therapists discussed use of models of family therapy in ways that extended practice based solely on the concept of therapeutic relationships. It was clear that the recovery model influenced the way nurses in the community sought to develop relationships with their clients. One view was that as with the therapeutic relationship, the recovery model was not seen to be consciously employed in practice:

E: I don't know that you're more aware that you use [the recovery model], but there's certainly an emphasis on how you work. (CN2/14).

However, there was no consensus about this, the resulting discussion showing differing perceptions of the influence of theory on practice. In an extended passage of dialogue (Appendix H), the interaction illustrates both perceived limitations of the concept of the therapeutic relationship and yet a perception that the therapeutic relationship remains the basis on which the community nurses develop their relationships with consumers. The tension between the therapeutic relationship as a fundamental influence on practice, and the influence of the recovery model indicate a conflict between clinical practice seen in atheoretical terms as a therapeutic relationship, and clinical practice as shaped by the influence of theory. The community nurses did not reach a consensus about this, indicating that within this group, recovery 'theory' occupies an indeterminate status, in contrast with the concept of the therapeutic relationship, which by consensus is foundational to their practice. The contested status of recovery theory is an indication that whereas the therapeutic relationship occupies an assured and fundamental position, recovery theory has not yet achieved the status of internalisation.

In the nurse-therapist group mention of specific theoretical influences was common, with the influence on practice seen as quite explicit:

K: ... so I guess the models that I, um, fall back on in my, in my practice, are both family therapy and psychodynamic psychotherapy... (NT1/2).

Other members of the group also spoke of the need to use specific models to guide their practice, and named the models they were most influenced by. Acquiring family therapy skills was seen as adding skills that were necessary to function beyond the limitations of the concept of the therapeutic relationship:

D: And then when I discovered family therapy it made sense to me, and so the therapeutic use of self and the whole systems approach, so that means that you have to use a broad range of skills. (NT1/16).

The clearest difference between the nurse-therapists and the other two groups was in the latter group's perception of the limitations of the therapeutic relationship. The therapeutic relationship was seen as being tied to a Rogerian approach to psychotherapy and to be quite different to the models of intervention that might be appropriate for some consumers":

L: But then you know other models of psychotherapy, um you know, are very very distinct from [the therapeutic relationship], like a strategic model you know is in many ways opposite / ... / some of the interventions would be really frowned upon within a Rogerian approach. (NT2/13).

However there was not a consensus about this, as another member of the group felt that a model such as strategic family therapy was a therapeutic relationship by another name, albeit with a very different emphasis:

D: It's necessitated the development of other skills and calling like the example I just gave, the therapeutic relationship by another name... as per whatever the model is, it still happens and I think it's a bit more sophistication. (NT2/16).

Theory was seen as necessary to overcome the limitations of the therapeutic relationship:

D: That's the difference for me, the therapeutic relationship is about, um, kind of getting alongside somebody and helping them through their illness but not really looking at more fundamental changes.

K: hmmm.

D: In a therapeutic model, the structural and strategic family therapy stuff, systems theory about how systems change and the person within that ... (NT3/3).

D: It kind of goes broader *and* deeper. I think that just the therapeutic relationship, it was quite narrow. It was just focused on empathic listening, just listening and reflection... (NT3/4).

Despite the overt commitment to using theory to guide practice, this influence was not seen as rigidly dictating how individuals would develop their skills:

K: I mean it seems to me what we're all saying is that... we gravitate towards what... sits right for us...in our... you know in ourselves, with how we work... (NT1/6).

Models were seen as guiding practice, although ultimately to be inadequate for skilled practice:

D: We tend to immerse ourselves [in] the model we need, we need to do things in a step by step fashion, until we can integrate it and then we can, (?) discard some of it; we may learn other models. (NT2/12).

There was a sense that models could become more important than the relationship, which was seen as being of primary importance. The observation was made that models can assume such a status that they can 'become your identity'. Experience was seen as allowing theory to be 'blended' into practice:

K: ... because you've got theoretical stuff as well then you can blend that in and, and fit it which ever way but... you're talking about what you've learnt, eh, from what you've seen. (NT1/16).

Relationship to the practice context

Although this question was not explored in depth with the group, the inpatient nurses appeared to draw a distinction between use of theory for their work as inpatient nurses and what might be expected of nurses working in community settings or with specific groups of consumers. A fortuitous circumstance provided an opportunity for a demonstration of the contrasting role seen for theory between inpatient work and clinical work with a specific client group requiring a specific theoretical focus. One participant also had a role as a dual diagnosis resource nurse on the inpatient unit. A reference to this role showed its explicit use of theoretical constructs, in contrast with the usual inpatient nursing role:

S: And then for me, the motivational interviewing which takes a cognitive behavioural approach... um, I mean 'cos I work as an alcohol and drug nurse counsellor as well... that was pretty important for me. (IN1/8).

When pressed to explore the contribution of this body of theory to areas of practice outside drug and alcohol counselling, it is apparent that application to general inpatient nursing, while it does occur, is seen as an exception rather than the rule:

R: Does that generalise to other areas, do you think?

S: I use that in my practice... *even*... working on the ward here. (emphasis added) (IN1/9).

The idea that nurses working in community settings would make more use of theory that built on the therapeutic relationship was expressed in a subsequent interview with the same group:

B: Depending on the situation the client is in, and here in hospital we tend to do it on, mainly on whether the client is in contact with reality, but as the client gets better you would be using a lot more therapeutic models like they use in the community, just looking at discharge.

R: yeah.

B: You are looking at discharge and stuff you are using, you are looking at all the things that the community nurses look at, because the community plan starts from here, we have great input into the community plans so we've got to be thinking as the community nurses think, using theoretical frameworks... (IN2/11).

The inpatient nurses were quite clear that the specific models of intervention were more useful when consumers were not acutely unwell and were being cared for in settings other than the inpatient unit:

R: ... but I wondered whether, ah whether you think that in moving out of an inpatient setting you might use theoretical models more or not, and whether in the inpatient setting you respond to more immediate needs, and perhaps more intuitively... .

B: yes.

M: I don't know, depends on which area you work in.

S: Well, it does.

M: Long term rehab you may, but you also, because of... mainly acting on what you're seeing... and the amount of time you have to do that.

B: You are, depending on what sort of setting, in an acute setting you are doing a lot of assessment, using a lot of ... eclectic approaches, um, and you are using yourself as the therapy, but I guess as they start to recover from their illness, on their journey, that you can customize your treatment modalities a lot easier to suit, especially in the community you might use more of a cognitive behavioural approach or (inaudible) childhood

psychodynamic approach, A & D's got motivational interviewing...so you can customise it more...

R: hmmm.

B: as they recover. (IN2/5).

Overall, for the inpatient nurses, the therapeutic relationship was seen as a practical skill that depended for its development on characteristics of the nurse such as personality and common sense rather than theory. Despite having referred to learning experiences in which the therapeutic relationship was taught using quite deliberate strategies, which were recalled with some clarity, the therapeutic relationship had come to form taken for granted knowledge in the day to day practice of this group. Theory was seen as playing a secondary role to personality, natural qualities, common sense and experience, although it was important that practice was perceived as influenced by theory even if this influence was unconscious.

Although as noted earlier the community nurses shared many of the perceptions of the inpatient nurses, they were distinguished from the latter group through their reference to the recovery model as a theoretical resource that influenced their practice. Like the inpatient nurses the community nurses gave an atheoretical account of the therapeutic relationship and spoke of using an eclectic approach. They also referred to theory being used without conscious awareness, and to the place of experience rather than theory in developing relationships with consumers. Both the inpatient and community nurses' perceptions of the therapeutic relationship showed the therapeutic relationship as an "objectified sedimentation" (Berger & Luckmann, 1966, p. 87), an experience that has become congealed in the consciousness of the participants and that forms a common stock of knowledge.

Of the three groups, the nurse-therapists showed the most overt commitment to integrating theoretical concepts other than the therapeutic relationship into their practice. The nurse-therapist group saw the therapeutic relationship as foundational but limited, and at times in conflict with practice using different theoretical frameworks. This group saw the therapeutic relationship as practical rather than theoretical, although with theoretical roots. Thus the nurse-therapists held a critical view of the therapeutic relationship, ascribing to it the same foundational nature as the other two groups, but seeking to extend their theoretical boundaries to embrace concepts that went beyond the generic concept of the therapeutic relationship. There was a significant difference between the nurse-therapist and the community nurses'

groups, both of which expressed a commitment to a specific body of theory other than that implicit in the concept of the therapeutic relationship. In the nurse-therapist group there was discussion about the therapeutic relationship as something that had to be reconstructed in order to prevent it inhibiting their work as nurse-therapists, whereas the community nurses saw the therapeutic relationship as continuing along with their use of the recovery model.

The inpatient nurses' views of the influence of practice context on the use of theory is consistent with what was found with participants in the other two groups, who did make more explicit use of theoretical resources beyond that of the therapeutic relationship. Thus the concept of the therapeutic relationship in inpatient care as a practical skill, consistent with but not dependent on theory, is a perception of the inpatient nurses that is given further empirical support in the views expressed by the community nurses and nurse-therapists.

References to nursing theorists

Participants were not specifically asked to comment on nursing theory, but theorists' names were mentioned, albeit briefly, in every group. Those specifically mentioned were Peplau (in all groups) and Travelbee and Watson (in the nurse-therapists' group). When it came to identifying specific theoretical influences, nursing theories and theorists were mentioned in generalised and at times vague terms, indicating that nursing theorists played a minimal role in participants' perceptions of their relationships. The exception to this was one of the nurse-therapists who talked about the contribution of nursing theory to her practice, and mentioned the usefulness of theories derived from practice. Peplau was named in the community nurses' group where lack of familiarity with her theory precluded further discussion of it. The apparent self-consciousness about this was relieved by laughter, indicating a sense that participants 'should' show some understanding of nursing theorists. In two instances where specific aspects of theories were mentioned, participants either confused one theory with another, or were mistaken about details of the theories discussed. Nevertheless it would be reasonable to suggest that the commitment shown by all participants to the therapeutic relationship as fundamental to their practice suggests that nursing theory has had some influence. However any such influence has not extended to specific knowledge of particular theories. References to nursing theorists related to early educational experiences, although it seems that as with the more general understanding of the therapeutic relationship, the origins of knowledge become

obscured with time. However, the ideas learned persist as internalised understandings. Some implications of the references to nursing theorists are considered in Part Four, Chapter One.

Summary of theme two

The therapeutic relationship was considered by all groups to be atheoretical in that it did not need a specific theoretical framework to develop. Besides explicit statements that therapeutic relationships did not require theory to develop, non-theoretical resources such as personality, common sense, experience and natural qualities were cited as contributing to the development of therapeutic relationships. Despite the view that theory was not necessary, all groups referred to theory that influenced their development of relationships, although they also said that theory is likely to be used without conscious awareness. In some cases it appeared that use of theory was assessed by post hoc judgement of whether actions were consistent with a theory, rather than theory being used in a deliberative way. The community nurses made explicit use of the recovery model as a theoretical resource, and described this in ways that extended the therapeutic relationships. Therapeutic relationships, however were still considered to be the basis of nursing care for the community nurses. There was an unresolved tension about whether use of the recovery model was a neat fit with the therapeutic relationship, or whether it added something distinctive. The nurse-therapists identified a potential for mental health nurses' current models of therapeutic relationship to constrain the potential of relationships for change, and for conflict with the expectations of other models of intervention, specifically strategic family therapy. There was no consensus in the group on this issue and it was left unresolved. The group discussed the possibility that a putative therapeutic relationship could in fact be untherapeutic, an issue that did not surface in either of the other two groups. The possibility that practice context influences the use of theory in developing relationships was supported by the different uses of theory across the three groups, and by the discussion in the inpatient group around the differences between use of theory in inpatient and community care. Nursing theory has a minimal current influence on most participants' perceptions of their relationships with consumers, although it may have had a formative influence.

Part Three, Chapter Four

Theme three: The scope of the therapeutic relationship

Introduction

This theme describes the therapeutic relationship as a concept with a wide scope, from forming supportive, facilitative relationships, to involvement in coercive interventions. There was a sense, seen with all three groups, that involvement with individuals who were acutely ill, had high needs, or whose problems were difficult, served as a defining statement of what it is to be a mental health nurse. This involvement was seen as an integral part of the therapeutic relationship. The inpatient nurses talked of involvement with 'floridly psychotic' or 'manic' consumers, and the community nurses of the need to persevere with their involvement with consumers who became unwell and needed compulsory admission to hospital. In the nurse-therapist group there was discussion of the greater willingness of nurses to maintain involvement with consumers whose behaviour and clinical problems extended beyond those normally addressed in appointment-based therapy. In part, this perception was developed by contrasts with other disciplines, whose involvement was seen as more circumscribed and focused around specific issues. In the nurse-therapist group there was discussion about the implications of nurses' readiness to manage difficult situations and to be more available, although there were different perceptions within this group about how nurses should respond to these situations.

The idea that nurses bring a wider sense of awareness and availability to their roles than do other mental health professionals also contributes to this theme. In the nurse-therapist group, recognition of the limitations imposed on mental health nursing by acceptance of a wider scope of responsibility was seen as problematic and therefore as a necessary focus of change. In the other two groups availability seemed to be more taken for granted, although it still influenced their relationships with consumers.

Involvement in difficult situations as part of a therapeutic relationship was discussed in each group. When participants were pressed about limits to the therapeutic relationship, involvement in difficult situations was not always perceived as a limit to the therapeutic

relationship. Relationships could still be thought of as therapeutic even when managing difficult situations. There was a sense with the community nurses that involvement in difficult situations strengthened the therapeutic relationship.

In describing this theme I propose that nurses' early learning experiences in inpatient care has a significant effect on the development of their concept of therapeutic relationships. Inpatient care provides both a site and a model for learning about therapeutic relationships. Consumers in inpatient care by definition have acute or intractable problems and it is with this group of consumers that students learn their basic skills. At the same time as learning clinical skills in an inpatient setting, students are introduced to the concept of the therapeutic relationship, as reported by participants in this study and described in theme one¹.

In the history of mental health nursing, community care is a relatively recent development. Until the last 25 years, nursing students have had little opportunity to experience community based care as part of their pre-registration education. When community care experience first became available, it was placed later in the curriculum, with students gaining initial skills in inpatient settings before undertaking community experience. Although the majority of consumers are now cared for in the community, the inpatient unit continues to serve as a training ground for students. There are reasons for and against this practice and I do not intend to explore those here. Suffice to say that historically, the inpatient experience exerted a dominant influence by virtue of the status it was accorded in the educational experience of students, and that practice continues today. In discussing this theme I aim to show that these processes lead to a concept of the therapeutic relationship that is socially constructed in response to experiences in the inpatient unit.

Inpatient experience appears to have a formative influence on mental health nurses' orientation to their practice, and this was evident in this theme. In this chapter I will briefly report the comments from the nurse-therapist group that illustrate the formative nature of the inpatient experience, then I will describe how the idea of involvement in difficult situations was

¹ It is most common for nursing students in New Zealand to gain their initial mental health clinical experience in the second year of their three year programme. While the concept of the therapeutic relationship may be introduced in the first year of their programme, the clinical application in the mental health context is likely to come later. Although this analysis may need qualification in relation to initial mental health clinical experience in recent years, it is highly applicable to participants in this study.

apparent in each group. I will conclude by returning to the idea of the therapeutic relationship as a concept based in an ethical principle of beneficence, while also one that provides a potential justificatory device in the face of coercive practices. The section concludes with a discussion of this theme.

The formative influence of inpatient experience

The formative influence of inpatient experience on the identity of mental health nurses and their perceptions of the therapeutic relationship is perhaps best illustrated by those nurses who have moved furthest away from inpatient care, in the case of this research, the nurse-therapists. One participant in this group was a graduate of a comprehensive nursing programme, and felt that her identity as a mental health nurse was uncertain as she had not worked in a 'bin':

K:... the thing I always felt uncertain about calling myself a nurse-therapist is that because I'm Comprehensive trained, I'm not a psychiatric nurse, and I, um never worked in a bin environment /... / I did some of my training through there but never, you know, like I'm not a Carrington, an ex-Carrington nurse doing therapy on, you know? So that's quite different too... it gets lonely it gets, it gets quite difficult and you start to feel quite fuzzy about what your professional identity actually is, and I had quite a struggle with that, going, returning to work for /... / for example with which professional body would I belong to; was I going to go through the long haul and do the, um psychotherapy NZAP² thing, was I going to join the counsellors' thing, was I going to join the of College of Nurses or the College of Mental Health Nurses? (NT1/13).

It was interesting that this participant used the term 'bin' to refer to inpatient care, suggesting that experience in the more institutional environment would contribute more to an identity as a mental health nurse than experience in an inpatient unit in a general hospital. The same participant saw experience in inpatient care as influencing nurses towards a less individualistic approach to change in consumers.

K: I think one of the things as nurses is that, that, you know, for my thinking anyway is that when you're used to... um, like working in a ward or, or whatever, you, you're working as a team, and it, it's not necessarily any one person taking the glory for getting someone better, do you know what I mean? (NT1/9).

The significance of this comment is that it is the inpatient environment that is seen as providing this formative experience, rather than a community care environment. For another

² New Zealand Association of Psychotherapists.

participant, the inpatient environment presented certain structural constraints on the development of therapeutic relationships, and she felt a need to move to a different practice context to overcome those constraints:

D: ... often there wasn't time to have a therapeutic relationship because you had to attend to all these other things in the role of a primary nurse, usually I mean you were spinning like a top um, so ah, huge constraints... I always felt ah... I mean a lot of that's my own kind of perspective of... and why I moved into systems theory and working with families because I didn't want to be a bandaid... you know...(NT2/17).

For this participant there was a sense of conflict between the ideals of a therapeutic relationship, and the reality of inpatient experience. Despite this perception of the inpatient environment as being severely limited, it nevertheless was seen as contributing something important to the development of mental health nursing skills, and to contribute to the sense of professional identity.

In a subsequent interview, also with the nurse-therapist group, there was discussion about a 'wider sense of awareness and availability' that was thought to develop as a result of experience in inpatient care. This was a problematic concept. There were differences within the group in terms of how the issue of awareness and availability was seen.

L: There's other stuff that affects that parity thing /.../ is the stuff around nurses having an obligation around being present.

K: yeah.

D: yes.

K: being there, having the numbers.

R: That was discussed last time but it did seem to be quite an important theme, yeah.

K: But that's the history of the role of nursing.

R: And is that something that for you people you feel is, is um, perhaps, historical now? That's not part of your current role, that kind of presence?

K: Don't you think though, that in a multidisciplinary team, that often the nurses are the ones, I noticed this in my experience, that nurses are the ones who gravitate towards - they are the ones who are there, you know. They are the ones who are more likely to work there full-time, be there, um, be involved, you know, in just about all meetings, knowing what, you know our kind of mentality, almost like a ward mentality, of every person on your caseload, knowing what's going on with, you know, the clinic patients, you know hearing, being available.

L: Not where I work.

K: Aren't they?

L: No., I was just thinking about your work D. I've got some knowledge of that and thinking that like, just about every other discipline could disappear...

K: yeah.

D: hmmm.

K: and there'd be no...

L: and there would be a requirement...

D: hmmm.

L: for nurses to be present.

K: yeah. (CN3/5-6).

The reference by K to the inpatient unit as the source of the broad sense of awareness and availability is significant. The nurse-therapists are a group who have taken on a non-traditional nursing role, and have had to reflect deeply on their professional identity. Using Mills' (1959) classic formulation, their 'private trouble' of professional identity is the 'public issue' of professional identity of the profession, as the identity of the nurse as therapist is contested (Barker, 1989). This was illustrated in K's dilemma about which professional association to belong to. Despite the recognition that redefinition of their role is necessary, the nurse-therapists also saw that their formative experiences in inpatient care meant that they brought to their work as therapists some "background meanings" (Benner & Wrubel, 1989) that were specific to mental health nursing:

D: And I mean the core stuff that is missing that no one other than nurses will have, you know, whether they be mental health workers or any other allied health professional, you know the cheaper version, you know, I think it is that therapeutic relationship, the ability to create that facilitative, facilitative thing (inaudible) that, so it can happen. And what you were talking about, [R], that wider awareness of the environment, not just the people you are directly concerned with - your own patients, but other people's as well. You know, I haven't worked in inpatients since 86 and it still just happens. I'm still just as aware...

R: hmmm.

D: of every sort of raised voice or...

K: hmmm.

D: agitation or something and I just sort of go into this other mode... preparation, you know, not an over-reaction but I just kind of awareness - I know that someone - that other professionals won't have... and I notice other nurses doing that as well so...

K: hmmm.

D: I'm not saying that that's the core of the training but that's part of the awareness.

K: hmmm.

R: Because in some ways that skill of being aware of the environment in a global way is not part of what you learn in the therapeutic relationship, which is more individual.

K: But you pick it up though, I, don't you. Because you are always, you know, if you are going on your clinical placements or your whatever (sic). / ... /

R: hmmm.

K: ... you have to slot in, to find out about the team, who's in charge, who does what, where the toilets are, what everyone's names are and what they do and then you get a handle on that and you move on and do it again, so you are always having to fit in and you

are, I think, that's another feature of nurses is being part of being a productive part of a team, rather than, um, you know coming from one angle and having a very definite viewpoint / ... /. (NT3/8-9).

The significance of the inpatient experience was summarised by one participant:

L: Gosh, it gets hard, gets hard doesn't it? That you know, once you leave the inpatient setting, you know, to actually specify exactly what nurses do, uniquely, or better. (NT3/10).

By considering the views of the nurse-therapists on the influence of inpatient experience on the development of their concept of therapeutic relationships it is possible to see that inpatient care exerts a significant influence on mental health nurses' perceptions of their relationships with consumers. Privileging experience in a 'bin' environment over that in a general hospital inpatient unit, and the generalisation of skills learnt in that environment to other areas of mental health nursing confirms the role played by inpatient care in the development of mental health nurses' concepts of the therapeutic relationship. The therapeutic relationship is not an external reality independent of the context in which it is learned, but is socially constructed within discourses of observation, awareness and availability that are most visible in inpatient settings. The next section will consider one effect of socialisation into a therapeutic discourse within an inpatient setting: the focus on difficult situations.

Dealing with difficult situations: The inpatient nurses.

In the inpatient group, caring for either 'floridly psychotic' or 'manic' consumers was seen as the area of practice that participants were most comfortable with. Outside the acute stage of illness, the inpatient nurses were less confident of their skills. In describing the consumers they felt best suited to working with the inpatient nurses cited examples of people with florid psychosis or mania:

S: I mean I'd probably... people who are not in touch with reality, floridly psychotic people./... / I can get an empathy going with them. (IN1/14).

This participant expressed confidence in responding to the high level of need of the floridly psychotic person:

S: And it's a reality based way of interacting... quite straight... up front... no nonsense... and maybe some of that might be sometimes (inaudible) or seen as being paternalistic too. (IN1/14).

The fact that the care provided was paternalistic was no barrier to it being seen as appropriate nursing care:

S: But I think clients who are floridly psychotic and out of control might need some structure within a paternalistic model. (IN1/14).

This comment was reinforced in a later interview when confrontation was discussed:

B: It all has therapeutic outcomes, I mean if you feel confrontation with a patient that has therapeutic outcomes and that's a therapeutic relationship that's the way I see it. (IN2/3).

Another participant from the inpatient group cited 'manics' as those he could most easily work with:

R: What about for you B, is there any particular type of person you feel... best able to work with, or easiest to work with?

B: Manics actually. I um, I can relate to them, like... /.../. Being outgoing and extrovert, and sometimes when manics, um, um, what other people consider to be really manic, to me it'll just seem hypomanic.

R: hmmm.

B: and some people are just... they're very extrovert, they, they're hyper and that's quite their normal, at-home, premorbid, ah personality, they're like that... and for very quiet people /.../ [some nurses] would think 'oh we need to pm this one'...

R: hmmm.

B: but to me that would be... yeah, something that I can cope with, I, you know, they would probably would need to just be asked to slow down, and to me it would be just, I would treat them as hypomanic. (IN1/14).

This participant went on to talk about how he felt he could work easily with 'manics', and would use less intrusive interventions than some other nurses might with the same consumer. The third participant from this group also mentioned working with floridly psychotic consumers as a preference:

M: ... yeah, floridly psychotic, elevated people, yeah fine, yeah... somebody like that. (IN1/15).

It was evident that inpatient care frequently involved unplanned, sometimes ad hoc responses to situations as they arose, rather than carefully structured therapeutic interventions.

Despite this, the inpatient nurses felt that activities occurring during the day could be subsumed under the concept of the therapeutic relationship:

B: When you look back at some of the things you've done you sort of review your day... put that all as part of the therapeutic, um relationship. (IN1/4).

Participants discussed working with either floridly psychotic or manic consumers and saw this as providing them with the opportunity to practice in accordance with their concept of therapeutic care. The issue of availability did not arise in the inpatient nurses' interviews. This may be because it is taken for granted and therefore not readily seen as an aspect of their practice. The reality of availability was brought home to me in making arrangements for the research and conducting interviews. Interview arrangements were always made on the proviso that everything would have to be 'o.k. on the ward' for the interview to proceed. On two occasions I arrived to conduct an interview only to find that the immediate demands of the unit had intervened and it was not possible to proceed. On another occasion, an interview proceeded with an awareness that events on the ward might intervene and cut it short.

Dealing with difficult situations: The nurse-therapists.

So far I have presented some of the views of the nurse-therapists about the formative influence of the inpatient experience on their perceptions of the therapeutic relationship. In that discussion it was apparent that there were differences within that group in how that issue was seen. While widened awareness and availability were recognised as a reality of many nurses' roles, this was not seen as unproblematically good; it was regarded as something that should change.

The idea that nurses deal with difficult situations was developed in the nurse-therapist group through a contrast with psychotherapy. K had previously described psychotherapy as having an individualistic orientation, with a focus on a therapeutic encounter between therapist and client. Nurses, by contrast were considered to have a more general sense of the scope of their own practice and of the concept of a team, rather than one individual in it bringing about therapeutic change. Another difference was in dealing with the difficult individual situations that arose in her work as a nurse-therapist:

K: I know that in my role at times I was involved with doing lots of different things /.../ refeeding, and all sorts of things, and that the psychotherapy team, that they didn't want to get involved with...

R: yeah.

K: and would always shy away from...

/.../

K: Yeah, they always shy away from them and even, (?) I don't know if consciously, some of the more intense ones who are more intensively... or more sick or, more whatever, that they somehow would never end up getting that case on their books, you know? (NT2/18).

The broad scope of mental health nursing is apparent when it is recognised that the participant providing the above account was also functioning in a therapist role, and thus needed a concept of therapeutic relationships that enabled her to work with all the usual intrapsychic, interpersonal and systemic issues affecting her clients, and yet provide physical care and take on a limit-setting role.

Dealing with difficult situations: The community nurses.

The community nurses provided a striking example of involvement in a difficult situation that would appear to contradict a concept of a therapeutic relationship based on trust. The situation involved making a decision that a consumer needed to be admitted to hospital using the compulsory care provisions of the Mental Health Act. I went to some lengths to explore with the group whether they saw their involvement as being outside the remit of a therapeutic relationship, but they were clear and insistent that this work was within the scope of a therapeutic relationship. They even suggested, citing feedback that they had received from the consumer, that their involvement in this situation had strengthened their relationship, as it had demonstrated they were not there only when things were going well, but also when problems developed.:

A: ... part of us being involved so early on is about creating a therapeutic relationship. If you have seen someone in crisis it's really, if you've seen them at their very worst, it's a really good time to engage with them, but it also means that when they have recovered you have been part of that crisis so you get a bigger picture...

R: Right.

A: of what has happened rather than just taking over when everything is settled, and you just see this calm person who's been through a horrible experience.

R: Right.

A: If you are part of that experience then you have a closer relationship.

/.../

A: Even if the CAT team has to be involved, especially wherever a Compulsory Treatment Order is concerned, we are never far from, we are always there, very much so, we don't just pull out of somebody's life, you know. I mean, you can't do that. (CN3/9-10).

The significance of this excerpt is not that the nurse talked of staying involved. There are always limits to availability. But the involvement meant participating in what the consumer might perceive, especially at the time, as being coercive intervention, and yet the nurse saw the involvement as contributing to a therapeutic relationship. The distinctiveness of the therapeutic relationship in mental health nursing, with its extension into coercive intervention, was developed through a contrast with 'other professions':

N: [I] suppose I think nurses are pretty amazing, that they can have relationships with their clients despite all these coercive things that we need to do sometimes. Not many other professions are put in that position, so that if you were a therapist out in the community, there is no way you would be coercing the client into doing anything.

(Pause)

N: So, I mean, to be able to hang on to a relationship with a client despite all the coercion that goes on with some of them, not all the time, but with some it's pretty amazing. Does that mean we are great manipulators? (CN3/12).

The issue of coercion was not simply glossed over, but further discussion showed that involvement in coercive practices was specifically recognised as a necessary aspect of therapeutic relationships:

N: It must mean that nurses are able to make the best of a bad situation, to make it bearable for our clients to have to go through that.

R: What do you mean by that?

N: Just, I mean, there are ways of doing things, like coercion is coercion, but there are ways of coercing people into things, like injections and things like, you know, going into hospital when someone's unwell, and because nurses have... generally have really good relationships with their clients those things are able to have happened in a way that's not disrespectful, or undermining. Because the whole thing is really disempowering anyway. I think often nurses can make it seem more empowering for people.

R: Yeah, even when it is overtly quite coercive?

A: I don't know about coercive, I mean sometimes when I have managed... it might be seen as coercive persuading someone to have an injection, or come into hospital. When I think about it afterwards, I think, "damned good intervention", you know, and I think that, I wish that somebody could see this. What is therapeutic you know? I couldn't really put it into words. It wasn't coercive or just ... (break in tape). (CN3/12-13).

In a previous interview I had pursued the question of whether in the sort of situation described above, the relationship was still therapeutic. A similar situation had been outlined,

and another participant (E) had been involved in compulsory admission. She saw the process as therapeutic and as strengthening her relationship with the client:

E: ... and, but actually when I saw him, and met with him, and discussed it all through... it actually, my relationship with him did get stronger... with us actually processing... what had happened. (CN1/15).

Because the participant had volunteered the idea of coercive intervention being therapeutic, I persevered with questions about whether this level of intervention could still be therapeutic. The nurse who had originally described the situation said she worried about it, indicating some doubt, but another participant was insistent that a therapeutic relationship still occurred:

A: You might not feel that you've got alongside them..

R: hmmm.

A: but there would still be this relationship that occurs. (CN1/17).

Berger and Luckmann (1966, p. 87) explain how legitimations can succeed one another so that the actual origins of sedimented traditions become less important than current interpretations. In the perception that coercive intervention forms part of a therapeutic relationship this explanation is helpful. As previously noted, nurses perform a range of functions from facilitative care to coercive interventions. If the therapeutic relationship is fundamental to mental health nursing it is also fundamental to this whole range of activities. And yet it is clear that the therapeutic relationship in its early formulations was limited to the more facilitative function where the nurse encouraged the patient to explore problems verbally, and gain insight into their situation (Peplau, 1952/1988). In assuming the wide role it currently plays, the therapeutic relationship now legitimises both facilitative interpersonal interaction, and coercive intervention.

The therapeutic relationship appears to have generalised from the facilitative helping relationship described by Peplau and others and found in contemporary representations in nursing literature (Schwecke, 1999; Stuart, 1998), to a basis for a range of interventions from facilitative to coercive. What is significant from a social constructionist perspective about this theme is that nurses' involvement across a continuum of intensity is based on background meanings found in everyday life. This was outlined in the previous chapter. While theory plays a part in interpreting these meanings, intervention is still grounded in the common meanings

brought to the situation by nurses and consumers. Thus the therapeutic relationship, a concept that characterises both mental health nursing itself and the actions of nurses as beneficent, involves the enactment of 'common sense' understandings represented in the therapeutic discourse of mental health nursing. Because discourses have the power to make some understandings possible while closing off others (Burr, 1995), nurses' concept of the therapeutic relationship enables them, potentially, to appropriate common sense in support of a range of involvement from empathic listening and support to coercive persuasion and physical force.

Summary of theme three

The blending of the influences of learning therapeutic relationship skills and the clinical skills required in an acute care environment results in a concept of the therapeutic relationship that incorporates both facilitative and empathic listening and coercive measures of persuasion and control. At any point on this continuum there is potentially a legitimate rationale for increasingly coercive involvement. The remit of mental health nursing is broad, and covers a range of possible involvement from assistance with personal care and hygiene, through discussion of the mundane and intimate details of life, to legally mandated coercion and enforced care and treatment. If the therapeutic relationship is fundamental to mental health nursing, as described in theme one, then it is basic to this whole range of involvement. The analysis of the interviews conducted in this study provides an empirical basis for this account of the therapeutic relationship in mental health nursing. I do not claim that it is the 'truth' in a positivist objective sense. There was not a complete consensus around the ideas that lead to this account being developed. However, I do claim it to be a valid construction of mental health nursing based on the views of the participants in this study.

Part Four. Discussion and conclusions

Chapter One. Discussion

Introduction

This research has studied a small group of mental health nurses' perceptions of their practice by asking them to consider a concept that has been central to the discourse of mental health nursing over the past five decades. In the literature review I discussed the development of the therapeutic relationship in mental health nursing, suggesting that, as a rational account of mental health nursing, it has a continuity with interpersonal practices evident in the asylum era. Tilley (1995) regards the emergence of the therapeutic relationship, at least within British psychiatric nursing, as marking a break between theoretically informed nursing discourse and the discourse of common sense. Focusing on a single concept with a small group necessarily limits the scope of the research, and the implications of the results. However the study gains significance from the historical, conceptual and practical relevance of the concept of the therapeutic relationship for mental health nursing.

The therapeutic relationship, in the perception of the research participants, has emerged as a foundational concept in mental health nursing, which forms the basis for educational experiences in relationships between nurses and consumers, and comes to be experienced as natural in the day to day work of mental health nursing. Although not considered to be dependent on theory for its development and its application in practice, the therapeutic relationship supports development of other theoretical approaches to mental health nursing, and is considered consistent with an eclectic approach to mental health care. Personal qualities and experience enhance the development of therapeutic relationships, although for the nurse-therapist group the concept was perceived as imposing limits on their work as nurse-therapists. Therapeutic relationships in mental health nursing extend across a wide scope of involvement with consumers, from facilitative interpersonal care to coercive interactions.

Social constructionist theory has enabled the therapeutic relationship to be described as a product of discursive practices embedded in a historical context. The therapeutic relationship

emerged in the middle of the last century as part of the development of a general therapeutic discourse in psychiatry, and as an alternative to the custodial pattern of care that had been the prevalent model until that time. The concept has come to form part of the “background meaning” (Benner & Wrubel, 1989) that participants bring to their practice, indicating that it has become a “sedimented experience” (Berger & Luckmann, 1966, p. 85), the transmission of which is made easier by the common biographies of participants as mental health nurses. The following discussion considers the themes developed in the process of analysis in the context of relevant nursing and related literature. The therapeutic relationship as a socially constructed phenomenon is discussed, and the strengths and limitations of the study are considered. In the final chapter, some conclusions for education, research and practice are outlined.

The therapeutic relationship as fundamental

The common experience of participants in learning about interpersonal relationships as part of their introduction to nursing, in both generic and specialist psychiatric nursing programmes, goes some way towards explaining how the concept of the therapeutic relationship comes to be experienced as fundamental to mental health nursing. Olson (1996) has discussed the perception of interpersonal relationships as fundamental to mental health nursing, noting that its extension to nursing generally has left mental health nursing without a unique area of expertise. As noted in Part One, Chapter Two, Peplau (1952/1988) saw her theory of interpersonal relations as applying to the whole of nursing rather than just to mental health nursing. This was reflected in New Zealand nursing literature (Bazley et al., 1973; Raboobi & McEwan, 1968), and explains the emphasis placed on this concept in undergraduate curricula. The experience of learning about interpersonal relationships in undergraduate education was shared by participants who received their undergraduate education overseas, confirming the international trend towards interpersonal relationships as the basis of mental health nursing.

Contemporary nursing literature continues to stress therapeutic relationships between nurses and consumers as the basis of an introduction to mental health nursing. The two texts discussed in this thesis, Stuart and Laraia (1998), and Keltner, Schwecke and Bostrom (1999) both introduce students to therapeutic relationships as the basis of mental health nursing, while providing a range of conceptual models that extend the clinician into other models of care. Official discourse from nursing's regulatory body similarly stresses the therapeutic relationship (Nursing Council of New Zealand, 1997, 1998), marking a distinction between nursing in a

generic sense and the specialty of mental health nursing. Another source of literature, critique of mental health policy, takes the therapeutic relationship as a standard against which critique can be offered (Foster, 1998; Street & Walsh, 1994). Participants' perception of the therapeutic relationship as fundamental is consistent with the representation of the therapeutic relationship in contemporary literature.

Theory and the therapeutic relationship

The therapeutic relationship was seen by all groups as something that is not dependent on theory, despite its historical development in interpersonal theory. Even where this theoretical origin was recognised, as in the nurse-therapist group, the therapeutic relationship was seen as something that 'became natural', and had more in common with 'normal human interaction' than with theory. Rather than theory, personal qualities, experience, and learning from others were seen as a means of developing skills in therapeutic relationships. Participants cited an eclectic theoretical approach as important to the development of therapeutic relationships, as a narrowly theoretical orientation might prevent nurses from responding to the immediate needs of specific situations. In this perception, participants expressed views consistent with a range of literature, including empirical reports of clinical practice and theoretical accounts of practical knowledge.

The emphasis placed on personality by the inpatient nurses and to some extent supported by the other groups is consistent with a theme in the mental health nursing literature that questions whether mental health nursing is, or substantially involves, common sense or 'natural' skills. This is sometimes contrasted with academic skills as in the debate over whether the theoretical basis of mental health nursing is being overemphasised at the expense of 'practical' skills. Tilley (1995, p. 17) reports that the authors of a 1955 British report on the work of the mental nurse claimed that "...the work of the psychiatric nurse centres on the personality of the nurse rather than any more clearly defined features of 'role'" (sic). Altschul (1978, p. 335), in an apparent reversal of her earlier views on the role of theory in mental health nursing, argued that "...the chief instrument the nurse uses is her own personality." The comments from one of the inpatient nurses that mental health nursing involves 'natural skills' for which candidates in the past had been specifically recruited is consistent with the view that personality is the crucial variable in determining skill in mental health nursing.

Shanley (1988) comments that in the recruitment of mental health nurses, scant attention is paid to the inherent helpfulness of some candidates. This, Shanley argues, is exacerbated by lack of focus on development of the interpersonal skills of those who are selected for training. On the other hand, Peplau (1960) argued against the use of common sense in favour of theory, an argument supported in Altschul's earlier work (Altschul, 1971). Theoretically based nursing would appear to be the goal of degree programmes with their greater emphasis on academic aspects of nursing and on nursing theory. However as recently as 1995, inpatient nurses cited personal qualities as therapeutic skills. In a study of the perceived skills of inpatient nurses, Gijbels (1995) found that when asked what they understood to be therapeutic skills, participants cited "a number of personal qualities" (p. 461-2), rather than specific therapeutic skills.

Nursing theorists have recognised the contribution of non-theoretical skills in clinical practice. Peplau's theory and writing contain many references to the therapeutic significance of the personal qualities of the nurse. The role of personal qualities is best exemplified by Peplau's (1952/1988) statement that "...the kind of person each nurse becomes makes a substantial difference to what each patient will learn" (p. X). Travelbee's concept of the "educated heart and the educated mind" (1971, p. 19) also appeals to human qualities of the nurse. More recent nursing theory (Benner & Wrubel, 1989) challenges the idea that practice involves the application of theory through deliberative reasoning, and emphasises the practical knowledge of skilled practitioners.

The perception of participants of the significance of personal qualities is consistent with social constructionist views of science as embedded in culture rather than detached from it (Crotty, 1998). However, while recognising the cultural embeddedness of scientific knowledge, there are clearly important implications for nursing practice that cannot be located within a theoretical frame of reference. Tilley (1995) has described the nurses' construction of moral orders in the two sites of his study. His analysis shows nurses ordering patients' personal lives in response to violations of ordinary moral conduct, rather than in terms of any theory or account of mental illness, which might be expected of nurses functioning in a professional role. The perceptions of the therapeutic relationship discussed in this study showed something of the shading over from a clinical role into construction of an ordinary moral order.

In study of nurses relationships with 'problem patients', May and Kelly (1982) found that nurses exerted a tenuous authority that was implicitly challenged by consumers who did not readily respond to conventional approaches to care and treatment. May and Kelly found that nurses possessed "neither readily identifiable technical skills nor unambiguous authority" (p. 279). In the face of such critique, the assertion of 'personality' as a basis of nursing skill seems naïve. From a social constructionist perspective the development of such a perspective can be understood, but it leaves nurses in a problematic situation in articulating the basis of their work in specialist skill, and hence with a fragile professional identity. For inpatient nurses this is particularly problematic as they, of the three groups included in this study, have the most difficulty appropriating other theoretical resources with which to develop their practice.

For those nurses who do take on specific theoretical commitments, the therapeutic relationship continues to serve as an ideal of interpersonal relationships that cannot be subsumed by theory. Nevertheless, for the community nurses and nurse-therapists, the development of additional theoretical resources was seen as a necessary expansion of their concept of therapeutic relationships.

The scope of the therapeutic relationship

The range of involvement referred to in theme three, from facilitative interpersonal care to coercive practices has been given some recognition by Peplau (1987). Reviewing the skills needed by psychiatric nurses, Peplau described a range from nurturing skills through to providing custodial care. The reality of the more coercive practices such as those referred to in the community nurses' group has been the focus of critique of contemporary approaches to mental health nursing based on a generic concept of caring (Glenister, 1997). The place of caring as the focus of mental health nursing has also been questioned by Barker (1994). Peplau (1987) sees custodial care as of historical significance, but Reynolds and Cormack (1990) give custodial care as one of the core roles of the psychiatric nurse, although in their view, the primary function of nursing is a psychotherapeutic one. Reynolds and Cormack's fusion of these two aspects of psychiatric nursing within a single role seems consistent with the views expressed in the community nurses' group, that involvement in coercive aspects of care was consistent with maintaining therapeutic relationships. In another call to recognise the reality of nurses' involvement in coercive practices, Morrall (1998b) reflects on the societal level of the mental health nursing role. According to Morrall, "Psychiatric nursing is connected irrevocably

to the enforcement of control in society. Nurses regulate behaviour either directly (through their 'empathic' relationships with users of mental health services) or indirectly (at the behest of psychiatrists or by their own actions)" (p. 15). Morrall's critique supports the views of participants in this study, that their relationships with consumers extend from use of skills such as empathy, through to coercive practices.

The idea that inpatient experience contributes to the development of a working concept of therapeutic relationships, which for nurses involves a wider sense of awareness, finds some support in recent literature. In a study of inpatient nurses' interactions with consumers, Cleary et al. (1999) found that one of the constraints on interaction was nurses' difficulty in focussing on a single consumer, or even a specified group of consumers, due to the need to maintain a safe environment. Cleary et al state that the focus on a safe environment "... required nurses to 'keep an eye out' for all patients, not just those patients allocated to their care" (p. 110). Becoming involved in "unplanned activities" was also cited as a constraint on interaction, with participants stating that "something always comes up" (p. 111) to distract their attention.

Dealing with difficult situations was part of the theme of the scope of the therapeutic relationship, and there is evidence that the participants in this study are not alone in this experience. Participants in Gijbels' (1995) study of inpatient nurses felt that dealing with "disruptive patients and volatile situations" (p. 463) was part of their job, with one participant stating that "we take people when they're at their worst". The result, however, of taking on a diffuse range of responsibilities, was that, according to Gijbels (p. 463), "A picture of the nurse as a generalist emerged, assisting others, mopping up, without a clear identity of what it is they should be doing themselves." In the nurse-therapist group a similar reservation was expressed:

L: ... but I also am kind of cringing thinking yeah, if someone compartmentalises us in this way we are going to get all the crap jobs that anyone ever thought of, you know, can think of, and when they think of, we need a dogsbody in this service, there's a lot of dogsbody work not getting done, let's get a nurse. That horrifies me. (NT3/21).

Support for the observation that mental health nurses regard acutely ill psychotic consumers as a category of consumer that defines what it is to be a mental health nurse comes from British studies of nurses interactions with 'neurotic' patients, reported in Tilley (1995). Tilley cites several studies showing nurses' aversion to interacting with neurotic patients, and provides one particularly telling excerpt from Cormack (1976):

I don't like talking to neurotic patients, they are less ill than psychotic patients. Neurotics are out to gain something. They seem to take a loan of nurses. (Cormack, 1976, cited in Tilley, 1995, p. 35).

Issues to do with the scope of the concept of the therapeutic relationship seem to be particularly focussed on the inpatient environment. The unpredictable flow of inpatient units does not lend itself to adoption of appointment-based models of therapeutic intervention, although non-nurse participants in Gijbel's (1995) study felt that given the opportunity, nurses could "... do exactly the same therapeutic work" (p. 463). The lack of research into the specific issues of inpatient care was the subject of comment by Mellow (1985), and more recently by Barker (1998).

Nursing theory

It is significant that nursing theory received scant mention by participants. Those who did mention specific theorists had little to say about them and were confused about names and details of theories, needing prompting to complete their statements about nursing theory. The topic of nursing theory, when it did arise, generated little interaction or animation within the groups. Perhaps it cannot be concluded from this that nursing theory is unnecessary. The concept of the therapeutic relationship has, arguably, gained its place in mental health nursing through its explication in Peplau's and others' theories, even if individual nurses are unfamiliar with the form given to that concept within those theories. However the limited interest and awareness shown about nursing theory provides a cautionary note for those who would argue that practice should be theory based. Nurses appear to draw on a range of theoretical influences, perhaps somewhat superficially in some cases, lending some support to the notion that mental health nurses practice within an integrated theoretical framework (Wilshaw, 1997).

In much of the nursing literature, nurses are called upon to avail themselves of formalised accounts of nursing, most notably that of Peplau, in order to improve and develop their practice. However, the nurses in this study showed that although they were substantially unaware of the specific content of nursing theories (and even made mistakes in recalling them), the concepts that contributed to those theories have influenced their practice. The perception of the therapeutic relationship as fundamental is the most striking example of this. Moreover, the participants showed an awareness that the influence of theory is not necessarily to be measured in understanding its specific content.

It is significant in this context that both the community and nurse-therapist groups appeared to have a ready range of specific theoretical resources on which to base their work, and that the inpatient group acknowledged that nurses working in those settings are more likely than inpatient nurses to utilise specific theories. There has been some recent interest in the development of a theory of mental health nursing that might be applied in inpatient care (Barker, 1998). This perhaps meets the criticisms of Morse, Havens and Wilson (1997) that Altschul's studies of nurse-patient interaction have not been replicated, and Mellow's (1986, p. 183) comment that the "... unstructured, unpredictable flow of [inpatient nursing] has not been adequately emphasised in nursing research." Fagin's (1967) account of psychotherapeutic nursing recognises the specific issues arising in inpatient care, but there has been little specific development of theory that builds on Fagin's insights.

The therapeutic relationship: contrast with medical literature

The views of the therapeutic relationship found in this study contrast with those found in a sample of medical literature, and may indicate an important divergence between medicine and nursing in the way relationships with consumers are conceptualised. Where the nurses in this study regarded the therapeutic relationship as 'basic' to their practice, and present in all relationships with clients, a much more conditional view is apparently held by psychiatrists. For psychiatrists, the therapeutic relationship is defined and can be measured in terms of clients' responsiveness to medical treatment and compliance with prescribed regimes. This issue has also been discussed by Speedy (1999). Allan, Tarnoff and Coyne (1985, p. 188) identify two features of the therapeutic alliance, the affective relationship between client and therapist and "... the quality of work occurring in the process." These authors restrict their definition of the therapeutic relationship to the second of these features, defining the alliance as "...the extent to which the patient actively uses the treatment process as a resource for constructive change" (1985, p. 188).

This definition was adopted by Clarkin, Hurt and Crilly (1987), who note that there has been a distinction made between the "human alliance" and the "working alliance" (p. 871). Adopting the latter concept, Clarkin et al. studied the relationship between "alliance" and hospital treatment outcome. They found that positive treatment outcome was related to formation of alliance on admission, with negative outcomes also related to diagnosis of personality disorder and substance abuse.

A broader definition is outlined by Frank and Gunerson (1990, p. 228) who define the therapeutic alliance as "... an open, trusting collaborative relationship...", a definition that has more in common with those of the nursing theorists discussed in Part One, Chapter Two. However, in measuring the relationship between therapeutic alliance and treatment outcome, a more restrictive model is used. This model includes collaborative participation in the treatment process, and other criteria usually associated with cooperation and compliance. The definition leaves little room for a therapeutic relationship with uncooperative, resistant clients who do not share the clinicians' interpretation of their behaviour and presentation.

A similar concept was used by Beauford, McNeil and Binder (1997) in investigating potential for violence. These authors use the terms "therapeutic alliance" and "therapeutic relationship" interchangeably to refer to "... the quality of the relationship between therapist and patient." Beauford et al. (1997, p. 1273). Their emphasis is on "collaboration" although their discussion relates to something more akin to 'cooperation' than active involvement in negotiating treatment decisions. Another example of the construction of the therapeutic relationship in terms of compliance is found in the National Health Committee's depression guidelines:

Developing a therapeutic relationship. The health professional should take time to explain the nature of the disorder, its course, the side effects of any medication and the need to persist with treatment. (National Health Committee 1996, original emphasis).

In summary, a small sample of medical literature reveals a consistent pattern in which the concept of therapeutic alliance is related to specific characteristics of the client such as cooperativeness and willing engagement with treatment. This contrasts with the construction of the therapeutic relationship provided by study participants who saw the therapeutic relationship as an underlying commitment that was not related to cooperativeness or willingness to engage in care. The participants in the community nurses' group specifically rejected my persistent suggestion that in extreme cases they might not have a therapeutic relationship with their patients.

The social construction of the therapeutic relationship

Theoretically, Berger and Luckmann's (1966) representation of the social construction of knowledge supports the account of the therapeutic relationship in this study. As was shown in theme two, inpatient nurses conceptualise their practice in practical rather than theoretical terms. The therapeutic relationship was, for the inpatient nurses, developed using a range of resources of which theory was only one part. This is consistent with the process of social construction of knowledge described by Berger and Luckmann (1966). The concept of the therapeutic relationship, despite being the subject of specific educational strategies, is perceived as derived from non-theoretical sources such as personality, experience, common sense and natural skills. The skills of the therapeutic relationship are learnt in a community of mental health nurses whose common identity provides a shared biography, creating the conditions for "... reiterated objectification of shared experiences..." (Berger & Luckmann, 1966, p. 85). The crucial role of the inpatient unit becomes apparent when the constraints imposed by the nature of consumers' problems are considered. In an inpatient context it is more difficult for a range of possible positions on therapeutic relationships to develop. This can be expected to result in the creation of a particular discourse around observation, awareness and availability, which creates certain possibilities of knowledge while preventing others (Burr, 1995).

Berger and Luckmann (1966) use the term 'reification' to refer to a process whereby something that has been developed through human processes and dialogue comes to be perceived as possessing a reality originating beyond its human construction: "Reification implies that man is capable of forgetting his own authorship of the human world, and, further, that the dialectic between man, the producer, and his products is lost to consciousness" (Berger & Luckmann, 1966, p. 106). This research has sought to identify not an independently existing objectified facticity of the therapeutic relationship, but the process of its social construction. This process clearly has origins beyond the research process, although the research may be seen as contributing to the social construction of the therapeutic relationship by providing a forum in which taken for granted meanings can be rehearsed and affirmed. The introduction into mental health nursing of the concept of the therapeutic relationship has been a process whereby an external reality has become objectified as theory that can, through education, be internalised as a pre-understood reality by, and realised as part of nurses' everyday understanding of their clinical practice.

The therapeutic relationship has already been described, using the language of Berger and Luckmann (1966) as a sedimented experience in the consciousness of the participants in this study. The consensus surrounding the perception of the therapeutic relationship as fundamental is consistent with Berger and Luckmann's concept of "intersubjective sedimentation", which explains how a common stock of knowledge develops amongst individuals who share a common biography. The term 'therapeutic relationship' has become part of the culture of mental health nursing and as Geertz (1973, cited in Crotty, 1998, p. 33) argues, "Culture is the source rather than the result of human behaviour". Thus it could be said that the meanings given by participants to the concept of the therapeutic relationship arise from their immersion in the culture of the discipline, rather than merely through awareness of nursing or other theories.

Methodology

The philosophical framework of constructionism was useful not only in understanding the processes of social construction of knowledge occurring with the research, but in understanding the participants' views in the context of the historical development of mental health nursing discourse. Seen from the perspective of Berger and Luckmann's (1966) account of the social construction of reality, the perceptions of this group of participants can be seen in the light of the development of mental health nursing discourse of the therapeutic relationship that was outlined in the literature review.

The concept of discourse helps to explain how the therapeutic relationship can be perceived as fundamental across a range of involvement. According to Burr (1995) a discourse allows some possibilities to occur while closing off others. The therapeutic discourse of mental health nursing, which appears to underpin participants' perceptions of therapeutic relationships, opens the possibility of beneficent involvement based on nurses' assessment of clients' needs. However it forecloses on the possibility that such an assessment may lead to paternalistic and coercive intervention that conflicts with the ideals of therapeutic relationships.

The use of constructionist methodology, focused the study on the process of construction of knowledge within the groups. In many areas there was a ready consensus, especially about the fundamental nature of the therapeutic relationship. However in other areas, such as the use of theory, there were differences, although more between than within groups. At times

participants showed an uncertainty in their responses that indicated that the nature of the therapeutic relationship, apart from being 'fundamental', was not fixed or final. And yet there was a sense with each group that they 'knew what they meant'. The apparent disparity between this knowing, and the ability to articulate it in language may be understandable in terms of Schon's (1992) distinction between 'knowing how' and 'knowing that': practical knowledge in action is not amenable to articulation in language.

Focus groups proved to be a robust yet flexible way to generate data for the research. Focus group methodology allowed the emergence of a complex picture of how theoretical and other concepts inform and influence accounts of practice. The questions designed to structure the interviews brought a necessary degree of uniformity, but the freedom within focus group methodology to follow leads introduced by participants in interaction, led to the generation of concepts that would not have arisen from a more structured approach to data collection. The focus group imperative of encouraging and attending to interaction allowed ideas to develop in the research process. The commitment to attending to processes of interaction also allowed both "complimentary" and "argumentative" interactions (Kitzinger 1994) to contribute to the production of meanings within the groups. While consistencies in the perceptions of participants have been noted, the analysis has not shown a consensual set of ideas about the therapeutic relationship or about the influence of theory on practice. There were notable differences between the groups, and in some cases within groups. The assumption that this knowledge was not 'out there' awaiting 'discovery' proved fruitful in providing conditions in which knowledge could be constructed in the interview process.

Strengths and limitations of the study

Inductive research

Previous research and writing about nurses' use of theoretical models has accorded theory a privileged role over intuition or common sense in informing nursing action (e.g. Altschul, 1971; Howard, 1983; Peplau, 1960). This study focussed on nurses' perceptions of the therapeutic relationship, and of the role of theory in informing their practice. Thus the interest was in how participants made sense of these issues, rather than in how their views did or didn't conform to an external model. Previous work (O'Brien, 1999) showed that nurses describe a range of

practices not derived from theory, but which seem to be of practical value in meeting the needs of consumers, and to be consistent with the ethical task of mental health nursing to promote good. What distinguishes the inductive research that identified these practices is that the categories of understanding used to describe the nurses' practices arose from the language of the research participants, not from a pre-existing model of what constituted mental health nursing practice. This is consistent with the work of Benner, Tanner and Chesla (1996) whose studies of critical care nurses have shown the use of tacit knowledge in informing practice, and of McElroy (1990) with psychiatric nurses.

Partial perspective

This research used qualitative methods to explore mental health nurses' perceptions of the therapeutic relationship. It therefore represents one part of a total picture of mental health nursing: the view of some of the nurses themselves. It does not consider the perceptions of consumers, or the effect of interventions practised by the participants. The value of the research in articulating mental health nurses' perceptions of their practice imposes a limitation that actors' perceptions, particularly of concepts rather than action, contribute only a partial perspective to the understanding of mental health nursing practice. The study findings must be read alongside other literature that documents nurses' patterns of interaction and consumers' experiences and responses.

Number of participants and groups

The relatively small number of participants (nine) limits the generalisability of the study, although statistical generalisability is not an aim of qualitative research. It may be considered that a greater number of participants and groups would have increased the richness of data and hence of the descriptive account developed. In a thesis project such as this there are practical limitations that impose methodological limitations, and the numbers of participants and groups were considered adequate for the overall study purpose, and consistent with the literature on focus group research. There were certainly questions that arose from the analysis that would benefit from further research, but it was not possible to pursue them within the constraints of the current study. The use of groups from three different practice areas proved to be valuable, as it was evident that the discursive practices and views held of mental health nursing were in important ways shaped by practice context. This was apparent both in the content of discussions within each group, and in the views each expressed of other practice contexts. The

latter issue was not a research question, and although it was intended to compare perceptions of the different groups of nurses, eliciting their views of each other's practice context was not intended.

Focus

The study was structured by questions seeking to explore perceptions of the therapeutic relationship and so was limited to nurses' perceptions of that concept. Other aspects of mental health nursing practice were necessarily excluded by such a specific focus. However, highlighting one central aspect of mental health nursing has allowed that aspect to be examined in some depth, lending significance to the study. There was no attempt to explore untherapeutic relationships.

Mental health nursing literature

One of the major limitations is that the findings of the study have had to be interpreted in reference to literature from different practice contexts than that in which the research took place. Most of the literature used to discuss these findings is British. Although there are historical and contemporary similarities in British and New Zealand mental health services, there are also significant differences of culture and history, necessitating caution in considering the points raised in this discussion.

Characteristics of participants

For this study a purposive sample of experienced nurses was sought. The average length of experience was 14.2 years, and most participants, (six out of nine), received their undergraduate education in apprentice-style hospital programmes. The selective nature of the sample limits the transferability of the findings to more recent graduates. Some similarities in educational preparation were noted with the three participants who had been educated in generic diploma programmes. The influence of current entry to mental health nursing practice programmes on recent graduates' perceptions of their relationships with consumers is as yet unknown.

Part Four, Chapter Two

Conclusions

Introduction

This thesis began with a discussion of a concept central to the practice of mental health nursing, and which has played a prominent role in the conceptualisation of the discipline in the past 50 years. The findings would appear to have confirmed the fundamental place of the therapeutic relationship in mental health nursing. The therapeutic relationship was described by participants as fundamental to their practice, independent of theory, and to form the basis of their involvement in relationships ranging from facilitative interpersonal care to coercive interventions. However Olson's (1996) concerns about the adequacy of the therapeutic relationship for the future of mental health nursing is still relevant, and there is a need to consider the adequacy of the therapeutic relationship for professional continuity. Changes in the context of mental health care were outlined in the literature review, where it was suggested that despite changes, the therapeutic relationship may be the core concept by which mental health nurses define their involvement with consumers. The study would appear to have confirmed this view. With some qualifications, nurses practising in different contexts, using theoretical resources other than the therapeutic relationship, remain committed to the therapeutic relationship as fundamental.

One of mental health nursing's foremost authors Stuart (1999) has suggested that while the historical contribution of the concept of the nurse-patient relationship, particularly that of Peplau, must be acknowledged, that other domains of practice such as direct care, management and communication must be acknowledged. The current research has focused specifically on the domain of the relationship and so it is not surprising that the concerns noted by Stuart did not emerge in the research findings. However Stuart's concerns help to provide a broader professional context within which the findings can be understood. The mental health context has developed considerably in scope and complexity since the original formulation of mental health nursing as a therapeutic relationship. The development, by the community nurses and nurse-therapists, of theoretical approaches other than the therapeutic relationship, recognises this complexity. This chapter will consider critiques of the concept of the therapeutic

relationship in light of the research findings, and will outline recommendations arising from the research for education, research and practice.

Recommendations for education

The therapeutic relationship and the interpersonal nursing theory from which it is derived, have enabled mental health nurses to conceptualise their involvement with consumers as therapeutic, rather than custodial, and the interpersonal therapeutic role has generalised to the wider profession of nursing. The perception of participants that the therapeutic relationship is foundational to their practice is consistent with the direction shown by the Nursing Council of New Zealand in including the therapeutic relationship in mental health competencies in the undergraduate curriculum (Nursing Council of New Zealand, 1998). It suggests that the concept of the therapeutic relationship, rather than some more general construct, should form the basis of foundation studies of the nurse patient relationship in undergraduate programmes. It would also seem prudent that this teaching is undertaken by nurses who have specialised in mental health so that the boundaries between mental health and illness can be clearly outlined, and the generic nature of the skills of the therapeutic relationship can be contrasted with the more specialist intervention skills used in the different sub-specialties of mental health.

The Nursing Council of New Zealand is to conduct a review of undergraduate education in New Zealand this year (Nursing Council of New Zealand, 1999), having already been moved by criticisms of undergraduate programmes to establish specific competencies for the mental health component of undergraduate education (Nursing Council of New Zealand, 1998). It seems timely therefore to reflect on the significance for the participants of their introduction to therapeutic relationships in their undergraduate education, both comprehensive and specialist. I am aware from personal experience and anecdotally from others, that some undergraduate programmes have introduced into their foundation year, generic 'communication skills' modules taught by business and other non-clinical communications 'experts', none of whom have nursing or other clinical experience. This research has shown that a sound introduction to interpersonal relationships as therapeutic helping relationships stays with nurses as a formative experience. It seems implausible that the sort of relationship skills taught by business or general communications teachers could fulfill this function. This has particular implications for mental health in terms of the likelihood that undergraduate students would gain an appreciation of the

skills and traditions available to them in therapeutic relationships, and in terms of the quality of preparation offered by undergraduate programmes in this area.

The concept of the scope of the therapeutic relationship described in the third theme has implications for undergraduate and entry to mental health nursing practice programmes. If students are to be equipped with a concept of the therapeutic relationship that will enable them to function within the broad scope of clinical realities that constitute mental health nursing, they will need a concept that is broad enough to guide them in providing both supportive care and restrictive care, and negotiating the borderland between those two aspects of care. There is some evidence that a sense of procedural justice influences the experience of coercion (McKenna, 1998), suggesting that there are possibilities for development of what might be considered therapeutic practices, even in coercive circumstances. However for these to be integrated into nurses' working concept of therapeutic relationships, there needs to be explicit recognition of the scope of the therapeutic relationship in mental health nursing and the particular demands that creates for the development of practicable nursing theory. In teaching undergraduate students about the therapeutic relationship it would seem wise to ground that teaching in the clinical practice of mental health nursing, so that students are able to explore how concepts of the therapeutic relationship can be applied in a variety of clinical situations.

Recommendations for research

While this study contributes to an understanding of mental health nurses' perceptions of their relationships with consumers, there is little published New Zealand research on consumers' experiences of mental health nursing care. Small scale descriptive studies could contribute to understanding of how consumers experience what nurses regard as constituting a therapeutic relationship. In particular, the area of consumers' experience of coercion seems worthy of attention, in light of participants' views that this is an area of care routinely taken up by nurses. Some work has already been undertaken in this area (McKenna, 1998).

It was noted that the inpatient nurses showed the least commitment to integrating other theory into their use of therapeutic relationships, and gave the most atheoretical account of the therapeutic relationship. It is notable that movement into 'specialist' areas of mental health nursing practice calls for the development of different models of care, and yet there is no specific theory available to explain the process and phenomena of inpatient care. Mellow

(1986) commented on this neglect, and yet little has changed to provide inpatient nurses with theoretical resources with which to conceptualise their practice (Barker, 1998). A constant focus on 'interaction' as a basis of analysis of inpatient work has done little apart from reinforce what is generally known: that inpatient nurses do not practice in accordance with 'interaction' theories. Morse, Havens and Wilson (1997) commented that Tudor's 1952 study of mutual withdrawal had not been further explored, and Mellow (1986) has commented on the lack of specific research into the unique phenomena of inpatient nursing care. A recommendation from the study of Cleary et al. (1999) which has relevance given the findings of the present study was to "Consider developing a model of nursing care which incorporates aspects of primary nursing, but is more responsive to the unexpected nature of care delivery in the current acute care setting" (p. 114-5).

The issue of a lack of mental health nursing research in New Zealand poses difficulties for any research that is undertaken. There is not a substantial body of local literature within which new research findings may be located and this has been identified as a limitation of the current study. It is not a reason to avoid undertaking research. Rather, it is a reason urgently to advance a research agenda for mental health nursing in New Zealand.

Issues in nursing research have been debated in terms of a quantitative versus qualitative dichotomy. Constructionism offers a research paradigm that gets beyond such a simplistic distinction and focuses attention on the underlying theoretical and philosophical assumptions of the research, without assuming that these questions are answered entirely by methods. So far very little research has been conducted within a constructionist paradigm, although using Burr's criteria (page 48) much nursing research has commitments that are consistent with constructionism. The position offered by Appleton and King (1997) on constructivism is problematic as it appears to hold an essentialist view of knowledge, which is inconsistent with a constructionist research paradigm. The socially constructed nature of the therapeutic relationship that was described in this study suggests that constructionist research may have much to offer mental health nursing.

Recommendations for practice

The therapeutic relationship offers mental health nurses a means of conceptualising their practice in terms of an ethical principle of beneficence. Given the reality of the coercive

practices identified by participants in this study, and the support for this perception in the mental health nursing literature, it seems important that nurses in clinical practice are able to maintain a focus on how practice is beneficial to consumers. Speedy (1999) has suggested that the therapeutic relationship needs modification to incorporate the concept of alliance, to recognise the need to focus on the consumer's experience of care. In their perception that the therapeutic relationship is not dependent on theory, and has more to do with human interaction, participants recognised that the therapeutic relationship offers a human relationship as a therapeutic intervention, and that that relationship meets an ethical obligation to promote good, rather than simply bring about change. It seems important that mental health nursing practice is informed by ethical commitments such as those embodied in the therapeutic relationship. The skills needed to maintain ethically sound practice are less easily identified than the skills of specific interventions but are equally in need of careful development. The research provided participants with a limited opportunity to engage in reflective consideration of the quality of their relationships with consumers. Opportunities to engage in this sort of reflection on practice are limited, but valuable. Provision of clinical supervision may help to develop the qualities of relationships between nurses and consumers that might truly be called 'therapeutic'.

My experience in conducting the research was that inpatient nurses had the most difficulty in withdrawing from the workplace to give time to the research. In their finding that "something always comes up" (Cleary et al., 1999), and in Gijbel's (1995) finding that inpatient nurses were distracted from interactions with consumers by the need to "keep an eye out" in order to maintain a safe environment, there is further evidence that relationships are constrained by the structural dictates of the workplace (Porter, 1993). Managers and nurse-leaders in inpatient care need to work with practitioners to find ways of ensuring that nurses' attempts to develop therapeutic relationships are not submerged by the unpredictable pattern of events in inpatient care.

There has been recent debate about the adequacy of Peplau's theory for current mental health care (Jones, 1996). According to Jones, current interdisciplinary models of care mean that theories focusing on the skills of a single group of professionals are of limited value. In a similar vein, Hawthorne and McKenzie (1995) have criticised the adequacy of nursing theory for nurses working with delusional consumers. However it may be mistaken to assume that a very broad theory such as Peplau's should be expected to inform both the specific practices of

mental health nurses and their orientation to their relationships with consumers. Wilshaw (1997) has commented on mental health nurses' apparent preference for an integrated therapeutic approach, a comment that finds resonance with the perceptions of participants in this study that adherence to a single therapeutic modality has the potential to limit their contribution to the care of consumers. It may be that interpersonal nursing theory, with its commitment to developing therapeutic relationships, has an important place within an overall integrated therapeutic approach. In this role nursing theory may continue to influence practitioners' perceptions of their relationships with consumers, while allowing the appropriation of additional theoretical resources.

Epilogue

I began this thesis with a passage from Eliot's *Little Gidding*. I chose the passage because it alludes in a clear and immediate way to a sense of discovery and renewal. Eliot discovered faith and experienced a renewed sense of the purpose of life, neither artificially imposed nor fancifully imagined. We shall not cease from exploration. In seeking to respond to some of the pressing problems faced in describing 'mental health nursing', I am aware that it is easy to imagine an idealised past to which we should return or an ideal future to which we should aspire. Our efforts at research attempt to establish something achievable in between. In an address discussing the culture of mental health nursing, Webster (1996) spoke of the need for nurses to have the courage to acknowledge what they do not and cannot know. This reminds me of a nurse who, as a student, told of sitting in a seclusion room with a consumer and, although she did not understand what the consumer was experiencing, sensed that her presence was helpful. The nurse called this 'the not knowing', contrasting it with verbal communication in which the consumer's and nurse's thoughts are surfaced for discussion. We do not, and cannot, know all we would like. Like Eliot we might despair at our ignorance, and seek to understand through exploration. It seems to be some small mark of progress to recognise what it is we know and what still awaits exploration. It also seems that a measure of humility is necessary to acknowledge that we cannot know all we would like to. At the end of my exploring I have arrived at where I started enriched by the process of talking to nurses about their practice, by reading the literature resulting from others' explorations and with a renewed sense of what mental health nursing is.

References

- Agar, M., & McDonald, J. (1995). Focus groups and ethnography. *Human Organisation*, 54, 78-86.
- Allen, J. G., Tarnoff, G., & Coyne, L. (1985). Therapeutic alliance and long-term hospital treatment outcome. *Comprehensive Psychiatry*, 26, 187-194.
- Altschul, A. (1971). Relationships between patients and nurses in psychiatric wards. *International Journal of Nursing Studies*, 8, 179-187.
- Altschul, A. (1978). A systems approach to the nursing process. *Journal of Advanced Nursing*, 3, 333-340.
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychological Rehabilitation Journal*, 16(4), 11-23.
- ANZCMHN (1995). *Standards of practice for mental health nursing in New Zealand*. Greenacres, South Australia: Author.
- Appleton, J., & King, L. (1997). Constructivism: a naturalistic methodology for nursing inquiry. *Advances in Nursing Science*, 20(2), 13-22.
- Auckland Hospital Board (n.d.). *Ethics and rules of conduct for all members of staff in psychiatric and psychopaedic hospitals*. Author.
- Barbour, R. S. (1999). Are focus groups an appropriate tool for studying organisational change? In R. S. Barbour, & J. Kitzinger (Eds.), *Developing focus group research. Politics, theory and practice* (pp. 113-126). London: Sage.
- Barker, P. (1982). *Behaviour therapy nursing*. London: Croom Helm.
- Barker, P. (1989). Reflections on the philosophy of caring in mental health. *International Journal of Nursing Studies*, 26, 131-141.

- Barker, P. (1990). Cognitive therapy model: Principles and general applications. In W. Reynolds., & D. Cormack (Eds.), *Psychiatric and mental health nursing. Theory and practice* (pp. 43-62). London: Chapman and Hall.
- Barker, P. (1993). The Peplau legacy. *Nursing Times*, 89(11), 48-51.
- Barker P. J. (1996). The logic of experience: developing appropriate care through effective collaboration. *Australian New Zealand Journal of Mental Health Nursing* 5, 3-12.
- Barker, P. (1998). It's time to turn the tide. *Nursing Times*, 94(18), 70-72.
- Barker, P., & Fraser, D. (1985). *The nurse as therapist: A behavioural model*. London: Croom Helm.
- Barker, P. & Reynolds, B. (1994). A critique: Watson's caring ideology: the proper focus of psychiatric nursing? *Journal of Psychosocial Nursing* 32(5), 17-22.
- Barker, P., Reynolds, W., & Stevenson, C. (1997). The human science basis of psychiatric nursing: theory and practice. *Journal of Advanced Nursing*, 25, 660-667.
- Barker, P. & Whitehall, I. (1997). The craft of care. Towards collaborative caring in psychiatric nursing. In S. Tilley (Ed.), *The mental health nurse. Views of practice and education* (pp. 15-27). Oxford: Blackwell Science.
- Basch, C. E., (1987). Focus group interview: an underutilized research technique for improving theory and practice in health education. *Health Education Quarterly*, 14 411-448.
- Bazley, M. (1973). Psychiatric nursing in New Zealand. *International Journal of Nursing Studies*, 10, 103-110.
- Bazley, M. C., Cakman, N. C., Kyle, J. H. W., & Thomas, L. B. (1973). *The nurse and the psychiatric patient*. Auckland: Heinemann.

- Beauford, J. E., McNeil, D. E., & Binder, R. L. (1997). Utility of the initial therapeutic alliance in evaluating psychiatric patients' risk of violence. *American Journal of Psychiatry*, 154, 1272-1276.
- Benner, P., & Wrubel, J. (1989). *The primacy of caring. Stress and coping in health and illness*. California: Addison-Wesley.
- Benner, P., Tanner, C. A., & Chesla, C. A. (1996). *Expertise in nursing practice. Caring clinical judgment and ethics*. New York: Springer.
- Berger, P. L., & Luckmann, T. (1966). *The social construction of reality. A treatise in the sociology of knowledge*. Middlesex: Penguin Books.
- Breeze, J. A., & Repper, J. (1998). Struggling for control: the care experiences of 'difficult' patients in mental health services. *Journal of Advanced Nursing*, 28, 1301-1311.
- Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.
- Butler, S. (1996). Child protection or professional self preservation by the baby nurses? Public health nurses and child protection in Ireland. *Social Science in Medicine*, 43, 303-314.
- Caine, T. M., & Smail, D. J. (1968). Attitudes of psychiatric nurses to their role in treatment. *British Journal of Medical Psychology*, 41, 193-197.
- Carey, M. A. (1994). The groups effect in focus groups: Planning, implementing, and interpreting focus group research. In J. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 225-241). California: Sage.
- Carson, J., Leary, J., de Villiers, N., Fagin, L., & Radmall, J. (1995). Stress in mental health nurses: Comparison of ward and community staff. *British Journal of Nursing*, 4(10), 579-582.
- Cheek, J. (1996). Taking a view: qualitative research as representation. *Qualitative Health Research*, 6, 492-505.

- Christensen, J. (n. d.) The impact of American ideas on New Zealand nursing education. Part II. Change in New Zealand nursing education in the 1970's. In D. Phillips, G. Lealand, & G. McDonald (Eds.), *The impact of American ideas on New Zealand's educational policy, practice and thinking* (pp. 212-218). Wellington: New Zealand - United States Educational Foundation/New Zealand Council for Educational Research.
- Chung, M. C., & Nolan, P. (1994). The influence of positivistic thought on nineteenth century asylum nursing. *Journal of Advanced Nursing*, 19, 226-232.
- Clarkin, J. F., Hurt, S. W., & Grilly, J. L. (1987). Therapeutic alliance and hospital treatment outcome. *Hospital and Community Psychiatry*, 38, 871-875.
- Cleary, M. Edwards, C., & Meehan, T. (1999). Factors influencing nurse-patient interaction in the acute psychiatric setting: An exploratory investigation. *Australian and New Zealand Journal of Mental Health Nursing*, 8, 109-116.
- Clinton, M., & Redmond, S. (1999). Recovery, mental illness and mental health nursing. In M. Clinton, & S. Nelson (Eds.), *Advanced practice in mental health nursing* (pp. 260-277). Oxford: Blackwell Science.
- Colliton, M. A. (1965). The history of nursing therapy. A reactionnaire to the work of June Mellow. *Perspectives in Psychiatric Care*, III(2), 10-18.
- Cormack, D. (1976). *Psychiatric nursing observed*. London: Royal College of Nursing.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: choosing among five traditions*. California: Sage.
- Crotty, M. (1998). *The foundations of social research. Meaning and perspective in the research process*. St. Leonards, Australia: Allen & Unwin.
- Crowe, M. (1998a). Developing advanced mental health nursing practice: A process of change. *Australian and New Zealand Journal of Mental Health Nursing*, 7, 86-94.

- Crowe, M. (1998b). The power of the word: some post-structural considerations of qualitative approaches in mental health nursing. *Journal of Advanced Nursing*, 28(2), 339-334.
- Cunningham-Burley, S., Kerr, A., & Pavis, S. (1999). Theorising subjects and subject matter in focus group research. In R. S. Barbour, & J. Kitzinger (Eds.), *Developing focus group research. Politics, theory and practice* (pp. 186-199). London: Sage.
- Dakin, J. C. (1973). *Education in New Zealand*. Auckland: Fullerton.
- Deale, A., Chalder, T., Marks, I., & Wessely, S. (1997). Cognitive behaviour therapy for chronic fatigue syndrome. *American Journal of Psychiatry*, 154, 408-414.
- Duggan, C., Marks, I., & Richards, D. (1993). Clinical audit of behaviour therapy training of nurses. *Health Trends*, 25(1), 25-30.
- Fagin, C. M. (1967). Psychotherapeutic nursing. *American Journal of Nursing*, 67, 298-304.
- Fagin, C. M. (1996). Commentary. *Archives of Psychiatric Nursing*, X(1), 11-13.
- Farrell, G. A. (1997). *Getting up to speed with evidence-based practice*. Greenacres, South Australia: Australian and New Zealand College of Mental Health Nurses Inc.
- Faugier, J. (1985, May 15). Throwing down the gauntlet. *Nursing Times*, 81(20), 63.
- Firestone, W. A. (1993). Alternative arguments for generalising from data as applied to qualitative research. *Educational Researcher*, 16(7), 16-21.
- Forchuk, C. (1991). A comparison of the works of Peplau and Orlando. *Archives of Psychiatric Nursing*, V(1), 38-45.
- Forchuk, C., Beaton, S., Creawford, L., Ide, L., Voorberg, N., & Bethune, J., (1989). Incorporating Peplau's theory and case management. *Journal of Psychosocial Nursing*, 27(2), 35-38.

- Ford-Gilboe, M., Campbell, J., & Berman, H. (1995). Stories and numbers: coexistence without compromise, *Advances in Nursing Science*, 18(1), 14-26.
- Foster, B. (1998). Ethical practice and legal responsibility for duly authorised officers: Achieving a balance. *Australian and New Zealand Journal of Mental Health Nursing*, 7, 41-45.
- Frank, A. F., & Gunderson, J. (1990). The role of the therapeutic alliance in the treatment of schizophrenia. *Archives of General Psychiatry*, 47, 228-236.
- Frankland, J., & Bloor, M. (1999). Some issues arising in the systematic analysis of focus group materials. In R. S. Barbour & J. Kitzinger (Eds.), *Developing focus group research: Politics, theory and practice* (pp. 144-155). London: Sage.
- Gastmans, C. (1998). Interpersonal relations in nursing: a philosophical-ethical analysis of the work of Hildegard E. Peplau. *Journal of Advanced Nursing*, 28, 1312-1319.
- Gergen, K. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40, 266-275.
- Gijbels, H. (1995). Mental health nursing skills in an acute admission environment: perceptions of mental health nurses and other mental health professionals. *Journal of Advanced Nursing*, 21, 460-465.
- Glenister, D. (1997). Coercion, control and mental health nursing. In S. Tilley (Ed.), *The mental health nurse. Views of practice and education* (pp. 43-57). Oxford: Blackwell Science.
- Goffman, E. (1961). *Asylums. Essays on the social situation of mental patients and other inmates*. Middlesex: Penguin.
- Gournay, K. (1995). Mental health nurses working purposefully with people with serious and enduring mental illness - an international perspective. *International Journal of Nursing Studies*, 12(4), 341-352.

- Gournay, K. & Brooking, J. (1994). Community psychiatric nurses in primary health care. *British Journal of Psychiatry*, 165, 231-238.
- Grob, G. N. (1966). *The State and the mentally ill. A history of Worcester State Hospital in Massachusetts, 1830-1920*. Chapel Hill: University of North Carolina Press.
- Guba, E. G. & Lincoln, Y. S., (1994). Competing paradigms in qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). California: Sage.
- Hall, B. A. (1996). The psychiatric medical model: a critical analysis of its undermining effects on nursing in chronic illness. *Advances in Nursing Science*, 18(3), 16-26.
- Happell, B. (1996). Focus group interviews as a tool for psychiatric nursing research. *Australian and New Zealand Journal of Mental Health Nursing*, 5, 40-44.
- Harraway, M. (n.d.). *An historical outline of nursing education at Sunnyside Hospital, 1904-1987*. Christchurch: Author.
- Hawthorne, D. & McKenzie, A. (1995). Does nursing theory adequately prepare nurses to work with delusional patients? *Australian and New Zealand Journal of Psychiatry*, 29, 284-287.
- Hazelton, M. (1997). Reporting mental health. A discourse analysis of mental health-related news in two Australian newspapers. *Australian and New Zealand Journal of Mental Health Nursing*, 6, 73-89.
- Health Research Council of New Zealand. (1998). *Guidelines for researchers on health research involving Maori*. Auckland: Health Research Council of New Zealand.
- Hofling, C. K., Leininger, M. M., & Bregg, E. (1967). *Basic psychiatric concepts in nursing* (2nd ed.). Philadelphia: Lippincott.
- Hopton, J. (1997). Towards a critical theory of mental health nursing. *Journal of Advanced Nursing*, 25, 492-500.

- Howard, F. (1983). Staff-patient interaction patterns in hospital and community psychiatric facilities: a comparison. Unpublished master's thesis, University of Auckland, Auckland, New Zealand.
- Hutchinson, C. P., Barlow, D. J. H., & Hutchings, W. (1971). *Report of the Commission of Inquiry into psychiatric services at Oakley Hospital*. Wellington: Government Printer.
- Hutchinson, S. A., Wilson, M. E., & Wilson H. S. (1994). Benefits of participating in research interviews. *Image: Journal of Nursing Scholarship*, 26(2), 161-164.
- Jackson, M., & Cawley, R. (1992). Psychodynamics and psychotherapy on an acute psychiatric ward. The story of an experimental unit. *British Journal of Psychiatry*, 160, 41-50.
- Johnson, A. (1996). 'It's good to talk': The focus group and the sociological imagination. *The Sociological Review*, 44, 517-538.
- Johnston, R. L., & Fitzpatrick, J. J. (1982). Relevance of psychiatric mental health nursing theories to nursing models. In R. L. Johnston, A. L. Whall, A. L., & J. A. Floyd (Eds.), *Nursing models and their psychiatric mental health applications* (pp. 1-18). Maryland: Robert J. Brady Company.
- Johnstone, M.-J. (1994). *Bioethics. A nursing perspective*. (2nd ed.). Australia: Harcourt, Brace and Company.
- Jones, A. (1996). The value of Peplau's theory for mental health nursing. *British Journal of Nursing*, 5, 877-881.
- Kelly, N. R., Shoemaker, M., & Steele, T. (1996). The experience of being a male student nurse. *Journal of Nursing Education*, 35, 170-174.
- Keltner, N., Schwecke, L. H., & Bostrom, C. E. (1999) (Eds.). *Psychiatric nursing* (3rd ed.). St. Louis: Mosby.

- Kingry, M. J., Tiedje, L. B., & Friedman, L. L. (1990). Focus groups: a research technique for nursing. *Nursing Research*, 39, 124-125.
- Kingseat Hospital. (n. d.). *50 years, 1932-1982*. Auckland: Author.
- Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health and Illness*, 16(1), 103-121.
- Kitzinger, J., & Barbour, R. S. (1999). The challenge and promise of focus groups. In R. S. Barbour, & J. Kitzinger (Eds.). *Developing focus group research. Politics, theory and practice* (pp. 1-20). London: Sage,
- Koch, T. (1994). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing*, 19, 976-986.
- Koch, T., & Harrington, A. (1998). Reconceptualising rigour: the case for reflexivity. *Journal of Advanced Nursing*, 28, 882-890.
- Krawitz, R. (1997). A prospective psychotherapy outcome study. *Australian and New Zealand Journal of Psychiatry*, 31, 465-473.
- Krueger, R. A. (1994). *Focus groups: a practical guide for applied research* (2nd ed.). California: Sage.
- Lamb, G. S. Huttlinger, K. (1989). Reflexivity in nursing research. *Western Journal of Nursing Research*, 11, 765-772.
- Lambert, G. & Gournay, K. (1999). Training for the mental health workforce: A review of developments in the United Kingdom. *Australian and New Zealand Journal of Psychiatry*, 33, 694-700.
- Lego, S. (1992). Biological nursing and psychiatric nursing in America. *Archives of Psychiatric Nursing*, VI(3), 147-150.
- Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry*. California: Sage.

- Linhorst, D. M. (1995). Implementing psychosocial rehabilitation in long term psychiatric facilities. *Journal of Mental Health Administration*, 22(1), 58-67.
- Litchfield, M. (n. d.). The impact of American ideas on New Zealand nursing education. Part III. Becoming art of the pattern. In D. Phillips, G. Lealand, & G. McDonald (Eds.), *The impact of American ideas on New Zealand's educational policy, practice and thinking* (pp. 219-225). Wellington: New Zealand - United States Educational Foundation/New Zealand Council for Educational Research.
- LoBiondo-Wood, G., & Haber, J. (1994). *Nursing research. Methods, critical appraisal and utilisation* (3rd ed.). St. Louis: Mosby.
- Ludwig, F. M. (1993). Gail Fidler. In R. J. Miller, & K. F. Walker (Eds.). *Perspectives on therapy for the practice of occupational therapy* (pp. 17-40). Maryland: Aspen.
- Marks, I. (1985). *Psychiatric nurse therapists in primary care. A controlled trial*. Royal College of Nursing Research Series. London: Royal College of Nursing.
- Marks, I., Hallam, R. S., Philpott, R., & Connolly, J. C. (1975). Nurse therapists in behavioural psychotherapy. *British Medical Journal*, 3, 144-148.
- Marks, I., Lovell, K., Noshirvani, H., Livanou, M., & Thrasher, S. (1998). Treatment of posttraumatic stress disorder by exposure and/or cognitive restructuring. *Archives of General Psychiatry*, 55, 317-325.
- Massey University (n.d). *Code of ethical conduct for research and teaching involving human subjects*. Massey University: Author.
- Masson, J. (1993). *Against therapy*. London: Harper Collins.
- May, C., & Purkis, M. E. (1995). The configuration of nurse-patient relationships: A critical view. *Scholarly Inquiry for Nursing Practice: An International Journal*, 9, 283-295.
- May, D. & Kelly, M. P. (1982). Chancers, pestes and poor wee souls: Problems of legitimation in psychiatric nursing. *Sociology of Health and Illness* 4, 279-301.

- McElroy, E. (1990). *Uncovering clinical knowledge in expert nursing practice*. Michigan: UMI Dissertation Services.
- McEwan, R. (1961). What is psychiatric nursing? *The New Zealand Nursing Journal*, 11, 13.
- McKenna, B. G. (1998). Patient perception of coercion on admission to acute inpatient psychiatric services. Unpublished master's thesis, University of Auckland, Auckland, New Zealand.
- Mellow, J. (1968). Nursing therapy. *American Journal of Nursing*, 68(11), 2365-2369.
- Mellow, J. (1986). A personal perspective of nursing therapy. *Hospital and Community Psychiatry*, 37, 182-183.
- Mental Health Commission. (1998a). *Blueprint for mental health services in New Zealand. How things need to be*. Wellington: Mental Health Commission.
- Mental Health Commission. (1998b). *A travel guide. For people on the journeys towards equality, respect and rights for people who experience mental illness*. Wellington: Mental Health Commission.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded source book* (2nd ed.). California: Sage.
- Mills, C. W. (1959). *The sociological imagination*. Middlesex, England: Penguin.
- Ministry of Health. (1997a). *Moving forward. The National mental health plan for more and better services*. Wellington: Ministry of Health.
- Ministry of Health. (1997b). *Extending limited prescribing rights to registered nurses. Draft discussion document*. Wellington: Ministry of Health.
- Montgomery, C. L., & Webster, D. (1994). Caring, curing and brief therapy: a model for nurse-psychotherapy. *Archives of Psychiatric Nursing*, VIII(5), 291-297.
- Morgan, D. L. (1988). *Focus groups as qualitative research*. California: Sage.

- Morgan, D. L. (1996). Focus groups. Using focus groups in research. *Annual Review of Sociology*, 22, 129-151.
- Morrall, P. (1998a). *Mental health nursing and social control*. London: Whurr.
- Morrall, P. (1998b). Speaking out. *Nursing Times*, 94(19), 15.
- Morse, J. (1991). Negotiating commitment and involvement in the nurse-patient relationship. *Journal of Advanced Nursing*, 16, 455-468.
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals*. (2nd ed.). California: Sage.
- Morse, J. M., Havens, G. A. D. & Wilson, S. (1997). The comforting interaction: developing a model of nurse-patient relationship. *Scholarly Inquiry for Nursing Practice: An International Journal*, 11, 321-343.
- National Health Committee. (1996). *Guidelines for the treatment and management of depression in primary care. A summary*. Wellington: National Health Committee.
- Newell, R., & Gournay, K. (1994). British nurses in behavioural psychotherapy: A 20 year follow-up. *Journal of Advanced Nursing*, 20, 53-60.
- Nightingale, F. (1860/1992). Notes on Nursing. What it is and what it is not. In V. Skretkovicz (Ed.). *Florence Nightingale's notes on nursing* (Revised ed.). Middlesex: Scutari Press.
- Nolan, P. (1993a). *A history of mental health nursing*. London: Chapman Hall.
- Nolan, P. W. (1993b). A history of the training of asylum nurses. *Journal of Advanced Nursing*, 18, 1193-1201.
- Nursing Council of New Zealand. (1997). *Draft framework for competence-based practising certificates for registered nurses*. Wellington: Nursing Council of New Zealand.

- Nursing Council of New Zealand. (1998). *Guidelines for mental health nursing education*. Wellington: Nursing Council of New Zealand.
- Nursing Council of New Zealand. (1999). *Review of undergraduate nursing education*. Untitled newsletter. Wellington: Nursing Council of New Zealand.
- O'Brien, A. J. (1999). Negotiating the relationship. Mental health nurses' perceptions of their practice. *Australian and New Zealand Journal of Mental Health Nursing*, 8, 153-161.
- O'Brien, A. J. (2000). The therapeutic relationship. Historical development and contemporary significance. Manuscript submitted for publication.
- Olson, T. (1996). Fundamental and special: the dilemma of psychiatric-mental health nursing. *Archives of Psychiatric Nursing*, X(1), 3-10.
- Orlando, I. J. (1961). *The dynamic nurse-patient relationship*. New York: G. P. Putnam's Sons.
- Parkes, T. (1997). Reflections from the outside in. My journey into, through and beyond psychiatric nursing. In S. Tilley (Ed.). *The mental health nurse. Views of practice and education* (pp. 58-72). Oxford: Blackwell Science.
- Parse, R. R. (1981). *Man-living-health. A theory of nursing*. New York: John Wiley and Sons.
- Pelletier, L. R. (1984). Nurse-psychotherapists: whom do they treat? *Hospital and Community Psychiatry*, 35, 149-1150.
- Peplau, H. E. (1952/1988). *Interpersonal relations in nursing. A conceptual frame of reference for psychodynamic nursing*. London: MacMillan.
- Peplau, H. (1960). Talking with patients. *American Journal of Nursing*, 60(7), 964-966.
- Peplau, H. E. (1987). Psychiatric skills: Tomorrow's world. *Nursing Times*, 83(1), 29-32.
- Peplau, H. E. (1988). The art and science of nursing: Similarities, differences, and relations. *Nursing Science Quarterly*, 1(1), 8-15.

- Playle, J. F., & Keeley, P. (1998). Non-compliance and professional power. *Journal of Advanced Nursing* 27, 304-311.
- Polit, D. F. & Hungler, B. P. (1995). *Nursing research. Principles and methods*. (5th ed.). Philadelphia: J. B. Lippincott Company.
- Porter, S. (1993). The determinants of psychiatric nursing practice: a comparison of sociological perspectives. *Journal of Advanced Nursing* 18, 1559-1566.
- Purkis, M. E. (1994). Entering the field: intrusions of the social and its exclusion from practice. *International Journal of Nursing Studies*, 31, 315-336.
- Raboobi, N. A. & McEwan, R. (1968, May). Mental health. The pivot of human relationships. *The New Zealand Nursing Journal*, 5, 5-8.
- Render, H. W., & Weiss, M. O. (1959). *Nurse-patient relationships in psychiatry* (2nd ed.). New York: McGraw Hill.
- Reynolds, W., & Cormack, D. (1990). *Psychiatric and mental health nursing. Theory and practice*. London: Chapman and Hall.
- Ritter, S. (1997a). *An overview of interpersonal approaches to communication between nurses and people with mental health problems*. Keynote address presented at 23rd Annual conference of Australian and New Zealand College of Mental Health Nurses, Adelaide, October, 1997.
- Ritter, S. (1997b). Taking stock of psychiatric nursing. In Tilley, S. (Ed.). *The mental health nurse. Views of practice and education* (pp. 94-117). Oxford: Blackwell Science.
- Russell, R. (1988). The lunacy profession and its staff in the second half of the nineteenth century, with special reference to the West Riding Lunatic Asylum. In W. F. Bynum, R. Porter, & M. Shepherd (Eds.). *The anatomy of madness. Essays in the history of psychiatry. Vol. II. Institutions and society* (pp. 297-315). London: Tavistock.

- Ryan, T. (1997). Pushing the bus: Articulating the practice base of mental health nursing. Paper presented at 23rd Annual conference of Australian and New Zealand College of Mental Health Nurses, Adelaide, October, 1997.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27-37.
- Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor mortis in qualitative research revisited. *Advances in Nursing Science*, 16(2), 1-8.
- Sangarran, R. (1993). Mental projections. *Nursing New Zealand*, 1(2), 12-14.
- Schon, D. (1992). The crisis of professional knowledge and the pursuit of an epistemology of practice. *Journal of Interprofessional Care*, 6(1), 49-63.
- Schumacher, L. P., Fisher, S., Tomey, A. M., Mills, D. I., & Sauter, M. K. (1998). Ida Jean Orlando (Pelletier). Nursing process theory. In A. M. Tomey, & M. R. Alligood (Eds.). *Nursing theorists and their work* (4th ed) (pp. 351-363). St. Louis: Mosby.
- Schwandt, T. (1994). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin, & Y. S. Lincoln (Eds.). *Handbook of qualitative research* (pp. 118-137). California: Sage.
- Schwecke, L. H. (1999). The nurse-patient relationship. In N. Keltner, L. H. Schwecke, & C. E. Bostrom (Eds.). *Psychiatric nursing* (3rd ed.) (pp. 123-1). St. Louis: Mosby.
- Shanley, E. (1988). 'Inherently helpful' people wanted. *Nursing Times*, 84(3), 34-35.
- Sharma, V., Whitney, D., Kazarian, S. S., & Manchanda, R. (2000). Preferred terms for users of mental health services among providers and recipients. *Psychiatric Services*, 51, 203-209.
- Sim, J. (1998). Collecting and analysing qualitative data: issues raised by the focus group. *Journal of Advanced Nursing*, 28, 345-352.

- Sines, D. (1994). The arrogance of power. A reflection on contemporary mental health nursing practice. *Journal of Advanced Nursing*, 20, 894-903.
- Skilton, H. (1981). *Work for your life. The story of the beginning and early years of Occupational Therapy in New Zealand*. Hamilton: Hudlo Printers.
- Smith, L. D. (1988). Behind closed doors, lunatic asylum keepers. *The Society for the Social History of Medicine*, 1, 301-327.
- Smoyak, S. & Skiba-King, W. (1997). Historical influences on today's education and practice. In A. W. Burgess (Ed.). *Advanced practice psychiatric nursing* (pp. 15-26). Connecticut: Appleton & Lange.
- Smoyak, S. (1993). American psychiatric nursing. History and roles. *American Association of Occupational Health Nurses Journal*, 41(7), 316-322.
- Speedy, S. (1999). The therapeutic alliance. In M. Clinton, & S. Nelson (Eds). *Advanced practice in mental health nursing* (pp. 59-76). Oxford: Blackwell Science.
- Street, A. F., & Walsh, C. (1994). The legislation of the therapeutic role: implications for the practice of community mental health nurses using the New Zealand Mental Health (Compulsory Assessment and Treatment) Act of 1992. *Australian and New Zealand Journal of Mental Health Nursing*, 3, 39-44.
- Street, A. F. & Walsh, C., (1995). "Not a rubber stamp". *Mental health nurses as Duty Authorised Officers in New Zealand*. Wellington: Victoria University of Wellington.
- Street, A. & Walsh, C. (1996). Community nursing issues in Maori mental health. *Australian and New Zealand Journal of Mental Health Nursing*, 5, 54-62.
- Stuart, G.W. (1998). The Stuart stress-adaptation model. In G. W. Stuart, & M. T. Laraia (Eds.), *Stuart and Sundeen's principles and practice of psychiatric nursing* (6th ed.) (pp.54-81). St. Louis: Mosby.

- Stuart, G.W. (1998). Therapeutic nurse-patient relationships. In G. W. Stuart, & M. T. Laraia (Eds.), *Stuart and Sundeen's principles and practice of psychiatric nursing* (6th ed.) (pp. 17-53). St. Louis: Mosby.
- Stuart, G. (1999). Psychiatric nursing on the cusp of the new millenium: Looking forward, looking back with American eyes. Keynote address presented at 25th Annual Conference of Australian and New Zealand College of Mental Health Nurses Inc. Launceston, Australia, Sept 18-21.
- Stuart, G. W., & Laraia, M. T. (Eds.). (1998). *Stuart and Sundeen's principles and practice of psychiatric nursing* (6th ed.), St. Louis: Mosby.
- Sullivan, P. (1998). Therapeutic interaction and mental health nursing. *Nursing Standard*, 29(12), 39-42.
- Sutch, W. B. (1966). *The quest for security in New Zealand. 1840 - 1966*. Wellington: Oxford University Press.
- Thomas, L., MacMillan, J., McColl, E., Hale, C., & Bond, S., (1995). Comparison of focus group and individual interview methodology in examining patient satisfaction with nursing care. *Social Science in Health*, 1, 206-220.
- Tilley, S. (1995). *Negotiating realities. Making sense of patients diagnosed as neurotic and nurses*. Aldershot, England: Avesbury.
- Torn, A., & McNichol, E. (1998). A qualitative study using focus groups to explore the role and concept of the nurse practitioner. *Journal of Advanced Nursing*, 27, 1202-1211.
- Travelbee, J. (1971). *Interpersonal aspects of nursing* (2nd ed.). Philadelphia: F.A. Davis.
- Truman, K. (1984). *The development of mental health services in the Wellington region*. Unpublished master's thesis, Victoria University of Wellington, Wellington, New Zealand.

- Tudor, G. (1952). A sociopsychiatric nursing approach to intervention on in a problem of mutual withdrawal on a mental hospital ward. *Psychiatry*, 15(2), 193-217.
- Tuke, S. (1813/1964). *Description of the Retreat. An institution near York for insane persons of the Society of Friends. Containing an account of its origins and progress, the modes of treatment, and a statement of cases*. London: Dawsons of Pall Mall.
- Vaughn, K., Webster, D., Orahood, S., & Young B. C. (1995). Brief inpatient psychiatric treatment: finding solutions. *Issues in Mental Health Nursing*, 16, 519-531.
- Walk, A. (1961). The history of mental nursing. *The Journal of Mental Science*, 107(446), 1-17.
- Watson, J. (1979). *Nursing: The philosophy and science of caring*. Boston: Little, Brown.
- Watson, J. (1985). *Nursing: Human science and human care*. Connecticut: Appleton-Century-Crofts.
- Webster, D. (1996). *The culture of psychiatric nursing* Keynote address presented at 22nd Annual conference of Australian and New Zealand College of Mental Health Nurses, Tamaki Makaurau / Auckland, October, 1996.
- Webster, D., Vaughn, K., Webb, M., & Playter, A. (1995). Modeling the client's world through brief solution-focused therapy. *Issues in Mental Health Nursing*, 16, 505-518.
- Weir, R. J. (1992). An experimental course of lectures on moral treatment for mentally ill people. *Journal of Advanced Nursing*, 17, 390-395.
- Welch, A. Z. (1998). Madeleine Leininger. Culture care: Diversity and universality theory. In A. M. Tomey & M. R. Alligood (Eds.). *Nursing theorists and their work* (4th ed.). (pp. 439-462). St. Louis: Mosby.
- Wilshaw, G. (1997) Integration of therapeutic approaches: a new direction for mental health nurses. *Journal of Advanced Nursing* 26, 15-19.

- Wilson, L., & Barker, P. (1986). Behaviour therapy nursing: a new era? *Nursing Times*, 82(1), 48-49.
- Wilson-Barnett, J. Lend me your ear. *Nursing Times*, 84(33), 51-53.
- Winship, G. (1997). Establishing the role of the nurse psychotherapist in the United Kingdom. *Perspectives in Psychiatric Care*, 33(1), 25-31.
- Wolcott, H. F. (1994). *Transforming qualitative data. Description, analysis and interpretation*. California: Sage.

Appendix A

Information for Research Participants

Massey University letterhead

The therapeutic relationship: perceptions of mental health nurses

INFORMATION FOR RESEARCH PARTICIPANTS

My name is Tony O'Brien. I am a nurse and I am currently studying for my MPhil thesis at Massey University.

I am seeking 15 participants for my thesis project which will explore mental health nurses perceptions of the therapeutic relationship. This research will build on an earlier study of mental health nurses' perceptions of their practice in which the therapeutic relationship was found to be a central theme.

The requirements for participation are that

1. you are a registered psychiatric or comprehensive nurse
2. you are currently employed in inpatient care or community care or as a nurse-therapist in any mental health setting. (In this study a nurse-therapist is any nurse whose practice involves use of a specific therapeutic modality to provide nursing care. A nurse who uses (for example) cognitive therapy, individual psychotherapy or family therapy to assist clients with anxiety, depression or other mental health problems will be considered a nurse-therapist, while a nurse who integrates cognitive therapy or psychotherapy skills into a generic nursing role would not be considered a nurse therapist).
3. Participants will need to have a minimum of three years experience in their current area of practice to meet the criteria of experience

The research project has received ethical approval from the Auckland Ethics Committee and the Massey University Human Ethics Committee.

Involvement in the study will involve a commitment to two focus group interviews of an hour to an hour and a half each.

The interviews will be audiotaped and transcribed for analysis.

The interviews will be conducted in a mutually agreed venue. I anticipate that for most participants this will be a private area at their place of work. I anticipate that interviews will take place between February and May 1999.

Confidentiality will be maintained by ensuring that your name is not used in transcriptions or written documents other than a Consent Form. Interview transcripts, disks, tapes and Consent Forms will be kept in a secure place when not in use.

I would like to retain the transcripts for possible secondary analysis. Secondary analysis is a further research study which would require your consent, and would require ethical approval from the appropriate Ethics Committees.

Audiotapes and disk files will be erased on completion of the study.

The final research report will be submitted to fulfill the thesis criteria for an MPhil degree, and may be used in publications conferences or seminars. Individual participants will not be identifiable in any reports or presentations.

The research is being supervised by Christine Palmer. She is available to answer questions about the study at any time during the conduct of the study. Her contact number is 443 9376 (Massey University, Albany).

Participation in this study is entirely voluntary. If you do agree to take part you may withdraw at any time without disadvantage.

If you have any concerns about your rights as a participant in this study you may contact the Health Advocates Trust, telephone 623 5799.

Please do not hesitate to contact me if you have any questions about this research.

If you are interested in participating you can contact me on 3737599 ext 5693 (work) or 8179541 (home).

Appendix B

Consent Form for Research Participants

Massey University letterhead

CONSENT FORM FOR RESEARCH PARTICIPANTS

Title of project: The therapeutic relationship: perceptions of mental health nurses

Principal investigator: Anthony O'Brien RGN, RPN, BA.

Name of participant:

I have heard and understood an explanation of the research study that I have been invited to take part in.

I have been given, and have read a written explanation of what is asked of me, and I have had an opportunity to ask questions and to have them answered. I am satisfied with the answers I have been given.

I understand that my interview will be audio-taped.

I understand that everything I say will be confidential and that my anonymity will be preserved.

I understand that audiotapes will be transcribed (typed) for analysis, and that transcripts may be retained for possible secondary analysis.

I understand that my participation in this study is voluntary and that I may withdraw from the study at any time, and if I do, I will not be affected in any way.

I understand that my consent to take part does not alter any of my legal rights.

I consent to be a participant in this research. YES/NO

I consent to my interview being audio-taped YES/NO

I would like the researcher to discuss the final outcomes of the study with me. YES/NO

Signed.....(Participant) Date.....

Signature of witness.....Name of witness.....

The name of the researcher, and the person who has explained the project is: Tony O'Brien (09) 817 8541

Appendix C

Transcriber's acknowledgement of confidentiality

I have read the Information Sheet and Consent Form for the study "The therapeutic relationship. Perceptions of mental health nurses" conducted by Tony O'Brien, M Phil student, Massey University.

I agree to keep confidential any information revealed in the process of transcription.

Name _____

Signed _____

Date _____

Appendix D

Notice announcing research and seeking participants

My name is Tony O'Brien. I am a nurse who is conducting a research project for a master's degree at Massey University.

I am looking for volunteers to participate in my research project.

The title of the project is: The therapeutic relationship. Perceptions of mental health nurses.

The participation would involve being interviewed by me for approximately one hour on two occasions.

The requirements for participation are that

1. you are a registered psychiatric or comprehensive nurse
2. you are currently employed in inpatient care or community care or as a nurse-therapist in any mental health setting. (In this study a nurse-therapist is any nurse whose practice involves use of a specific therapeutic modality to provide nursing care. A nurse who uses (for example) cognitive therapy, individual psychotherapy or family therapy to assist clients with anxiety, depression or other mental health problems will be considered a nurse-therapist, while a nurse who integrates cognitive therapy or psychotherapy skills into a generic nursing role would not be considered a nurse therapist).
3. Participants will need to have a minimum of three years experience in their current area of practice to meet the criteria of experience

The research project has approval from the Auckland Ethics Committee and the Massey University Human Ethics Committee.

Supervision is provided by staff of the Department of Nursing and Midwifery, Massey University.

If you are interested in participating in this project, please contact me for more information at 3737599 (extension 5693) during office hours, or 817 8541 after 5pm and weekends.

Appendix E

Data Collection Form

Massey University letterhead

Research project: The therapeutic relationship: perceptions of mental health nurses

Principal investigator: Anthony O'Brien RGN, RPN, BA.

DATA COLLECTION FORM

Please provide the following information:

Gender: Male / Female

Categories of nursing registration: RPN RGN RGON

Other (please specify).

Current area of clinical practice: Inpatient care Community care

Other (Please specify)

Years of full time equivalent experience in your current area:

Do you practice as a nurse-therapist within the definition given in the Information for Research Participants sheet?

Appendix F

Example from transcribed interview, showing column notes made in the process of analysis

	analysis	codes	constructionist lens	
A		doing things <i>to</i> people	adds to B's views	but it can also be seen, especially us as nurses, like you're (?) there to do those sort of things <i>to</i> them
B				yeah
A	similarity to NT & IN groups concept of 'intense' & difficult situations	doing things to people that they might not want, but 'getting them on board'	A builds on account begun by B, expanding and elaborating on B's account.	the sort of thing that you have to impose on them, like <i>giving</i> medication <i>giving</i> education and I think for us what is quite significant in terms of our job...here for B and I is that big part of it is about getting people on board and really getting them, explaining to people about their symptoms, like a <i>big</i> focus on education and providing information about diagnosis and we were having a discussion
B			agreement from B	Hmm
A		listening, attending to the cl story dealing with a difficult situation		earlier on about somebody that B had met who...um we were talking about these very distressing symptoms you know like all sort about his psychotic ideas he had had before and like how he was feeling quite restless, but nobody would listen to him, instead what they did they increased his medication, whereas he was so appreciative of the fact that we said well this could be akathisia, you know
B			agreement from B	hmm
A	compare w above 'doing to'...emphasis on doing to' as an appearance	not just about visible tasks; includes 'invisible' tasks		and um...and he suddenly though 'yes, but why didn't anybody tell me about it?' you know, um...it is about that so for us its not just being perceived that we are going and doing these
B			agreement from B	hmm
A		there's this other part of us that's a there for them as well...		things to the [good] dressed up even though we're <i>doing</i> those things...to them...we're doing it as part of a package, we're not just going to (?) there's this other part of us that's a there for them as well...

Appendix G

Explanation of abbreviations used in transcripts and in reporting results

[]	text summarises actual text or inserts terms needed to make a quote comprehensible
(inaudible)	a section of the audiotape could not be transcribed
/.../	a section of text has been omitted
....	a pause in the dialogue
(?)	the word/s immediately following were not completely clear on the tape, but probably were as shown
hmmm	a nonverbal utterance, can be given a variety of interpretations, from assent to "keep talking" or "I'm listening"
<i>Italics</i>	words spoken with particular emphasis
CN3/12	Group, interview number and transcript page from which material is taken. In this example: Community Nurses' group 3, transcript page 12.
IN	Inpatient nurses' group
NT	Nurse-therapists' group
S B M E N A K L D	Research participants
R	Researcher

Appendix H

Section of transcript from interview with community nurses

R: ...so how does, how does the recovery model fit with developing a therapeutic relationship?

N: For me I think its about is there...I think its about (?) working that long term what's happening for a person, the patterns in their life that they might be (inaudible) what's going on...a picture of things rather than just...

R: Right, right.

/.../

A: Yeah, yeah and the recovery model is very much about fostering hope and um basically E said already, fostering hope and working very much in partnership with the person...collaborative...

R: So is hope, is that like a concept that's different...in the recovery model, is there something...that is not quite as much there in what you would normally understand as a therapeutic relationship?

(long pause)

E: Its not that there isn't hope in the personal therapeutic relationship but I think its very much something that's a focus in the recovery process.

R: Right.

E: Its more promoted...positive...

(pause)

R: Its quite a specific...thing isn't it?

E: hmmm

R: In the recovery model.

A: I guess with the sort of therapeutic ah...sort of relationship, there's quite a bit of yourself that you have to give I guess to, um...whereas the...recovery model is really getting the person to look at...their selves more rather than ah, you know...I think I know what I'm trying to say

R: the recovery model gives you new ways of thinking...

A: yeah.

R: about things.

A: yeah, yeah.

R: So there are things about hope, and things about...collaboration...

A: hmmm.

R: and...trying to get the person to...find their own resources?

A: hmmm.

R: I guess what I'm trying to understand...thinking about the therapeutic relationship is it...is it a sort of um, a new way "all new improved" way of developing a therapeutic relationship? Does it seem like that?

(inaudible)

R: Well, last time, last week one of the things that, that um, was discussed was the therapeutic relationship as this, basic, fundamental thing...

N: hmmm.

R: and I wondered whether that changes with using the recovery model.

(A shakes head)

N: You don't think so A? ...I disagree, I think it does.

A: I don't think it changes no matter what model you're using, you can use any model you like or no models at all, or not be aware of the models that you're using at different times, that you still have that therapeutic relationship, I don't think its based in a model.

E: hmmm.

N: I think its separate.

R: Is that how other people would see it, not based in a model?

A: I...(inaudible) in terms of I guess it doesn't really matter which model you use we still, from a nursing perspective I mean your relationship will be, is very much like an interactive process that's going on all the time, you know, and hopefully out of that, will achieve their goal, you helping and the...um facilitating them I guess, achieving that goal. So...because I don't go out ah, everyday and say 'well, today I'm actually, I'm using this model or now with this situation I'm using that model, ah it, its an interactive thing I think.