



# **A THERAPEUTIC NURSING RELATIONSHIP**



**SUZANNE KRISTINE BLUME MOUNTFORD**

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**Department of Nursing  
Victoria University of Technology  
Footscray Campus.**

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Mountford, Suzanne Kristine  
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# A THERAPEUTIC NURSING RELATIONSHIP

## ABSTRACT

The relationship between nurse and patient is important to nursing care and health outcomes. This relationship can be therapeutic for both nurse and patient. However, the current lack of conceptual consensus and descriptive clarity in nursing theory has precluded the relationship from the realms of therapy and healing. The goal of this study was to discern, from descriptions given by nurses and patients, the essential structure, dynamics, practical application and advantages to nursing practice of a therapeutic relationship between nurse and patient. Descriptions were gathered from three perspectives: those of nurses who had been patients (nursepatients), practising nurses and their patients. A combination of phenomenology and concept synthesis saw the development of descriptive and definitive data. From the phenomenological inquiry, descriptive themes and meanings emerged, together with a list of the essential elements of a relational concept which was then synthesised into a practical definition, functional model and descriptive theory. The concept of therapeutic nursing relationship depicts a symbiotic involvement of nurse and patient which promises mutual benefits and healing. The definition simply establishes the therapeutic nature and construction of relationship. The model visually maps the framework of the concept, displays its structural components and demonstrates its relational dynamics. The accompanying theoretical description clearly explains the meaning of this therapeutic nursing relationship for, and to, nurses, patients and nursing. This adds to existing nursing theory of the relational involvement between nurse and patient and gives clear direction for practice, management, education and research.

# A THERAPEUTIC NURSING RELATIONSHIP

## PREFACE

This study began with a desire to understand the world of the patient from the perspective of nurses who had been patients (nursepatients). Phenomenology was the method chosen to explore the lived experiences of these nursepatients whose rich descriptions told of the phenomenon of being a patient who was also a nurse. Examination of this world uncovered a concept which epitomises the good life in nursing care - a therapeutic nursing relationship. In response to these findings, the focus of the study changed in direction to examine the relationship between practising nurses and their patients who were, essentially, *not* nurses. The initial search for description and meaning of the experiences of nursepatients had grown into a quest for confirmation of the concept of a therapeutic nursing relationship as a practice reality. Using the process of concept synthesis, the notion of a therapeutic nursing relationship was expanded through the descriptions given by all three groups of participants into a definition, model and theory of relational contact between nurse and patient.

The study of the relationship between nurse and patient began in the researcher's personal observations of nursing practice. These observations of nursing interactions had exposed great variety in the types of relationships engaged by nurses with patients. Curiosity was bolstered by repeated observation of the hesitancy of nurse practitioners to look after particular patients, primarily their peers, and the differing degrees of satisfaction and dissatisfaction expressed by nurses regarding their relationships with patients in their care, and conversely, patients' comments about their nurses as caregivers. Dreher, (1995,1) says that "there is great variation among nurses ... one will make the patient feel attended to and cared for, while another will make the patient cringe and hope that the nurse will never return". This focus was supported by anomalies of perceptions of the relationship between nurse and patient presented by nursing theory, perpetuated through patient satisfaction survey findings and fostered by the disgruntled comments of nurses who had been patients. Thus began a search for accurate descriptions of the relationships experienced by nursepatients, exposure of those essential elements which potentiate sound working relationships and elucidation of the factors which leave both nurse and patient feeling satisfied with the relationship and the outcomes.

A qualitative approach was chosen because the research problem involved examination of the personal subjective nature of the relationship between nurse and patient, with the aim to reach an understanding of its properties (Swanson & Chenitz, 1982). The study was designed around the dichotomy of quantitative and qualitative research to highlight the chosen method as a different way of looking at the world of nurses and patients and as a legitimate means of understanding that world. As such, some terminology oft ascribed only to quantitative research is used in its ordinary, everyday context and meaning, to demonstrate that such terms can mean different things to different people, and alternative uses do not diminish their value in the overall scheme of life. Hence, some definitions of terms used in this research appears appropriate here. Analysis of this complex

relationship into its simple parts will be discussed in terms of "reduction" and "reductionist". In examining the descriptions of the participants, differences in opinion will be couched as "variance" between statements, while the mutual relations between two or more things will be called "correlation". At this stage, the variables or factors that impinge upon the relationship between nurse and patient were unknown; the hypothesis or conjecture/s about that relationship yet to be determined (Maclean,1987).

An examination of research methods, in the context of the researcher's search for description, understanding and articulation of the nature of nursing relationships, alighted upon phenomenology as method, direction and design of the research process (Wilkes,1991; Bartjes,1991; Paterson & Zderad,1988; Oiler,1986a,1986b,1982; Knaack,1984; Omery,1983; and Davis,1978). Phenomenology examines human experiences of a phenomenon in order to determine what makes this phenomenon, a phenomenon, and to gain an understanding of this phenomenon from the perspective of the human beings involved in such an event. Descriptions gained in this manner demystify the phenomenon by investing it with human properties, and facilitate change in the perceptions of those exposed to this new information. In nursing, phenomenologically-based research allows exploration of topics central to nursing practice while dissemination of the findings encourages changes in practitioner thinking and approaches to every day practice. Subtle change occurs when nurses come to understand the effects of their being in relationship to patients and appreciate the patients' perceptions of being in that world (Wald & Leonard,1964).

The phenomenological method is complementary to nursing where "personal knowing is essential to 'being' in a nursing situation ... [for] nursing ... only occurs through entering the world of the person being cared for" (Boykin & Schoenhofer,1991,247). Phenomenology, by method and principle, validates personal perceptions and meanings as aspects of reality and legitimate ways of knowing about the world, which are, more often than not, denied credence in traditional scientific methods of examining phenomenon. Wolfer, (1993,145), says that these "different" methods of knowing are derived from "the eye of the mind (and heart)" and have the potential "to improve the quality of caring for the whole patient and the whole nurse".

The selection of method required the researcher to assess and determine her own focused personal philosophy regarding relationships with patients. Jasper (1994) confirms that nursing and phenomenology share beliefs and values. Not surprisingly then, self-searching revealed an ethic which aligned with phenomenology as a science and a process. Three major personal beliefs cemented this relationship. Firstly, subjective feelings have equal importance with objective happenings in understanding a human experience. Secondly, how a person feels about what is happening and what is done has equal relevance to more measurable items such as achieving outcomes or change. And thirdly, a relationship between two people is a sharing union which supports individuality, requires bipartisan participation and recognises the needs and rights of both parties for satisfaction in process and outcome, or outcomes. Reflection revealed a personal



practice paradigm which was an antithesis of anecdotal observed and reported practices. It cemented the primacy of the relationship between nurse and patient and the importance of gaining mutual satisfaction from this union. A central practice and research goal was exposed, that is, in order to affect the health of others (Hinds et al, 1992) and maintain a personal satisfaction with nursing, it was essential to understand the whole care situation from the perspective of both nurse and patient.

Phenomenology was the chosen method *and* philosophy for the research. It matched the researcher's own beliefs about life and nursing, and acknowledged the value of both subjective and objective feelings to gaining knowledge about this human world. Phenomenology allowed exploration of personal retrospective experiences of relationships between nurse and patient in specific contexts. Its descriptive focus assured exposure of the relationship through a logical sequence of investigation and outcomes. The method was designed to be a rigorous and scientific endeavour. Morrison and Burnard (1991,12) assert that

"There is a danger of qualitative methods being associated with the idea of their being 'easier', because they deal with the less tangible. In fact, matters are the other way round: qualitative research may have to be even *more* rigorous because it is dealing with human experience and with often more elusive concepts and cannot rely on statistical techniques to help make sense of large data sets".

The meaning of the relationship in the researcher's personal practice was exposed, but the question arose about the meaning of the relationship for others (Munhall,1994). The theory of Joyce Travelbee (1971, 1966), detailing a therapeutic relationship between nurse and patient, was complementary to the research design and aims. As proven nursing theory, Travelbee's therapeutic connection between nurse and patient legitimised the researcher's own beliefs that the relationship between nurse and patient rests upon certain essences or components which have particular effects. The theory directed this study's search for a supporting body of evidence that this way of looking at a relationship is a practised means of nurses relating to patients. Curiosity about the real world of relationships provoked a willingness to set all this aside and discover how relationships function in practice. Thus the journey began through the lived experiences of nurses who became patients.

The purposive sample of nursepatients was designed to uncover the nature of the relationship for the nurse who is also a patient and understand why anecdotal accounts portray these relationships as different and somewhat difficult. Participants were asked to relate their stories of life as a patient (Maclean,1987). Boykin and Schoenhofer (1991) advocate that the use of story brings "to mind the commonalties of nursing situations as well as the beauty and uniqueness of each [which]...preserves the integrity of nursing knowledge and enhances understanding and knowing of nursing". Consequently, nursepatients were asked what it was like to be a patient and what types of relationships they had experienced with their nurses as caregivers. Their perceptions of life as a patient painted a grim picture of that world, but established the relationship as an important focus in evaluation of care. Inherent in this process was an acceptance or assumption that, given the right

circumstances or qualities, the relationship between nurse and patient could also be satisfying for both its participants. The challenge was to find these elusive therapeutic qualities by examining the real-life experiences of nurses who had been patients, and comparing and contrasting these experiences to determine the essence of a truly therapeutic nurse-patient relationship.

Overwhelmingly, the relationships experienced by nursepatients were deemed non-therapeutic. The participants attributed much of this ill-feeling about the relationship to the conceptions held by their nurses as caregivers who saw them as nurses, rather than as patients. This misplaced identification was felt to compromise the quality of patient care and foster inappropriate nursing interventions. Nursepatients frequently found themselves monitoring and performing their own care, which their state of ill-health did not, and often could not, support. In reality, the nursepatients wished to be seen only as patients in need of nursing care and to be afforded the level of care and contact appropriate to their diagnosis, and not their occupation. This clash of expectations and intent was perceived to preclude the formation of an sound relationship between nurse and nursepatient.

Through their reflections about the nature of these relationships, it was evident that, as patients and nurses, nursepatients separated relationships into categories of "good" and "bad". Examination of the two relationships identified the characteristics of each. Based upon the participants definitions, these two categories were named "therapeutic" (positive, pleasant, satisfying, mutually beneficial) and "non-therapeutic" (negative, unpleasant, dissatisfying, non-beneficial) relationships. Through reflective comparison, nursepatients were able to identify and firmly state the elements which constituted an 'ideal' relationship between nurse and patient. The elements each had a clear meaning, and a collective effect upon the relationship. Thus experience, vis-à-vis reflective thought, exposed "the essence of the phenomenon, i.e. the element or elements in the phenomenon as phenomenon that make it precisely what it is" (Crotty,1994,158-9). This was consequently named "a therapeutic nursing relationship" in order to demonstrate its intent and context.

Continuous concurrent searches of the current literature were conducted during all phases of the research process to locate sources which supported or refuted the findings. These searches revealed vast differences in literary conceptualisations regarding the relationship between nurse and patient. The intent of the relationship as a therapeutic modality added complexity and perplexity to the search for understanding. The importance of the relationship to nurses and nursing was confirmed by the literature. Nursing theories were disparate in their approaches to the relationship. The notion of therapeutics in nursing was met with diverse receptions by nursing scholars. It became apparent that the inability of nurses and nursing as a profession to develop a clear, concise and common definition of the relationship between nurse and patient added to the practice melange. Nurses were left to define the relationship, interpret its meaning and evaluate its connection to quality of care according to their own personal experiences. Although this theoretical diversity fostered knowledge, it had an adverse effect upon practice, because it left the definitive decisions

about the relationship to each nurse. Thus the theoretical melee surrounding the relationship is perpetuated in practice.

The revelations of nursepatients, coupled with literary diversity, stimulated questions about the legitimacy of therapeutic relationships in the practice arena, with particular reference to the relationships experienced by nurses with patients who were *not* nurses. The perceptions of nursepatients were context specific and their descriptions presented a somewhat extraordinary type of relationship (Hinds et al, 1992). Examination of other "ordinary" relationships between nurses and patients was necessary in order to understand the whole experience and its impact upon nursing practice and patient care. Therein began the search for confirmation of the elements or things that in practice make a therapeutic nursing relationship, a therapeutic nursing relationship.

The relationships of practising nurses and their patients were probed in the light of the emerging concept and its therapeutic nature. The claims of nursepatients about the nature of an effective relationship between nurse and patient needed to be investigated from the perspective of other who had experienced such a relationship. Because

"people experience situations [then]... express their own meanings and understandings through their own words and through their own responses ... [and the researcher] reflecting on knowledge from these sources and interpreting the meanings of relationships [as] experienced by all parties concerned, [puts] what is known in the context of feelings, values and different perspectives"(Meleis,1992,113)

To achieve a better understanding of this relationship, a convenience sample of nurses was selected, asked about their experiences of a therapeutic relationship with an identified inpatient who, in turn, was interviewed. This way of knowing, through examination of another's experience, was essential for accurate and comprehensive synthesis of the concept of a therapeutic nursing relationship.

The journey culminated in a description which conveys a meaningful understanding of the concept of a therapeutic nursing relationship to nurses and the nursing profession. The concept is defined and encapsulated into a model for ease of understanding and practical application. The underlying hypothesis is exposed for consideration by researchers and practitioners. This research has achieved its "goal of understanding or making sense of" this thing called 'a therapeutic nursing relationship' and has moved on to the more "extremely pervasive...general purpose" goal of communicating this theoretical schema to others (Donaldson,1992,1). Hopefully, reading of the concept of a therapeutic nursing relationship will leave nurse practitioners with, firstly, a heightened awareness of the relationship's import and impact upon patient care; secondly, a practical approach to relationship formation with patients which achieves mutually beneficial and satisfactory outcomes; and thirdly, the outlines of a new voyage of discovery in their relationships with patients.

# CHAPTER ONE: INTRODUCTION TO THE JOURNEY

## BACKGROUND MUSINGS

In nursing theory and practice, the relationship between nurse and patient is considered to be an important facet of care and caring. Traditionally, nursing has recognised this by upholding the nurse-patient relationship as a central tenet of professional nursing practice. More recently, the relationship has been encapsulated with the tenets of holism and caring as important indicators of what nursing is and does in the sphere of quality health care delivery and satisfactory health care outcomes. Nurses' perceptions of the relationship are a consequence of their theoretical knowledge, past experiences and personal beliefs, and shaped, in part, by the area of nursing in which they work. Nurses practise nursing and enter into relationships with patients in vastly different ways. Some relationships are therapeutic, while others are not. Patients are not always satisfied with the type of health care and relational involvement afforded them by nurses. The nurse-patient relationship does not always meet the ideals of quality and outcome for the profession, nurses and patients.

### *Searching for an ethic*

Disparity lies within the current literary conceptualisations of the nature of the relationship between nurse and patient, and its significance for nurses and nursing. There is a current theoretical emphasis upon holism and caring as concepts which drive nursing actions and distinguish the profession from other health care providers. The therapeutic nature of the relationship has been subsumed by this fascination with particular concepts. The nurse-as-healer and the nurse-as-therapist do not appear to be popular abstractions in nursing ontology. Nursing epistemology does not admit the notion of the nurse as a beneficiary in the relationship between nurse and patient. A therapeutic nursing relationship presents a different image and approach to the relationship between nurse and patient. It does not differentiate practice areas and places the emphasis within the relationship upon the therapeutic and healing functions of nursing for both nurse and patient.

### *Relational connections*

Relationships are important aspects of human life. Social interactions between people help to validate self-worth and promote a sense of identity and integrity. The relationship between nurse and patient takes place within the arena of health care, but its social implications are still valid. Nurses spend an inordinate amount of time with patients. They work in all areas of health care, relating to and with individual consumers and other health care providers. Within this framework, relationships formed by nurses are mediums of health care. How patients feel about themselves, their health and the outcomes of nursing care is influenced by the interactions which occur with nurses. Similarly, nurses' feelings about themselves, their nursing care and the outcomes of it are influenced by the interactions they have with patients. Nursing then, by action and intent, has a therapeutic role in the provision of health care to consumers and providers.

## **Theoretical Tenets of the Relationship:**

### *Process of Change*

Descriptions of nursing and consequently, the relationship between nurse and patient, have changed over time to reflect the current ideology of nursing care. Reformulations of definition, name and nature mirrored concurrent social conceptualisations of relationships between professionals and people seeking their help (Bond & Bond, 1986). The words "care", "caring", and "wholism" or "holism", abound in current theoretical discussions (Easley, 1989). Kyle (1995) conducted a study of the concept of caring through a review of the literature, and concluded that caring was viewed as the central focus of nursing. Under these tenets, developing holistic, caring, effective relationships with patients is an important facet of day to day nursing practice.

### *Paradoxical theories*

Drew and Dahlberg (1995) found that although caring was espoused as the essence of nursing, and holistic practice hailed as revolving around this humanistic concept, current nursing theories presented paradoxical views. There appeared to be a common alignment to a reductionist paradigm which lead to presentation of caring and holism as depersonalised descriptions. There was an emphasis upon nurses acting as agents of change for the health status of patients. Relationships were perceived to be developed by nurses to influence the physiological and psychological health care outcomes of patients. Although these theories ascribe to caring holistically, their singular focus upon the benefits for the patient is denying the nurse's subjective experience in the caring process (Oiler, 1986). However, holism and care, in relation to nursing *patients*, appeared to be accepted and acceptable canons of nursing.

### *Narrow visions*

Drew and Dahlberg (1995) believed that when nursing literature talked of holism, it was through a narrow vista which limited its description to the effects and benefits for the patient. This vision failed to recognise the contribution of the nurse to relationship development and the benefits that nurses can derive from their relationships with patients. They advocated the adoption of a philosophy which recognises the primacy of the relationship between nurse and patient in the delivery of holistic caring and gives due attention to the reciprocal benefits for both nurse and patient.

## **Focal Differences in Practice Areas:**

In practice, there are distinct differences in relationships developed between nurses and patients and the nursing actions undertaken toward effecting patient care. Different theoretical persuasions and definitions of the relationship between nurse and patient have developed in different areas of nursing practice. Nurses' perceptions of the relationship reflect their area of practice and its particular emphasis within the relationship. Psychiatric nursing has adopted a "therapeutic relationship" as its ideal for practice, while general nursing practice has a "nurse-patient relationship" stance to clarify the relationship's position in practice. These two interpretations of the relationship between nurse and patient reflect the focus of nursing care in each particular area.

### *Psychiatric nursing practice*

Therapeutic relationships are the basis of psychiatric nursing. The nurse uses the power of self to effect changes in patient behaviour and constructively uses each encounter to gain personal and professional competence in healing through relationship building (Yonge, 1994). Being there for, and with, the patient is an important focus of this type of healing. Bortoff (1994,2) says that "the seemingly ordinary, non-technical, and sometimes invisible actions of some other person helps us feel better, revitalised, however temporary this may be". Psychiatric nursing theory recognises that the relationship is also complicated by the complexity of the human qualities and physical demands that both nurse and patient bring to it. These directly affect the development and outcomes of the relationship between nurse and patient and are often predictors of its therapeutic function (Forchuk,1994). This type of nursing relationship is essentially one of "mind to mind" to bring about a change in patient affect, and theoretically, perhaps, ignores the patient's "body" needs.

### *General nursing practice*

The nomenclature "nurse-patient relationship" expresses the functional nature of the connection between nurse and patient within the premises of general nursing practice. In this area, nursing practice is charged with a dual function: care of the mind and the body, that is, the *whole* person. The conceptualisation of the relationship as therapeutic appears to be subdued, both in theory and practice, by a different nursing interpretation and action. Although many nurses would acknowledge the therapeutic nature of nursing itself, the interplay of the relationship between nurse and patient and its therapeutic intent, lacks clarity. Added to this are the demands of practice. Because of circumstances effecting the patient's bodily health, care of the mind is often sacrificed to the immediate care of the body. In this clime, holism is not always the prime concern. The relationship between nurse and patient takes on a different meaning, when its therapeutic properties are directed primarily at the patient's body, and where the "doing" may eclipse the "being" in terms of function and moment.

### *Advantages of amalgamation*

These differences in areas of practice and perception may explain the inability of some nurses to effect a mind, and body, caring perspective. But, caring for the patient as a person encompasses mind and body care. Mind and body are one in ethical nursing practice. Noddings (1994,171) says that carers, or caring nurses, cannot "dismiss thinking and reasoning from ethical conduct, [but must learn to] recognise the affective ... [and] think effectively about what [they] should do in response to the other". Jurchak (1990) maintains that the ultimate ethical health care occurs when nurses pay attention to the relationship between nurse and patient, and base their decisions about body care upon patients' values and perceptions. Nurses in all areas of practice need to adopt a mind-set toward their relationships with patients that reflects their intent to deliver quality therapeutic care to the *whole* person.

## **Practical Applications:**

### *Disunity in diversity*

The diversity of definitions and descriptions of the nurse-patient relationship available in nursing literature *may* explain the extremes of relational involvement afforded patients by nurses. Theoretical miscellany has apparently led each nurse to arrive at a meaningful definition of the relationship based on personal experience and professional knowledge. Each nurse's definition of nursing and its nature is thus highly personalised and individual. This lack of definitive clarity has attributed nursing a wide practice repertoire, but robbed the profession of distinctive action in relationship-building with patients. Uniformity of practice appears to be thwarted by the multitude of different personal meanings which nurses attach to the relationship between nurse and patient. Consequently, nurses have developed highly individualised methods of practice and levels of relational commitment to patients.

### *Consequences of individuality*

In day to day practice, nursing is a highly individualised art and science. Nurses practise, and enter into relationships with patients, in vastly different ways. The type of relationship developed with a patient is dependent upon the nurse's interpretation of the meaning of the relationship between nurse and patient and its value to health care outcomes. This may, in part, be complicated by the highly individual needs presented by the diverse range of clientele with whom nurses build relationships. Effective relationship formation appears to occur more readily when nurse and patient hold complementary interpretations and meanings. The views of the patient toward the relationship need to be solicited, and considered, to ensure the meanings and values of both nurse and patient correspond. Mismatched meanings and values can lead to relationships which are potentially and actually harmful to either nurse or patient, and or, both. The outcomes can thus be conducive or detrimental to good health, depending upon the type of relationship established between nurse and patient.

## **Industrial use of the relationship:**

### *Evaluative tool*

Nurses' estimations of the relationship with patients may be coloured by its association with methods of evaluating care. A certain interdependence exists between the relationship of patient and nurse, and patient satisfaction with hospitalisation and health care. Patient satisfaction surveys reflect that certain types of relationships have lasting effects upon patients' perceptions of health care and influence their return rate as consumers of that service (Westbrook, 1993). Patients develop differing perceptions of hospitalisation and nursing through their exposure to the many personalised styles of delivery and relationships afforded them by nurses (Schroeder, 1991). Patients, according to patient satisfaction surveys and letters to hospitals and journals, are able to distinguish individual care providers, if only by personal characteristics and types of service offered.

### *Inherent bias*

Evaluating health care, however, by examining one perspective of a two-party relationship is unbalanced and essentially biased. The value of the nurse component of the healthcare evaluation equation has been neglected, possibly because of the perception that service providers are indistinct entities in needs-driven teamwork approach to care (Schroeder, 1991). Nurses identify each patient individually in, and for, everyday practice. The perspective of both nurse and patient are equally valuable to the specific evaluation of nursing care in the context of healthcare outcomes, and as indicators of quality of care delivered.

### **Relationship Beneficiaries:**

#### *Patients*

Most theoretical descriptions of relationships between nurse and patient are orientated toward effecting benefits for the patient. The benefits for the nurse are mere implications and, or, abstract suggestions. Nurses traditionally appeared to have been perceived, by themselves and others, as self-effacing givers of care whose rewards lie with the satisfaction of seeing patients achieve health goals. Nursing models give direction for the process of relationship and its potential outcomes (Morse, 1991), but the emphasis is, however, upon the benefits and outcomes for the patient. This focus upon consequences, or outcomes, for the patient from the relationship between nurse and patient is a mirror of the measures taken by healthcare organisations to gauge the effectiveness of services through patient satisfaction surveys, and their relevance to health care economics, particularly patient return for service indications. Presumably, it is the patient-only evaluation of outcome that matters to organisations and the nurses they employ, as patients are the principal consumers.

#### *Patient-driven Outcomes*

Nursing theory appears to focus upon patient outcomes through the use of particular processes of nursing care. The relationship between nurse and patient is no exception. It is often portrayed as a series of steps or stages which culminate in an improved state of health for the patient. Bamum (1990, 143) maintains that most theories can be reduced to a "sequential triad: 1) the patient's undesirable initial status, 2) the nursing act and 3) the patient's desirable status (goal or end point)". The stages are considered to be useful as a framework for assessing human behaviour and directing goal attainment through complementary nursing interventions (Thome & Robinson, 1988). This process-driven approach to the relationship discounts the complexities of the relationship in favour of a manageable mode of practice.

#### *Mutuality*

The relationship can be beneficial for both nurse and patient. Practical considerations indicate that there has to be reciprocal contact between nurse and patient for a relationship to develop. Both parties must derive some benefit from their interactions in order for the process to continue and for outcomes to be achieved. Seeing the relationship as beneficial for *both* nurse and patient gives a



new emphasis to nursing care. It recognises that nurses need to derive personal and professional satisfaction from working with patients, while acknowledging that the primary concern of nursing care is a change in health status, perceptually and, or, actually, for the patient. The duality of benefits is a facet of the relationship rarely emphasised in theory, but which, in reality, cannot be ignored.

### **Current terminology:**

#### *Inadequate portrayal*

Perceptions of the relationship between nurse and patient are formed by association with its words, and the use of relevant terminology in nursing literature and practice. The term "nurse-patient relationship" imparts mere connection by position and association (Bond & Bond, 1986). It labels recipient and provider by capacity and function, negating the subjectivity of the connection between nurse and patient. The words bear no relation to the purpose of the relationship, that is, a joint quest for quality health care. There is no recognition of the properties of the relationship, its mode, actions or components. Its very structure does not convey the wealth of descriptive involvement that such a relationship engenders between nurse and patient.

#### *Mechanical process*

Descriptions in current nursing theory do little to dispel these practical orientations and perceptions of the relationship. They recognise that the relationship between nurse and patient is the connection through which nursing care occurs. It is the vehicle for the expression of patient problems, fears and worries and the delivery of nursing interventions designed to overcome these concerns. The outcomes of such a relationship are changes in the patients' health status. The process is mechanical and belies the humanity in the relationship between nurse and patient. It does not acknowledge the manner or significance of the relationship.

#### *Time for a change*

A timely change in terminology to encompass these features would protect nursing's vested interest in delivering quality nursing care to its clients by recognising the distinctive function that a relationship between nurse and patient serves in the health care sphere. A "therapeutic" relationship is a functional term which removes the visual separation of nurse and patient as presented by the words "nurse-patient relationship". However, it remains discriminatory by implying that benefits can be obtained by the patient through association with another knowledgeable person, the nurse. Combining the two views into a "therapeutic nursing relationship" may be a big syntactical step for nursing.

### **Therapeutic and Healing Nursing:**

#### *Nurses are therapists and healers*

Nurses who, through their relationships with patients, effect beneficial changes for patients and themselves, are acting as therapeutic agents. These nurses are healers. Theoretical descriptions of the relationship between nurse and patient which include the expressions, "healing" and

"therapeutic", are less evident in nursing literature. There appears to be little recognition of this facet of nursing care, although every philosophy implies this point of nursing action. This suggests that these constructs are not universally perceived as elements of nursing care. McCabe, Ramsay and Taylor (1994,23) claim that "strategies for choosing nursing interventions to promote healing are not currently informed by a theoretical understanding of healing appropriate to nursing practice". They call for the development of a theoretical description to fill this gap and allow nurses to approach "whole person healing in a more unified, directed and knowledgeable way". The concept of nurses as healers is synonymous with nursing's caring ethic which revolves around restoring people's health.

### *Nursing as therapy*

A therapeutic nursing relationship involves being, and doing, to bring about change in affect and effect. This conceptualisation is not always easy to assimilate or enact in practice. Therapeutics are associated with the cure of disease. This may explain nursing's hesitancy to adopt this terminology as part of its dogma. The cure model of health care is essentially and traditionally medically orientated (Barratt,1990). To distinguish its knowledge from that of medicine, nursing chose care and abandoned cure. In doing so, nursing may be denying itself use of the very terms which succinctly describe its place in health care.

### *Obstacles*

For many nurses, the concept of a therapeutic relationship between nurse and patient represents a practice dilemma. Theoretical descriptions of the relationship between nurse and patient are technically simplified, setting nurse and patient apart by characteristics or needs, "thus polarising the relationship" (Bamum,1990,142). The properties and workings of the relationship are left obscure. This leads to lack of involvement with the patient, denial of the very human feelings that both nurse and patient experience and added complexity in everyday practice, which further alienates nurse and patient. Lack of theoretical clarity about the relationship between nurse and patient and, in particular, its therapeutic role, adds to the confusion. As yet, there is no theory which facilitates unity of practice in this area. There is no common definition of the nurse-patient relationship which recognises its bi-partite therapeutic effects for patient *and* nurse.

### *Benefits*

A therapeutic relationship generated by nursing action ideally facilitates physical and psychological healing, and bestows benefits upon all its participants. This relationship appreciates the very real, but different, human needs of nurse and patient. It acknowledges that both nurse and patient need to benefit from their connection as people, patients and nurses. The value of such a relationship lies with its ability to validate these needs through the interactions which take place between nurse and patient, and to acknowledge its own inherent healing capacities. A therapeutic relationship is thus healing and mutually beneficial for nurse and patient.

### *Potentials*

An ethic of therapeutic relational contact between patients and nurses has the potential to effect many changes for nursing, nurses and patients. Its mutually beneficial nature assures that both nurse and patient enjoy some perceptual and actual gains. Patients' sense of self-worth may increase, while personal health goals are reached. Nurses may enjoy a feeling of increased confidence and satisfaction in their care and the manner of its delivery. Through the interaction and connection of the relationship, both achieve personal growth and a heightened sense of well-being in the world. The theoretical discrepancies relating to the relationship between nurse and patient may be overcome with the acknowledgment of nurses' humanness and healing capacities within these relationships. It may also lend support to nursing's claim as a unique discipline and profession, by identifying that which sets nursing apart from other healthcare disciplines: a distinctive method of patient *and* nurse care.

### **PURPOSE AND AIMS**

This study was conducted in two phases to elicit the structure of a therapeutic nursing relationship and develop the concept. The properties of a therapeutic nursing relationship were first exposed through examination of the relationship that occurred between nurses who had been patients and their nurses as caregivers. Through these perceptions, and in conjunction with examination of the available literature, a conceptual definition of a therapeutic nursing relationship was exposed for scrutiny of its value to nursing practice. The applicability and relevance of this definition to everyday nursing practice was investigated in the context of descriptions of mutually beneficial relationships between practising nurses and their patients, and with reference to the current literature. Gathered data were reduced into a schematic model which demonstrates the interfacing elements of a therapeutic nursing relationship. The accompanying theoretical description reflects the association of the concept of a therapeutic nursing relationship to affective nursing care and effective patient outcomes. The concept of a therapeutic nursing relationship is thus exposed for its utility in nursing practice, and to further, and future, research.

### *Phase One*

The first part of the study employed phenomenological inquiry to examine the experiences of nursepatients in the context of their relational involvement with nurses as caregivers, in order to capture and describe the essence of a therapeutic nursing relationship (van Manen,1990). Studying the character and behaviour of human phenomenon as it is lived, grounds the data in the actuality and reality of people's experiences of a phenomenon and legitimises their descriptions as ways of knowing about the world (Munhall & Oiler,1986). The inferences drawn about phenomenon by the uninitiated are replaced with the authenticity of experience (Montague,1978).

The focal aims of the study were to elicit descriptions and stories of relationships with nurses as caregivers. Each nursepatient was cognitively engaged by direct questioning to examine and compare the relationships afforded them by nurses as caregivers. Through reflection (Saylor, 1990)

on the nature and intent of nursing, these nursepatients were able to describe perceived personal practice paradigms and those of the nurses who looked after them. This highlighted any differences in practice orientation between the nursepatients and those nurses who looked after them. The nursepatients explored the perceptual differences between being nursed and being a nurse to expose the basis of power in the relationships they had experienced as patients. They were able to identify factors which influenced the development, or non-development, of a nurse-patient relationship in the context of being a nursepatient. Because of the experience of being a patient while being a nurse, the nursepatients were able to examine, compare, and contrast, relational experiences to expose those elements that they perceived to be essential to a therapeutic nursing relationship. The meaning of the experience evolved from examination of the consequential practice and conceptual changes that had occurred for each nursepatient because of the experience of being a patient. These meanings had three facets or perspectives, those of nurse, patient and nursepatient. Each represented different concepts of self for the participants. Thus by identifying, examining and ascribing meaning to the relational involvement of nursepatients with nurses as caregivers, the research question - *what do nurses who have been patients perceive as the essence of a therapeutic nursing relationship* - was answered. Participants' perceptions of and reflections upon the experience of being a patient isolated those elements perceived to be essential to the development of a therapeutic relationship between nurse and patient. The basic structure of the concept was exposed and a loose definition formed.

### *Phase Two*

The second part of the study combined phenomenological inquiry, and the principles of concept synthesis (Walker & Avant, 1988), to fully explore the concept of a therapeutic nursing relationship for its utility in practice. The aims were to test the operational definition offered by nursepatients, seek confirmation of the structural components of the relationship, clarify their association to each other and affective nursing care, and demonstrate the significance of the concept to nursing practice, education, management and research. By examining the narratives of personal encounters in which the relationship between practising nurse and patient was deemed to be therapeutic, and comparing and contrasting these with the stories of nursepatients, the resulting descriptions were refined into a schematic model and a comprehensive theoretical description. This synthesis answered the research questions - *what is a therapeutic nursing relationship, how does the concept function and what does experiencing a therapeutic nursing relationship mean for practising nurses and their patients*. A comprehensive picture of the concept, its inherent components, defining attributes, structural dynamics and meaning for the participants was unfolded for consideration by nurses in all areas of practice.

### *Outcomes*

Using a combination of inquiry methods, this research was able to revisit the relationship between nurse and patient. The what, why and how compilation of questions focused the research in actual nursing situations. This compilation bridges "the theory-practice gap" by meeting the needs of both

nurses and researchers for "practitioners want to know *how*, while researchers want to know *why*" (Barratt,1990). Nurse practitioners do know how to relate to clients therapeutically. Theoretical description about the relationship between nurse and patient, in this context, adds to nursing knowledge "as much of nursing is based on interaction between human beings" (Barratt,1990,23)

This research scrutinized the relationship between nurse and patient for its ability to foster satisfactory patient *and* nurse outcomes, mode of therapeutics and impact upon health care provision and delivery. The design utilised Montague's six sources of knowledge: "testimony, intuiting reason, sense-perception, [successful] practice and doubt" (1978,233) to study the character and behaviour of the relationship between nurse and patient as it happened for its participants. From these ways of knowing, a new conceptual format of the relationship was developed which recognises the mutually beneficial and healing properties in its practical application.

## CHAPTER TWO: LITERATURE REVIEW

Clarifying the place of the nurse-patient relationship in nursing and health care is problematic. There are many different interpretations of the relationship in nursing literature as each nursing theory has approached the relationship between nurse and patient from a uniquely different focus. The components of a nursing relationship remain in constant debate, with many researchers challenging the essence of the relationship's success in practice. Patients' and nurses' perceptions of the relationship and its components differ, and their perspectives of caring relationships are not always congruent. The correlation between patient satisfaction and quality nursing care is pertinent, but its utility in assessing nursing services is fraught with complexity. Descriptions of the relationship are always evolving. This milieu has fostered confusion and led to praxis development of many different types of relationships between nurse and patient.

### **The Relationship between Nurse and Patient**

#### *Early beginnings*

A great deal has been written on the relationship between nurse and patient and its value to nursing care. As early as 1971, Jourard recognised the mutually beneficial and healing potentials of the relationship between nurse and patient. He believed that an excellent health care relationship gave its participants a sense of being valued as individuals, cared for, and understood, as worthwhile human beings. Jourard felt that there was a direct connection between the calibre of the relationship and patient recovery. He also maintained that their relationship was beneficial for patient *and* nurse. An excellent health care relationship, wrote Jourard, meant that patients were able to increase their capacity to "throw off illness", while nurses gained professional and personal benefits. The personal experience of being involved in an excellent health care relationship meant that nurses developed insight into their caring capacities and were renewed to care again. Professional confirmation of competency was rebound in the attainment of satisfactory outcomes for the patient. The therapeutic nature of the relationship had been identified, and disseminated through Jourard's writings, but, at this time, was not to be fully embraced by nursing theory or practice.

#### *Theoretical diversity*

In the myriad of nursing theories which describe the relationship between nurse and patient, there is diversity of interpretation and some mystery (May,1990). The relationship is central in many theorists' conceptualisations of nursing and is often perceived by both theorists and practitioners as the "essence of nursing" (Garvin & Kennedy,1990,213). Morrison and Bumard (1991,11) cited Leininger to support their claim that although the relationship between nurse and patient appears to be at "the heart of therapeutic help to clients, [its nature] between caregivers and care recipients is limitedly known". Morse (1992,255) upholds Leininger's observation and maintains that "future research must explore the nature of the developing nurse-patient relationship" in order to effect better patient outcomes. Very often, the practice environment insures that "we 'have' [relationships] or 'live' them before we 'know' them" (Kesterbaum,1982). Making visible the hidden dynamics and

meanings of the relationship will enhance a nurse's professional ability to relate to others in a more effective manner.

### *Descriptive individuality*

Nursing is seen as the "humanising influence in the health care system" and the relationship between nurse and patient as its medium, because of the intimate, lengthy contact between nurse and patient during delivery of nursing care (Moccia, 1986). Most theories revolve around this "special" relationship (Bamum,1990) between nurse and patient, and recognise it as the vehicle for caring interactions. While every nursing theory alludes to the nurse-patient relationship in some form or another, each description is highly individual in action and terminology regarding the relational dynamics between nurse and patient. This has "led to a number of ambiguities and tensions" about the place of the relationship in nursing practice and theory (May,1990).

### *Conceptual restrictions and restraints*

Although "existing research shows the nurses view relationships with patients as an important part of their nursing care" (May,1990,307), there are several factors which reduce this importance in practice. May (1990) asserts that definitions of nursing often create barriers to the formation of a therapeutic relationship as they lack clarity of description, or refer to the level of skills required to practise nursing, thus reducing relational activities to the realm of "not real work". Many definitions of the nurse-patient relationship are ambiguous, confusing and, or, tend to formalise the relationship into a series of steps which inhibit the free-flow development of a relationship. Particular ward management methods may place emphasis upon practical skills in patient allocation, which, says May, means that recognition of these skills takes precedence over less concrete skills required to create therapeutic relationships. In these tightly controlled situations, relationship formation is precluded by the pursuit of skills.

### *Perceptual restrictions and restraints*

Because health care is multifaceted, and nurses need to interact with many other health care professionals in the course of a day, this reduces the time available to develop an effective relationship between nurse and patient (Morrison and Burnard,1991). In this type of occupational climate, time is tightly allocated over an eight hour shift to encompass the many necessary interactions and transactions made by nurses with each other, and allied healthcare professionals, and structured to achieve the best outcome for the patients. This altruistic search, albeit for the overall benefit of their patients, has paradoxically led nurses to exact the greatest control over the time spent in interactions with patients. The very division of time into work spaces sets limitations upon the length of contact between nurses and patients, and impinges upon the quality of their interactions (Kagan and Evans,1995). Nurses, for expediency, often deny the patient equal time and input into the very interactions which assure acknowledgment of patients' needs.

### *Actual restrictions and restraints*

The very nature of healthcare, nursing and society (Kagan and Evans,1995; May, 1990; Murphy & Hunter, 1983; Gadow,1983) may prevent development of a relationship which is therapeutic for the patient. Relationship formation can be constrained by factors which cannot be controlled. The healthcare environment in which the nurse and patient interact is subject to external pressures and demands of economics, professional standards and performance-based assessment criteria. Both nurse and patient are social beings with highly individual personal agendas, cultural affinities, behaviour patterns, codes of conduct and expectations. The relationship is context bound. Stein-Parbury (1991,17) says that each relationship is "unique and dynamic in its own right" because of the "host of variables" involved, and asserts that "there are no context-free rules about interacting with patients".

### *Possibilities*

Despite the barriers and, or, obstacles to nurses wishing to develop *any* sort of relationship with patients, there is evidence that relationships between nurse and patient can be closely bonded and effective. This suggests a need for further research in the practice arena, as "theoretical conclusions drawn from fieldwork ... have a direct relation to the realities of nursing practice and are accessible to practitioners - who are the intended beneficiaries of nursing theory" (May,1990,312).

### *Ideological changes*

The nurse-patient relationship has changed over time, "as paradigms in use change" (Taylor,1985,13). The form that the relationship should take is constantly in question. The emphasis has moved from nurse-centred to patient-centred care (Murphy & Hunter,1983), where "the standard of care delivered depends upon the quality of the relationships that individual nurses build with their clients" (Minardi,1988,990). The dynamics of both these relationships are nurse-initiated, while patients remain passive recipients. More recently advocated is a partnership between nurse and patient with both parties responsible for, and to, the formation of a relationship (Christensen, 1993; Northouse & Northouse,1992; Salvage, 1990; Putillo, 1990). These relationships are built upon the premise of inequality because the patient comes to the nurse for help.

### *Theoretical changes*

Christensen (1993) eloquently illustrates the concepts of partnership in tables listing nursing tasks and skills to be performed which are offset with complementary patient responses. The professional responsibility, or obligation, of the nurse is to use skills to effect better healthcare for the patient who, in turn, must be responsive and responsible for its ongoing status. This is not a new way of thinking about the relationship between nurse and patient and does not afford the patient mutuality. This concept of "partnership" is an anachronistic type of stimulus-response model which does not sit well alongside contemporary consumerism and awareness of health rights.



### *Conceptual inequality*

To date, there is no universal recognition of the nurse and patient as human equals in a relationship. Although the current paradigms of nursing hint at equality, they do not completely recognise this facet in the context of the relationship between nurse and patient. The four components of interest in nursing paradigms are person, environment, health and nurse/nursing (Thibodeau, 1983). These concepts are commonly illustrated by a model of four interlocking circles, meant to give equal representation to each, but this cognitive construct "divides almost everything" and does not recognise the dynamics of the encounters between the concepts (Steinem, 1992, 218). There is no intellectual consensus on the meaning of these concepts (Hayne, 1992). Each nursing theorist constructs a meaning for each of the four concepts which stems from his or her own theoretical bias toward, and personal philosophy of, nursing. Kesterbaum (1982) asserts that the main problems of paradigms, models and world views is that they are constructed by a profession's "habits of mind", or its culture, and that these constructed experiences do not quite capture everyone's reality. This leads to multiple interpretations of the existing paradigm and development of highly individual meanings associated with its practical application. Recognition of the concept of patients and nurses as equals in their nursing relationship may well depend upon a paradigm shift. This dramatic change is necessary to affect nurses' perceptions of the relationship, and the individually constructed nursing paradigm within which each nurse practises.

### *Co-existing paradigms*

Contemporary thought ascribes two nursing paradigms (Parse, 1987). The first is the "Totality" paradigm wherein the nurse is the focus of the relationship between patient and nurse (Parse, 1987). The second "Simultaneity" paradigm advocates a relationship in which the nurse guides the patient (Parse, 1987). These two paradigms do not embrace a true partnership where both nurse and patient have equality, but polarise the concepts in the relationship because there is an uneven distribution of power. Parse acknowledges that nurses may align to either or neither paradigm for practice guidance. This juxtaposition of practice is reflected in focal differences in relationships formed with patients by individual nurses.

### *Some Conclusions*

It would appear that the relationship between nurse and patient remains somewhat of an enigma. Theoretical perspectives have done little to clarify the relationship for ease of practical application. Acceptable paradigms with their simplistic representations of the relationship between nurse and patient belie its practical complexities. Nurse practitioners faced with such indecisiveness and diversity have developed their own "habits of mind" (Kesterbaum, 1982), which add to the imbroglia.

## **Theoretical Perspectives of the Relationship between Nurse and Patient**

### *Perceptual duality*

Theoretical descriptions of the relationship between nurse and patient vary. The continuum of time has seen many changes to the context and content of the relationship. There are commonalities of

description and purpose. All theories support the place of the relationship between nurse and patient in nursing care. The relationship is often cited as the basis for a process of development and delivery of nursing care aimed at solving the patient's health care problems (Oiler in Moccia, 1986). In the semantics of intent, there are differences. The place of the relationship in nursing is still in evolution. Some nursing theorists, for example, Travelbee, Peplau and Orlando, see the relationship as the essence of nursing, while others, including Watson and Hall, see caring as the primary ethic expressed through the medium of the relationship between nurse and patient. However, none of the current theories furthers unity of nurse and patient by reducing the duality of their relationship.

#### *Scrutinising the theories - compartmentalisation*

Taylor (1992) examined all historical and current theories from Nightingale to Benner. She maintains that all theories are distinctly similar because, in their quest for convenience of description, they have placed "nurses and patients into discrete compartments" (1992,1042). Taylor believed that this trend to separate nurse and patient for the purpose of description began with Nightingale, and has continued to the present day. Her analysis found that Peplau, Henderson and Hall perpetuated this distinction between nurse and patient by their portrayals of nurses as helpers and patients as helpees and that this "separateness" of nurse and patient was maintained by the descriptions of Orem, Johnson, Abdallah, Orlando, Weidenbach, King, Roy, Roper and Newman. These latter descriptions were somewhat different in that they reclassified the patient as a human being, but failed to attach this descriptor to nurses.

Taylor found that there was "less differentiation in the identities of nurse and patient" in the writings of Rogers, Paterson and Zderad, Watson, Parse, Leininger and Benner, because they demonstrated more imagination and flair in their descriptions. Nevertheless, both nurse and patient remained separated by their descriptive labels of helper and helpee. Taylor (1992,1046) concluded that this segregation of nurse and patient was common to all theories, because all described nurses terms of "people who had special knowledge and skills which were sensitively dispensed to the foci of their care", that is, patients.

#### *Disunity and discrepancy*

Taylor (1992) also found that dichotomy was perpetuated by descriptions of the concepts of nurse and patient as entities with very different characteristics. Descriptions of the nurse in terms of role and function, and the patient with human qualities, formed the concepts into a dyad which influenced nursing thought about the relationship and created a moral and ethical gap for nurse practitioners. Her views are supported by Parker (1990) who felt that these conceptualisations alienated nurse and patient, and added complexity to the relationship between nurse and patient in everyday practice. Parker believed that the current theory bases did not encourage nurses to become involved with patients on a more human and humane level, nor did they allow nurses to acknowledge the very human feelings that both nurse and patient have experienced as people.

Smith's 1991 examination of the differences between the nursing theories of Parse, Paterson and Zderad, Watson and Benner supports this view. She found that although these theories differed in their interpretations, no one theory was fully fleshed out to "encompass every human emotion" specific to nursing situations. Both Parker and Taylor maintain that there is, as yet, no nursing theory that facilitates unity of patient and nurse as human beings in relationships. Taylor called for a re-conceptualisation of theoretical terms to admit and accept the humanity of both nurse and patient into nursing theory and practice.

*Separatism: for unity of purpose*

The historical continuation of theoretically separating nurse and patient into distinct entities for descriptive purposes has been supported and constrained by nursing's adoption of a universal paradigm composed of four separate, but interrelated concepts - nurse, patient or client or person, environment and health. All theories include definitions and descriptions of each concept individualised to each theorist's view of nursing (Mamner, 1986). This common approach recognises and supports the importance of these concepts to nursing's body of knowledge and professional practice. Separation is essential to establish the place of each concept, firstly in the theorist's perceptions of nursing, and secondly, in the universality of practice that is accepted as belonging to nursing.

*Reductionism: the small parts within the whole picture*

Simplifying descriptions into distinct categories central to nursing's body of knowledge ensures that practising nurses and students can identify and work with those factors to reach a greater understanding of all theories and their place in nursing care. This cognitive arrangement of factors, common to all theories, assists assimilation of knowledge into practice, promotes articulation of what nursing is and does, and provides the beginning nurse practitioner with a sense of identity and purpose (Driver & Oldham, 1986). There is a need to look at the relationship between nurse and patient in order to understand how it is lived, elicit its meanings and make them visible in practice. This will enhance nurses' abilities to relate to others, for "we 'have' [meanings] or 'live' them, before we 'know' them" (Kesterbaum, 1982)

**Components of the Relationship between Nurse and Patient - Descriptive Debate or Debacle?**

*The struggle*

The essential components of a quality relationship between nurse and patient are constantly being examined and re-examined by new researchers in the ongoing search for a relational ethic for nursing theory and practice which reflects, and is cognizant with, current social thought about health and nursing care. This search mirrors nursing's own past struggle for professional identity in the health care arena. Although the relationship between nurse and patient is well established in nursing theory, it is subject to change indicative of, and adapted to, the prevailing social and behavioural qualities demanded of professional health care providers by society. Consumers of health care are

demanding, and obtaining, greater input into their health care. Jurchak (1990) purports that as consumers are faced with a multitude of different relationships in the health care arena, nursing research needs to "consider what distinguishes the nurse-patient relationship from these others". Placing these current demands within the perspective of available nursing theory calls for re-examination of the components of the relationship between nurse and patient.

### *Descriptors*

Recent writings and analyses of the relationship between nurse and patient have focused upon the subjectivity of its nature, and the presence of certain factors which foster good working relationships in the context of nursing care (Bond & Bond, 1986). There has been a proliferation of "new" terms as nursing scholars search for more apt descriptors for the relationship which reflect nursing ownership. The nature of the relationship has not always been reflected by its labels and several suggestions have been put forward to redress this deficit. Research-generated terminology which describes the relationship between nurse and patient includes words such as: companionship (Campbell, 1984), interpersonal (Watson, 1985), interaction (Chinn, 1986), confirmation (Drew, 1986), collaboration (Kasch, 1986), commitment (Kitson, 1987), connectedness (Taylor, 1991), empowerment (Gibson, 1991), involvement (May, 1991), humanness and ordinariness (Taylor, 1991&4), trust (Morse, 1992) and caring (Clarke, 1992; Morrison, 1991&2; Kitson, 1987).

### *Constraints*

Although these descriptors have emerged as a means of identifying and qualifying the subjective elements of a nursing relationship, and naming those elusive qualities that make a relationship work in practice, consensus is yet to be reached. This encourages further research into the relationship between nurse and patient. Morse calls for future research to "explore the nature of the developing patient-nurse relationship" (1992, 255) and identify those properties which lead the relationship toward "therapeutic goals". Clarifying the essential properties of the relationship is complicated in by its own subjectivity and the inability of many patients to accurately describe situations which concern their feelings (Minardi, 1988). This may explain the apparent emphasis in research findings upon the skills and competence of the nurse in effecting a successful relationship and the quality of its outcomes. Emphasizing the part of the nurse reinforces the omnipresence of professional control and power over the relationship in practice.

### *Power differentials*

The influence of the consumer movement has seen nursing research questioning the power relationship between nurse and patient for its ability to foster patient input into nursing care. Answers have been sought through examination of the patient's perspective of decision-making processes (Tmobjanski, 1994), and care and caring (Farrell, 1991). These studies have demonstrated that the ultimate power and control within the relationship rests with the professional because of the social and organizational contexts within which nursing occurs. Bond and Bond (1986) supported this view of an asymmetrical power relationship between nurse and patient. They found that the unfamiliar

environment of the hospital, patient vulnerability and the ability of the professional to control the distribution of information, the work and the work environment severely reduced patient control within the relationship.

### *Changing views*

Taylor (1985) proposed that each new perception of the relationship brings change to the nature of the relationship in practice, clouding nurses' perceptions of rights, responsibilities and obligations within the relationship. This leads to practice confusion about the moral and ethical position of the nurse in the relationship. However, others would argue that refurbishing new and different descriptions of those qualities and quantities which are purported to belong to the relationship challenges the status quo and prevents complacency (Bandman & Bandman, 1988). Challenging existing theory with emerging ideas about the nature and construction of the relationship between nurse and patient invites and encourages debate necessary to determine consensus. From the midst of the confusion evoked by debate, it is possible to identify those components of a successful relationship between nurse and patient and clarify directives for practice, which in turn, will cement nursing's place as a unique health care profession.

### *Practice-theory gap*

Theoretical definitions of caring within the relationship between nurse and patient are being challenged for their lack of practical reality. Lowenberg (1994,167-8) argues that although there are plenty of descriptions of the relationship between nurse and patient which focus upon "idealistic conceptualisations of the composite elements of caring", there are few studies which have ventured beyond this to look at the relationship as it happens and "generate theory based on empirical research". She maintains that learning about components and dynamics of the relationship has important implications for patient outcomes, patient satisfaction, and future health care delivery. Kitson (1987) claimed that until the characteristics of caring and nursing are clearly defined, nursing would be limited in its ability to "set standards related to the quality of care". Current definitions of nursing do not embrace all the uniquely nursing and caring properties engendered by the relationship between nurse and patient. This disparity between practice and theory may explain the random and sparse use of theoretical models of patient and nurse inter-relationship in nursing practice.

### *The need for research*

Lowenberg's view is supported by Garvin and Kennedy (1990). These authors assert that nursing has been slow to assimilate into practice the research findings of other disciplines, and even slower in using the available knowledge of interpersonal relationships as a basis for generating nursing research. They all call for a comprehensive research agenda to include investigations of actual encounters between nurse and patient which elicit, by critical analysis, the true components of the relationship, the processes involved and highlight the differences and similarities between nursing models and those of other disciplines. This manner of research will allow nurses to develop insight into the complexity of nurse-patient relations, and a richer understanding of the processes involved.

## **Incongruent Perceptions**

### *Added complexity*

The relationship between nurse and patient is a complex phenomenon. It appears to be rendered "inherently problematic" (May, 1993, 181), particularly by its multi-dimensional nature and structure. It is subject to external and internal constraints, some of which arise from nurses' perceptions and expectations, while others are imposed by patients (Kagan & Evans, 1995; Molzahn & Northcott, 1989; Gadow in Murphy & Hunter, 1983). Both nurse and patient are influenced by prior and present experiences, accidental and purposive outcomes of encounters, education and media images. Thus patients develop their own "habits of mind" about their relationships with nurses (Kesterbaum, 1983). Nurses have been subject to professional socialisation and educational processes superimposed by the real world of nursing practice. Because of the complicated human natures of both nurse and patient, their perceptions of aspects of health care are very often incongruent. This perceptual discrepancy also affects the relationship between nurse and patient. This adds difficulty to complexity in discerning the constituents of an effective relationship between nurse and patient.

As early as 1963, Brown wrote of the "failure of [nursing] staff to see more clearly the patient's point of view" because they "took it for granted that the patients think and feel much as they do about matters" (1963, 13). She felt nurses did not take the time to discover patients' opinions and that this was detrimental to patient recovery. Molzahn & Northcott's 1989 analysis of the literature found significant evidence that discrepancies in health/illness perceptions between nurse and patient have persisted in time. They felt that poor communication between nurse and patient often lead to disastrous consequences for the patient.

In 1991, Farrell examined the correlation of patient and nurse perceptions of patients' needs in psychiatric and general nursing settings. He found little evidence of congruence in perceptions and concluded that nurses did not "know their patients very well" (1991, 1068). Similarly, Tittler, Cohen and Craft (1991) found that the incongruent perceptions of nurses and patients in a critical care unit were typified by nurses' lack of awareness of their patients' feelings about being hospitalised, and heightened by poor communication between the two.

### *Matching perceptions: a valuable tool for nursing*

Nurses are presented with many opportunities to improve their knowledge of patients' perceptions and overcome inconsistencies which may effect the quality of care delivered. They spend more time with patients and "often know the patient more intimately than anyone else [in the health care field]" (Moss 1988, 615). Eliciting patient's perceptions gives the practitioner valuable information about the patient's level of understanding and expectations of nursing interventions which can then be incorporated into care planning (Jacobs, 1980). Jurchak (1990, 456) maintains that effective relationship building depends upon nurses spending time with patients and being willing to "meet the patient where he [sic] is, to come to know the patient and his values from his point of view".

## **Patient Satisfaction and the Relationship**

### *Utility*

The correlation between patients' perceptions of quality healthcare, relationships with health care providers, and satisfaction with services received, are well-established (Rempusheski et al, 1988). Research findings indicate that interpersonal relationships between consumers and healthcare providers mould patients' opinions of care providers and care received, and shape their attitudes toward potential return for future services (Hulme, 1996). Relational contacts have a significant influence upon patient perceptions of satisfaction with healthcare. Westbrook (1993) asserts that "patients are able to evaluate validly and reliably the quality of both clinical and non-clinical aspects of health care services", and as such, their opinions should be "actively sought" as a valuable means to improving healthcare.

### *Applicability*

The relationship between nurse and patient has been shown to be important to patients' satisfaction with nursing (O'Connor, 1989). Satisfactory relationships with nurses foster health promoting behaviours in patients (Thome & Robinson 1988) and increase their sense of satisfaction. The relationship also has the potential to increase patient dissatisfaction, says Schroeder (1991), as patients remember their contact with nurses, and each meeting with a nurse has the potential to "produce negative or positives outcomes and challenge the attainment of customer satisfaction". He calls for research to focus upon, and identify, the functionally active components of satisfactory working relationships so that what it is that "helps one patient to health and satisfaction may become commonplace for all patients".

### *Biased results*

Patients' opinions of care and quality are actively sought as a means of evaluating health care services and as indicators of prospective returns and anticipated income (Morrison, 1992, Leebov & Ersoz, 1991, Strasser & Davis, 1991). The oft employed tool for assessing patient satisfaction with hospitalisation is a self-administered questionnaire which can be used constructively by health care services to moderate and upgrade existing services "to improve the health outcomes of their patients" (Westbrook, 1993). French (1981) suggests that the questionnaire method of collecting information from patients invites bias because it is usually administered only after the experience of being hospitalised, and this needs to be recognised when effecting changes in health care delivery.

Westbrook (1993) argues that the tools for measuring patient satisfaction are of a high standard and that patients assessments of technical competence and information provision by health care providers have been demonstrated to be reliable and valid. While these processes are valuable in assessing quality of care, most represent only one perspective in a two party relationship that may only be authenticated by also examining the perspectives of both professional health care workers and patients (Strasser & Davis, 1991; Salvage, 1990; Morgan, 1990). However, organisations that

employ nurses often do not solicit their input into evaluative processes because of inherent provider bias (Schroeder, 1991).

## **Nurses as Patients**

### *Informed consumers*

Nurses who have been patients have developed a unique perspective of the relationship between nurse and patient, having experienced the giving and receiving of nursing care. Nurses who have been patients have an opinion of what it is like to be the patient component of a nurse-patient relationship (Coleman, 1995; Shetlar, 1991; Cotter, 1990). This unique viewpoint, however, has not been fully explored for its value in understanding the complexities of the relationship between nurse and patient. Nursepatients are often perceived to be nursing's strongest critics, because they *are* nurses. Nursepatients' perceptions of nursing care are informed and accurate. They know what nursing is and does. Nursepatients can base their evaluations of nursing care on personal experience *and* professional knowledge. They are effective consumer voices. No exceptions are given in nursepatients' professional evaluations of services rendered them by nurses as caregivers.

### *Discrepancies in care*

Anecdotal accounts of nurses who have been patients express varying degrees of satisfaction with nursing care received during hospitalisation (Coleman, 1995; Hodgkinson, 1993; Grimster, 1993; Carlisle, 1992; Sutton, 1992; Samerel, 1990; Sherrard, 1988; Fazey, 1985; Orr, 1985). Most express dissatisfaction with the level of care received and the quality of the relationship offered them by nurses. A common theme in these accounts is the lack, or low standard of, psychological or emotional care and support given by nurses to these particular patients and or their loved ones. There are also similar complaints about the physical given and, in some cases, not given. Many of these anecdotes bemoan their caregivers' impersonal, indifferent and unconcerned attitudes and poor attempts to develop effective caring relationships with patients who are nurses. This is not flattering to the claim that this relationship is essential to quality nursing care and patient outcomes (May, 1990).

### *A living paradox*

Two research-based studies of nurses experiences of being patients have focused upon different aspects of this phenomenon (Shetlar, 1991; Cotter, 1990). Both studies utilised phenomenological methodology to examine the lived experience of being a nursepatient. Each describes the relationship between nurse and patient in different contexts. Shetlar examines the experience of nurses being cared for by others; Cotter, that of health care workers who are ill. Both studies suggest that nursepatients have balanced perspectives of nursing care and that the nursepatient represents a living paradox to nurses as caregivers.



### *Being cared for*

Shetlar (1991) examined the experience of nurses being cared for by another (not necessarily another nurse) and sought the meaning for the experience of being a patient as lived by female nurses. She postulated that the socialisation process inherent in the nursing profession promotes an image of a self-sacrificing female who never admits to being ill, nor allows personal illness to affect the capacity to work. This makes it difficult for nurses to feel comfortable with being ill and being cared for by another. There is an assumption that nurses are always the providers and never the recipients of health care, unless surreptitiously. Her findings supported these conjectures. Shetlar found that "for nurses to remain in balance, they must be able to remain within the boundaries of care; they must experience being cared for in order to be caring with others" (1991,9). Shetlar concluded that, for the participants in this study, the meaning of being cared for was "persons sharing self with another" (1991,123). This has implications for the nurse-patient relationship where the patient is a nurse, and for all patients requiring nursing care.

### *Being caring*

Cotter's 1990 study of nurses' experiences of being ill focused upon the concept of the wounded healer and the effect this had upon the nursepatients work-practice arena. It examined the experience in the context of the professional and personal care given these nursepatients by their colleagues. The descriptions illuminate the difficulties wounded healers have in coming to terms with being ill, and the indifference shown them by their peers. She describes two types of care experienced by these nursepatients: "healthism" with an emphasis on being healthy workers; and "holism" that recognises the whole person, well or unwell. Cotter found that the latter was experienced less often than the former. She felt that "the root of dissatisfaction with [consumer-provider] relationships lies in the power imbalance" (1990,6). A therapeutic relationship was possible if the nurse had good interpersonal skills and practised from an holistic paradigm. Cotter herself was hospitalised and she believed that this experience gave her "insight into the patient's position, and highlighted the difference between being a health worker and a health service consumer" (1990,10). The findings indicated that those nurses who had been patients often adopted a more holistic approach to nursing care because of the experience of being a patient.

### **Nurses' Satisfaction in their Relationships with Patients**

There has been little research which looks at the benefits of the relationship for *both* nurse and patient. There is an inherent assumption that nurses derive satisfaction from being involved in the process and outcomes, and obtain "their *real* satisfaction from nursing as a career" (Morse, 1992,251). Nursing work is structured to enable patient care to be delivered continuously twenty-four hours a day by many nurses. Organisations appear to assume that nurses meet their obligations of care within set standards. There is no recognition of excellence in care, nor retribution for substandard care. In this environment, rewards are few. The means of attaining professional satisfaction relies upon feedback from peers and achieving results for patients. Personal satisfaction is derived from self evaluation and patients' comments. With the recent upswing of literature and

research into nursing "burnout", stress and attrition rates, it would appear that today's nurses are deriving less satisfaction from their work and its outcomes. The bounds of nurses' needs for satisfaction from their relationships with patients have yet to be fully examined.

## **Therapeutic Relationships in Nursing**

### *Travelbee and Peplau*

Several nurse theorists have written about therapeutic relationships, including Joyce Travelbee (1971,1966) and Hildegard Peplau (1952,1985). Both theorists have a psychiatric nursing background and their theories reflect this nursing branch's alliance with the principles of a therapeutic relationship for successful psychiatric nursing care. Both are considered "interactionists" or theorists who hold the nurse-patient relationship central to nursing practice (Marriner, 1986; Meleis, 1985). Their theoretical assumptions rest upon nurses doing to, or acting upon, patients and sets the patient into a passive recipient role. Similarly, each theory describes a therapeutic relationship developing through deliberate nursing action in response to the patient's situation, and progressing in stages to reach its climax wherein the patient's behaviour changes. The age of these theories may explain why their concepts of a therapeutic relationship between nurse and patient have not been fully integrated into current nursing practice. These theories appear to have been passed over in the search for more favourable terms and jargon which describe the functions of nursing and nurses in present times. However, the basic principles, held by Travelbee and Peplau of therapeutic nature of nursing, have some relevance in today's practice.

### *King and Parse*

Other theorists have also considered the relationship between nurse and patient important to quality nursing care. King emphasised the interpersonal relationship between nurse and client as means of goal attainment for the patient (Oermann, 1991). Parse focused upon the relationship between nurse and patient as a process of 'human becoming' which enabled the patient to make choices regarding health patterns (Takahashi, 1992). Models of this ilk attempted to move the axis of nursing care away from the nurse, but in description prescribed to a nurse-patient focus which locks into nursing actions and process-driven relationships. While giving directives designed to achieve therapeutic outcomes in practice, these descriptions do not clearly demonstrate the infrastructure of a therapeutic relationship between nurse and patient. This clouds interpretation and implementation. Morse (1991) challenges contemporary researchers to find those elusive qualities that promote therapeutic consistency in a relationship between nurse and patient.

### *Consumerism*

Societal pressures, via the consumer movement, coupled with nursing's desire to be perceived in a positive light, demand that the profession adopt a caring approach to nurse-patient relations. This means a move away from nurse-controlled interactions toward those which expressly involve patients in their care. Nursing paradigms have begun to mirror the social changes that are taking place in health care in which consumers were demanding, and obtaining, more say in the services to

which they prescribe (Morrison and Burnard,1991). Contemporary nursing theory reflects recognition of the complexity of the relationship, the factors that affect its development and the effects of consumerism (Oermann, 1991).

#### *Contemporary consumerism - Watson's theory*

Watson's theory of transpersonal caring (1985,1990) talks of the connectedness of nurse and patient in the experience of illness and the futility of using objective control and problem-solving approaches for subjective happenings. Nurses and patients enter into transpersonal experiences to be transformed by "a way of knowing" of and about others which is "consistent with caring" (Watson, 1990, 111). Watson's theory recognises that nursing is more than tasks and physical care, but a means of knowing more about people and their healthcare needs. She places nursing on a more esoteric plane, but paradoxically moves from this subjective stance to describe a plan for nursing action based upon a detailed set of ten carative factors which separate nurse and patient by function and purpose.

Meleis (1986), in her synthesis of the common ideas in the theories of Johnson, Roy, Rogers, King, Orlando, Paterson and Zderad, Travelbee, Wiedenbach, Levine, Orem and Nightingale, found that this sifting down to designated activities was necessary to identify specific nursing actions. Translating theory into direction for practice meant disconnecting nurse and patient and reducing the relationship objectively into designated halves. This conflicts with the intent of Watson's theory, and does little to assist practitioners in their quest for more understanding nursing approaches to patient care.

#### *Effects in practice*

Morrison and Burnard (1991) studied the relationship of caring and communicating in nursing. Their investigations found that, although nurses talked of active client participation in health care, nurses did not generally demonstrate "a marked tendency towards a client-centred attitude" (1991,89). Nurses controlled and directed the relationship to affect what they perceived to be 'quality' care. Reasoning for this attitude centred around work ethics (pressures and the need for instant decision-making), work environment (too many patients, too little time) and personal defense mechanisms (do not need the stress of closer personal contact with patients). Morrison and Burnard deplored this attitude and claimed that their study supported the idea that "therapeutic relationships are more to do with how people feel about and perceive each other than they are about a particular set of skills" (1991,67). They advocated a practice change which could be accomplished by coupling awareness and understanding with skills to develop a "caring relationship [which] has a positive effect on all those people with whom the nurse comes in contact: patient, relatives, colleagues family, friends and others" (1991, xii). This offers nurses a starting point for instigating therapeutic interactions with patients, but again is nursing skills reliant. The model's necessary descriptive detail may also negate the ease with which it could become a practice reality.

### *A non-therapeutic mind-set*

The therapeutic nature of nursing has apparently been subsumed by the need to ascribe to the therapeutic nurse an essential set of skills, the possession of which renders the nurse therapeutic. Nurses do not presume that they, themselves, are therapeutic agents, but relegate this role to the actions that they perform. It would appear that Steinem (1992,217) was correct when she said that "accepting nursing as a therapeutic activity requires a paradigm shift, that is, a change in the organizing principle that underlies the way nurses think about themselves and their world". It is time to move beyond the caring/curing ethic and accept that nursing is healing art and science recognizable through the relationship between nurse and patient.

## **Nursing as Therapy**

### *Therapeutic role*

Discussions of nursing in which interventions are placed in the realms of therapeutic actions, and where nurses are described as therapeutic agents, are becoming more commonplace in nursing literature. In a recent paper produced by the Royal College of Nursing Australia, McCabe and others (1995) argued that holistic nursing practice recognises the nurse as "therapeutic agent" with the potential to benefit the patient through use of a broad range of nursing interventions. These authors contend that any interaction between nurse and patient has the potential to be therapeutic, and that given the appropriate knowledge, nurses can choose those therapeutic interventions which benefit individual patients. Their concept of holism accredits the nurse with a much greater "therapeutic role" which uses "the healing potential of both nurse and client" to achieve desired outcomes (1995,21).

### *Therapeutic nature*

Pearson (1985,1988,1990; and in 1991 with McMahon) championed the therapeutic nature of nursing and the nurse-patient relationship as its medium. In England and Australia, Pearson was successful in establishing nursing practice units which were hailed as new ways of nursing. These units embraced a philosophy based upon recognition of "nursing as a therapeutic agent" and "the healing potentials embodied in the acts of nursing" (1985). The relationship between nurse and patient played an important role in the successful implementation of this new way of nursing. Pearson saw the relationship between nurse and patient as an essential "milieu for expressing therapeutic methods" with its own "potential to serve as [a] therapeutic effect" (1988,75). These units were able to actively demonstrate that "professional nursing does have a therapeutic effect" with "significant improvements in patient outcomes and ... significant cost savings" (Pearson, 1990). However, external constraints inhibited the adoption of this way of nursing as common practice in hospitals and by nurses.

### *Difficulties in interpretation*

In 1991, Pearson, with McMahon as co-editor, published a book entitled "Nursing As Therapy" in which they, and various authors and researchers, contributed views of nursing in the context of its

therapeutic modality. These contemporary thinkers explored various aspects of nursing and used terms such as "therapy", "therapeutic" and "therapists" as descriptors in their findings. Each study was able to illustrate various obstacles to the acceptance of the terms and the method of therapeutic nursing. Some constraints came from within the profession, while others were external influences. It was recognised that more research needed to be conducted to capture the essence of a therapeutic relationship and elucidate its constituent elements.

McMahon (1991) asserts that nursing has to undergo a great deal of change to adopt therapeutic nursing as an everyday practice. Certain fundamental beliefs inherent in nursing theory and practice need to be altered for nurses to encompass a view of nursing as "promoting health and healing for the clients in their care" (1991,4). He maintains that a therapeutic attitude is difficult to adopt as a universal construct of nursing care when so few nursing theories refer to nursing in this way. The various definitions offered of therapy, in relation to nursing and health, prevents nurses identifying the means of being therapeutic and evaluating how well care is given. McCormack (1992) found similar difficulties when studying nurses' perceptions of care delivery in primary nursing units.

#### *Problems of implementation*

McMahon (1991) identified Muetzel's model as a recent development that describes the nurse-patient relationship as a therapeutic process which relies upon the maturity of the nurse as a person, and as a member of the nursing team, for its success. He acknowledged that there are difficulties in interpretation and implementation of any prescriptive approach to therapeutic nursing. This was compounded by the paucity of research which looks at therapeutic actions in general nursing practice. McMahon advocated consideration of the bias in research which reports on the practice of therapeutic nursing in specialised areas of nursing, particularly independent practice, as this compartmentalisation of the concept reduces its generalisability. Reluctance to place reliance upon the relationship as a practice mode was a complicated matter. Research has demonstrated that the relationship can be harmful to the patient and the nurse. Other factors outside the relationship affect the outcomes for the patient. Nurses and other health care providers recognise that nursing is but one aspect of the patient's total health care. McMahon calls for more research into the components and dynamics of therapeutic relationships between nurse and patient to enable nurses to "know what therapeutic nursing practice really is" (1991,12).

Muetzel (1988) speaks of the difficulties of implementing a model of practice. She acknowledges that friction is imminently possible in the relationship between nurses and patient, as both nurse and patient have different and highly individual philosophies, perceptions of each other's needs and rights, and expectations of health care. The health care environment also places demands and restrictions on the contact between nurse and patient, reducing the opportunity for therapeutic interaction. Muetzel (1988) believed that, despite these disparities, a therapeutic relationship was possible when nurses recognised it as the basis of caring and healing. She also found that such a relationship was easier to achieve in areas of autonomous nursing practice. Muetzel advocated

further research to discover the *nursing* nature of a therapeutic relationship and an appropriate *nursing* definition of the word "therapy", to enable nurses to use this information to achieve better outcomes for their patients and themselves.

Salvage (1992,1990), in her critical examination of therapeutic nursing in professional units, found several factors impeded the adoption of this focus as a practice ideal. Although the duality of the relationship means recognising the importance of the patient's perspective in considering changes in nursing practice, Salvage felt that little consideration had been given to the patient when the approach was conceptualised. Similarly, research-demonstrated inconsistencies between patients' and nurses' perceptions and expectations of relationships, meant that more evidence was needed to support the idea that patients want this kind of relationship with nurses. Salvage recognised that many factors within nursing itself worked against adoption of a more involved relationship with patients. She pointed out that "major changes are needed in occupational socialisation and in the organisation of hospital work if [nurses] are to practise in this way" (1992,21). Salvage highlights the managerial constraints of funding and staffing which act against major change. She acknowledges the 1988 research of Pearson which demonstrated the cost-effectiveness of therapeutic nursing. Salvage believed that if therapeutic nursing can be shown to be beneficial, in terms of better patient care and more satisfied nurses, then management would change to assist its development as nursing praxis. Unfortunately, these "outside" issues impinge upon the acceptance of therapeutic nursing, or nursing as therapy, as a practice ideology.

The Burdekin Report (1993) supports Salvage's argument. In its inquiry into mental health care, the committee looked at psychiatric nurses' relationships with patients and found that very few patients perceived their relationships with nurses to be therapeutic. The report concluded that the internal and external organization of nursing work similarly restricted the formation of therapeutic nurse-patient relationships in the practice of psychiatric nursing. The implications for practice and research are enormous. As this area of nursing holds the therapeutic relationship central to its practice ethic, and patients self-reporting denies this, re-examination of the relationship between nurse and patient for its therapeutic value is apropos.

Nursing does not appear to recognise itself as a stand alone therapy (Muetzel, 1988). In Australia, this is highlighted by the small numbers of independent practitioners and the multitude of legal constraints which prevent nurses from participating in private practice enjoyed by so many other health and allied health professionals. The word "therapy" and "therapeutics" have been linked with nursing theory, but in the practice of nursing appear to be more loosely appreciated as a facet of nursing care. Speculated reasons for this are: reluctance of practising nurses to accept the terminology; a blinding assumption that nursing is therapeutic and there is no need to state the obvious; submersion of nursing's particular therapeutic role by the multi-faceted nature of health care; and the effects of structural organization which renders nursing care invisible in financial costings of health care. Each of these factors acts to reduce and maintain nursing's subordinate

status and lack of recognition as a therapy. Whether or not the concept of nursing as therapy will, or can be, adopted as a universal nursing practice ideology, remains a moot point.

### **Nurses as Healers**

The notion of nurses as healers is gaining acceptance in nursing literature. Pearson (1988) cited Capra as stating in 1982 that "the important role that nurses play in the healing process through their human contact with patients is not fully realised" by nurses themselves, although this deficiency may be overcome by adopting an holistic dogma which reinforces the therapeutic nature of the relationship. Pearson, however, believed that nurses were aware of their healing powers and that the theoretical writings of Lydia Hall and Carl Rogers had directed nurses toward healing practices. The central focus of this healing was the nurse-patient relationship and the qualities of self that influenced the nurse's therapeutic practice. Oliver (1990) found that, although there was no common theoretical definition available for reference, nurses could adequately define the process of healing and identify themselves as healers. It would appear that, in this decade, at least, some progress had been made toward adopting a healing focus in nursing philosophy.

McCabe et al (1995) found the processes of healing, therapeutics and holism synonymous. Moreover, therapeutic actions aimed at improving the "whole" (physical and psychological) health of the patient were healing. However, acceptance of the process required some higher order thinking by nurses to acquire an acute awareness of self and its power in relationships with patients. These authors believed that nursing strategies were increasingly moving into the practice of therapeutics, but lacked the substantive theoretical knowledge necessary to support these actions as healing modalities.

### **Summary**

The nurse-patient relationship is an important construct in nursing theory and practice. In the proliferation of research which looks at the relationship in the context of certain components which enhance good practice and quality of care, there is no accord of description. The philosophical dissection of the relationship into its effective concepts has formed the basis of much intellectual contemplation. Stein-Parbury (1993) maintains that the relationship covers aspects of helping, counseling and psychotherapy, but as yet no single description has been developed that conveys all that the relationship means and encompasses for both patient and nurse. The debate continues about the relationship's components, the importance of one over the other, the complementary or contradictory natures of these elements and the manner in which these components work toward achieving quality outcomes for the patient. Few research studies have demonstrated that it is legitimate for nurses to derive benefits from the relationship. The relationship needs to be accurately portrayed for what it is and means for patients *and* nurses. The continuing search for nomenclature which aptly describes the relationship for nurses, nursing and patients mirrors the controversy surrounding the significance of the relationship within nursing.

The relationship between nurse and patient is an integral part of nursing, but it essentially remains a mystery. Theoretical descriptions do little to clarify its position for nursing and nurses. Many nursing theories cite the relationship as being beneficial for patients, but fail to acknowledge the nurse component of the relationship in the same manner. The notion of nursing as therapy has been slowly assimilated into nursing practice. Relationships between nurses and patients can be mutually beneficial, therapeutic and healing, but the qualities and operative demeanor of these relationships are often obscure. Practitioners "used to relying on precedent, commonsense and previous experience will continue to do so" (Barratt,1990,23), perhaps to the detriment of patient care, unless research informs practice and policy.



## CHAPTER THREE: THEORETICAL FRAMEWORKS

Underpinning this study are several theoretical positions and the research findings of many nursing studies. In the initial component of the study, the framework for investigation was provided through, and by, the writings of nurse theorist Joyce Travelbee (1966,1971), the phenomenological methods espoused by Colaizzi (1978) and the anecdotes of nurses who had been patients. The second part of the study built upon the first. Its development was assisted by the theory of Hildegard Peplau (1952,1965), the phenomenological stance of Max van Manen (1990,1995), the method of concept synthesis advocated by Walker & Avant (1988), and the studies of Pearson (1988,1991), Muetzel (1988), Morse (1991,1992), Taylor (1991,1994), Ersser (1991), Morrison (1992), Christensen (1993), Brammer (1988) and, serendipitously, a chance discovery of the Burdekin Report's examination of the relationship between nurse and patient in the context of Mental Health Care (1993). These collective works influenced and supported the research direction, and substantiated the search for a relational ethic which encompassed the therapeutic nature of the relationship between nurse and patient.

### **Theoretical Persuasions**

#### **JOYCE TRAVELBEE**

The nursing theory of Travelbee (1966,1971) provided the initial framework for the study. This theory emphasised the relationship between nurse and patient as a therapeutic, mutual and sharing union. Using the traditional literary presentation of theoretical definition, schematic model and discussion of the relevance for nurses and nursing, this theory illustrated the nature of the relationship between nurse and patient by recognising the importance of both nurse and patient to the relationship. Its portrayal of relationship formation as a series of steps culminating in rapport between nurse and patient, gave clear directions for achieving this outcome by direct and indirect methods, and emphasised the importance of meaning for the patient.

In 1966, Joyce Travelbee first developed a theory of nursing which described a therapeutic, interactive nurse-patient relationship (1966). Travelbee later revised and renamed this association, "The Human to Human Relationship" (Travelbee, 1971; Marriner, 1986). Nurses and patients were described as human beings. A relationship developed between nurse and patient through involvement based on recognition and appreciation of the humanness of each. Through a series of stages wherein roles were transcended, a therapeutic relationship of rapport was reached. This was the essence of nursing (Meleis, 1985). Travelbee believed that this relationship, in which nurse and patient perceived, communicated and shared all thoughts, feelings and attitudes about the patient's experience, enabled the patient to find the meaning of illness.

Travelbee's theory stressed the importance of finding meaning in experience (1971; 1966). The theory's constructs mirror those of phenomenology. For Travelbee, finding and sharing meanings is facilitated by two methods. One is indirect, involving the use of narratives, analogies, veiled

approaches or personal experience. The other is direct with a basis of questions and clarifications, utilizing open-ended questions, reflection and sharing of perceptions of the experience. Travelbee advocated that either or both of these two methods expedited culmination of the relationship in a pinnacle of rapport. A therapeutic outcome for the patient was assured when both nurse and patient were able to discover and share the meaning of the experience. Travelbee believed that constructive and purposeful use of nurses' personal experiences with illness assisted patients to accept the "humanness" of their own situation (1971).

Travelbee's theory gave the researcher hope that the relationship between nurse and patient could be more than just a work ethic. Examination of the theory provoked questions about its appropriateness in practice and the effects of other personal, social and professional factors in the development of a relationship between nurse and patient. Knowledge, gleaned from literature and fueled by personal experience and observation, presented evidence of relationships contrary to the picture painted by Travelbee. This pondering led to an intense interest in the reality of relationships between nurses and patients, and in particular, to that experienced by nurses who were patients.

### **PAUL COLAIZZI**

From the many theories and forms of phenomenological inquiry, Colaizzi's interpretation (1978) became the theoretical framework for the direction of the study. His directives for data collection and analysis provided another formal process of investigation, and a means of validating the findings. Travelbee's methods of forming a relationship complement those of the phenomenological inquiry process advocated by Colaizzi (1978). Together these two processes directed the collection of data by in-depth interviews. Colaizzi's steps for analyzing data lent further direction, addressed the issues of validity, and gave the study purpose. The method was based upon isolation of themes and meanings from the data, a process which complemented Travelbee's theory. Participants in the research were also utilized as validators of the researcher's interpretations. The purpose was clearly directed toward obtaining a thorough description of the phenomenon under investigation, and identify and organize its fundamental composition for understanding by others.

### **Anecdotal Evidence**

The anecdotal tales of nurses who had been patients (Fazey, 1985; Orr, 1985; Sherrard, 1988; Samerel, 1990; Carlisle, 1992; Sutton, 1992; Grimster, 1993; and Hodgkinson, 1993) and the research findings of Shetlar (1990) and Cotter (1991) supported the contention that relationships between nurses as patients and nurses as caregivers vary in nature. They identified some of the issues, albeit often based upon the subjective opinions of nurses and patients. The truth of these opinions was borne out by the volume of, and similarities between, the narratives of nurses who had been patients. There were also analogous narratives from patients who were not nurses. With due consideration to these stories and their portrayals of nursing, the word 'care' was something which began to disappear from connection with nursing delivered to patients, be they nurses or non-nurses. "The words care, caring and cared ... basically all mean: to have interest in; to be concerned for; to

provide for; or to look after self/others .... [and] For the nurse, 'others' refers not only to clients, but also fellow practitioners..." (Angell & Duffy, 1991, 105). The appropriateness of the word 'care' in any context as a descriptor for nursing appeared questionable. This provoked an intense desire to know why nurses as patients had such difficulty achieving satisfactory relationships with nurses as caregivers, and why patients in general appeared to have such poor relational experiences of nursing.

### **Theoretical Confirmations**

The relationship between nurse and patient was the catalyst for, and focus of, the research. The findings followed from the process of gleaning a picture of the experience of being a nursepatient and isolating its descriptive themes and meanings. But from this data, there emerged another contradictory picture of the relationship between nurse and patient which was labeled "a therapeutic nursing relationship". This concept could be operationally defined and described in terms of its essential elements. However, its perspective was narrow, having been formed from perceptions of nurses who had been patients. It begged extension through a theoretical definition and needed confirmation of its constituents by examination of the perceptions of practicing nurses, and their patients, with the support of an appropriate conceptual framework.

### **HILDEGARD PEPLAU**

The therapeutic aspect of the professional relationship between nurse and patient is recognised and supported by the theory of Hildegard Peplau (1952,1965). Peplau had also successively transposed her theory into a simple model with clear directives and directions to assist its articulation to practising nurses. In both modes, she placed emphasis upon the therapeutic role of the nurse and the importance of the nurse as change agent. However, the focal point of this therapeutic relationship was the "mind" care of the patient. As such, Peplau's theory did not completely address the needs of patients who required mind *and* body care. It specifically met the needs of psychiatric nurses for practice direction, but needed adjustment and interpretation to meet the needs of general nurse practitioners.

Hildegard Peplau maintained that the relationship between nurse and patient was the crux of psychiatric nursing care. Her "Interpersonal Relations" theory was first published in 1952 (George, 1985). The theory described a relationship which was essentially one of nursing response to human need, with the effects being a change in the diagnosed problems of the client. In 1965, Peplau argued that "the interpersonal relationship between the nurse and the client is the core of nursing" (Oermann, 1991).

Central to Peplau's beliefs was that the nurse-patient relationship determined whether or not the patient's experience of illness was positive (Fowler, 1994). The nurse was perceived as a thinking practitioner who cognitively evaluated, diagnosed and reacted to specific situations to effect behavioural changes in the patient. Peplau believed that the nurse shaped and controlled the

therapeutic intent of the relationship to effect beneficial outcomes for the patient (O'Toole & Welt, 1989). Peplau considered the relationship to be unequal, because the nurse, as a professional, "is the keeper of the purpose of the relationship which is to produce whatever improvements in health status possible for the client by suggesting paths toward that end" (O'Toole & Welt, 1989,57).

Peplau described a model for the development of a therapeutic relationship in practice. It was a series of overlapping phases: orientation, working (identification and exploitation) and resolution or termination which were directed toward solutions (George, 1985). Nurse and patient progress through, and may return to, these stages in the course of their interactions as provider and consumer of nursing care. These stages direct nursing practice in its "corrective work [which] occurs within the nurse-patient relationship" (O'Toole & Welt, 1989,193). The purpose of the relationship was clearly satisfactory outcomes for the patient.

Peplau acknowledged that each successful therapeutic "encounter influences the nurse's personal and professional development" and that "the kind of person the nurse becomes has a direct influence on the therapeutic, interpersonal encounter" (George, 1990, 75). The relationship was firmly rooted in the professional-patient mode. Peplau believed that the relationship was not an opportunity for social interaction. The process for the nurse was purely mechanical. She cautioned nurses about revealing personal information in their conversations with patients as "patients do not need and most often cannot wisely use personal data about the nurse" (O'Toole & Welt, 1989,197). This conflicts somewhat with Travelbee's perceptions of a nurse and patient relationship, but Peplau's contrary views added a cautionary note to complacent interpretation of the terms pertinent to the current study.

Peplau's theory has a strong orientation toward a professional relationship and the need for the nurse to remain objective in order to make effective decisions regarding patient care. This focus upon the professional nature of the relationship between nurse and patient, offered an alternative, but complementary, view to the theoretical framework of the study. Travelbee advocated closeness and sharing in the relationship, while Peplau urged professional distance. Pondering over these differences raised questions about the impact of professional conduct and its relevance in the development of a truly therapeutic relationship. It would appear that it could have an inhibitory or enhancing effect according to the perception of the nurse and the patient. As such, the theories of both Travelbee and Peplau provided a literary "brake", or precautionary note, to the research and a reminder that context and intent are important considerations when observing the relationship in practice.

## **VAN MANEN**

The phenomenological method of Colaizzi had afforded a description of the relational experiences of nurses who had been patients. Another methodology needed to be employed if the study was to move toward nurses and their patients. The works of Max van Manen (1984, 1989a, 1989b, 1990,

1991, 1995) provided the necessary direction, and support, for continuance (Munhall,1994). His emphasis upon the importance of the researcher thinking through and writing about the research (1990,1995) amalgamated the somewhat separate foci of this research. For van Manen, conceptual clarity, contextual reality and honest representation is achieved by adhering to the truths given by the participants (1989b,1990,1991), and writing "it as it is" (1984,1989b). The latter is essential in order to evoke reader response, cultivate awareness and understanding, and, ultimately, change practice. Van Manen recognised the importance of writing as a reflective tool which helps the researcher collect thoughts, review evidence and present findings (1995). These maxims became *a priori* assumptions in this next stage, guiding the process and maintaining the perspective of the researcher toward faithful reporting of each participant's story.

Van Manen is an exponent of phenomenology. He believes that the "deeper goal" (1990,62-3) of phenomenological research is orientated toward discovering the nature of a phenomenon as an essentially human experience. His method of phenomenological inquiry recognises the legitimacy of narrative as a means of understanding and knowing about the world in which we live. Looking at a particular phenomenon, through the stories of those people who have experienced it, exposes the full nature of that phenomenon, uncovers the deeper meanings of the experience for its participants, and compels outsiders to think about the impact of such an event upon themselves, and the world. Retelling these experiences allows humans to share the moment, experience the momentum, feel the emotions and appreciate the significance of the phenomenon for the participants and themselves. Vicarious learning occurs through hindsight portended by insightful awareness of the event and its impact upon human lives.

Van Manen's phenomenological perspective assures that writing about the research adds to the process of discovery (1984,1989a). Writing encourages reflection and action in both the writer and the reader. According to van Manen (1990,127-9) the writing up of research represents a paradox in learning for the researcher, for

"Writing separates us from what we know and yet it unites us more closely with what we know. Writing distances us from the lifeworld, yet it also draws us more closely to the lifeworld. Writing decontextualises thought from practice and yet it returns thought to praxis. Writing abstracts our experience of the world, yet it also concretizes our understanding of the world. Writing objectifies thought into print and yet it subjectifies our understanding of something that truly engages us".

For van Manen, writing serves two purposes, it articulates the nature of the phenomenon to others and engages the writer in the art of portraying that phenomenon accurately for interpretation by others (1984, 1989a, 1989b, 1990, 1995). "Writing fixes thought on paper" (van Manen, 1990,125), encourages reflection around what is known, and raises questions about this knowing. Writing conveys meaning by capturing the quality of the moment and the significance of it for those involved. Writing collates meaning and experience, facilitates an appreciation of the enormity of human experience through which people grow and learn, and informs those of lesser experience.

Writing is the beginning of the journey for the writer who, by reflection and critical examination of the content and context of the written words, searches for deeper understanding, accuracy and truth. The picture given by an accurate portrayal of a phenomenon, evokes, in the reader, a similar voyage which questions this new knowledge and places it alongside, or within, what is already known. In this mode, writers and readers gain insight and awareness of a phenomenon of a human experience about which, prior to this exposure, their knowledge was limited. In the context of this study, writing empirically demonstrates the human experience of being in relationship with another in a nursing context and conveys what has been seen to those who have yet to, or cannot, see it in practice.

Van Manen advocates the credibility of exploring and writing about "heartstrings-tugging", or subjective, components of human experience, because it mirrors the real world (1989b,1990). In the world constructed by human beings, subjective (what one feels) and objective (what one sees or reads) components of phenomena are married to understanding and relevance. Events that involve human beings are construed by our subjective involvement in, and objective observation of, what is occurring. The world is thus constructed by the subjective and objective components of the human mind. Subjective and objective enmesh in the human being. Both are important components of knowing and learning about the world in which we live as human beings (van Manen,1990). Nurses cannot divorce the subjective and objective components of a patient's world, as both are vital to his or her understanding of an experience of nursing care.

With an education background and a desire to effect "better" teaching methods and student learning, van Manen developed his theories of pedagogical competence, tactfulness and carefully edified thoughtfulness from phenomenological studies of the experiences of children as pupils (1991). He felt that if teachers had an understanding of the world of children as students, albeit vicariously gleaned from compelling descriptions of their experiences as pupils, then teaching and learning would be enhanced. He advocated that teachers practice from a life perspective which encompasses an internal vision of what it is like to be a student experiencing being taught, and an appreciation that student learning takes place in the context of emotional involvement and external (to teaching and learning) events. Similarly nurses, who can adopt this method of viewing nursing care from the perspective of the patient, may practise "better" nursing.

Van Manen's philosophy of phenomenology (1990) made visible the ultimate goal of this research: elucidating a therapeutic nursing relationship. His writings (1990,1991,1995) determined and supported the plausibility of articulating a phenomenological study, traditionally designed to elicit a description, into a theory-generating process. There are endless possibilities for phenomenological inquiry for "phenomenology asks for the very nature of the phenomenon, for that which makes a something what it *is* - and without which it could not be what it is" (van Manen, 1990, 10). Van Manen's enthusiasm for phenomenological inquiry, and recognition of the value of looking at the world from this perspective, provided motivation and inspiration in the search for evidence to support the reality of the concept of a therapeutic nursing relationship.

## **WALKER AND AVANT**

It was felt that the research also needed a firm "nursing" direction for the further collection and analysis of data. The concept of a therapeutic nursing relationship was in its infant stages. A search for clarification of conceptualisation processes alighted upon the works of Walker and Avant (1988) who describe various methods of concept development. Their process of "concept synthesis" provided the best match for development of the concept by complementing all of the foregoing theoretical positions - Travelbee, Peplau, Colaizzi and van Manen. This similarity was extended in the emphasis upon exhaustive data collection, together with continuous and concurrent literature reviews, to gain a complete understanding of the concept, its elements and its relevance to current knowledge on the topic.

### **Study Implications**

An amalgam of the theoretical stances saw the research centred upon examining and comparing nurse and patient perceptions of the operative characteristics of a therapeutic nursing relationship. This was necessary to facilitate a cognitive move from general, individual descriptions to a specific, composite view. Questions asked of the researcher, the participants and the data were couched in terms of: 'What is a therapeutic nursing relationship?', 'What it is like to be part of such a relationship?', and 'Is this what it means for nurses and patients and nursing as a whole?'. This was complemented by an intense desire to see if the concept was indeed a practical reality, uncover the circumstances in which it occurred, expose its relations and associations, refine its meaning and illustrate its relevance to nurses, patients and nursing. The focus of the research now moved from understanding individual experiences in a need to know what makes this phenomenon, a phenomenon (Crotty, 1996), toward discovering that which makes a therapeutic nursing relationship, a therapeutic nursing relationship.

## **RESEARCH STUDIES OF THERAPEUTIC RELATIONSHIPS**

In keeping with an exploratory phenomenological study, all types of data need to be examined to place the concept of a therapeutic nursing relationship in the context of current knowledge. Support for the relevance of the concept comes primarily from other studies conducted by nurse researchers who have examined the relationship's importance to nursing practice. Studies which look at the components of a relationship between nurse and patient were more difficult to locate. Some have principally identified one particular component, or concentrated upon specific aspects of nursing in connection with the relationship. These studies look at different ways of approaching the relationship and the importance of different elements in ensuring a beneficial outcome for the patient. Missimer (1990) argues that balanced truth-finding requires "a willingness always to entertain counter-arguments, even in positions on which a near certainty is felt". A composite picture of the relationship would be remiss without examination of these views.

A synopsis of the research studies makes possible their connection to the current project. They represent contemporary views of the relationship between nurse and patient. These studies also embrace similar and different nomenclature for that relationship. They present theoretical descriptions and give directions for practical application in line with past theories and models of nursing. The medley of description persists, and its necessity is attributed to the individuality of nurse and patient. Miscellany perpetuates diversity of practice and the wide nursing practice repertoire in which the patient remains a confused participant. The true nature of the relationship between nurse and patient remains obscure while theories lack conceptual unity.

### **Pearson, Morse and Christensen: Therapeutic Partnership**

The studies of Pearson (1988,1991) and Morse (1991,1992) confirm the international acceptance of the concept of a *therapeutic* nursing relationship, and the difficulties inherent in, and external to, the establishment of such a relationship between nurse and patient. Christensen's idea of nursing partnership (1993) provides a valuable, but complementary vision of the relationship between nurse and patient. The cultural mix of these perspectives - the authors being English, Canadian and New Zealander respectively - offer differences and similarities that supplement nursing knowledge in Australia.

Pearson confirmed the therapeutic role of the nurse. His studies (1988,1991) maintained the image of a nurse as a therapist and therapeutic agent. Pearson's championing of primary nursing led to the establishment of professorial units in various hospitals in Great Britain and Australia where nursing was regarded as the primary intervention. The nurse was recognised as a therapist and the therapeutic nature of the nurse-patient relationship emphasised. Pearson's findings indicate that both nurses and patients were positively influenced by this type of approach to nursing care. However, the many bureaucratic and professional challenges to this "new way of nursing" threatened the longevity of the units and their therapeutic focus (Salvage, 1991). These external factors rendered the approach, and hence the therapeutic relationship at its root, problematic.

The place of the word 'therapeutic' as a suitable descriptor of a relationship between nurse and patient was reinforced by Morse (1991-2). However, Morse saw the ideal relationship between nurse and patient as being more than just therapeutic. Morse envisaged the relationship as a typology of four phases: clinical, therapeutic, connected and over-involved. Each phase had certain defining characteristics which distinguished one from the other. A therapeutic nursing relationship was depicted as a professional to patient relationship, wherein nurses were committed to meeting the nursing needs of patients, but tended to ignore their needs as people. The "connected relationship" was Morse's conceptualisation of the ultimate nursing relationship. In this relationship, patients' concerns were of primary importance and each patient was seen firstly, as a person, and thereafter, as a patient. Morse's definition and descriptions of this connected relationship are questionably mirror images of the therapeutic relationship described by Pearson and McMahon (1991). For this latter relationship to be therapeutic for the patient, patient and nurse are connected to each other as



people. Morse acknowledged that a connected relationship develops through, and because, of the first two stages described in her study, that is, clinical and therapeutic relationships. She conceded that the relationship between nurse and patient was a complex phenomenon. Morse recognised the need for "future research ... [to] ... explore the nature of the developing nurse-patient relationship" (1992,255).

Christensen's 1993 theory of a relationship based on partnership between nurse and patient built upon the works of both Pearson and Morse. Her description of this relationship was developed from examination of the real experiences of patients and nurses. Its recognition of partnership as a valid type of relationship between nurse and patient added a different perspective to the argument. It also opened up the possibilities for admittance to nursing's theoretical base of other perspectives of the relationship derived from real life, primarily, a therapeutic nursing relationship.

Christensen recognised the work of both nurse and patient in developing a partnership. She saw the relationship as a two way process wherein certain activities and actions lead to the formation of a working partnership between nurse and patient. Partnership concepts are illustrated by activities and defined by actions. The process is goal-directed toward partnership. Nurses are directed by activities and actions which revolve around the elements of partnership, that is, things the nurse must do to effect a partnership with a patient. These were illustrated in tables, wherein elements of a concept of partnership are linked with set actions and activities performed by the nurse. In reducing the relationship to this work orientation, Christensen's approach becomes prescriptive in its attempt to relate or 'fit' theory directly to practice. With the major emphasis based upon nurses' work, that is, physical activity, the theory neglects the psychological concerns in the relationship and ignores the cognitive functions of relationship formation.

### **Muetzel, Brammer and Ersser - therapeutic reductionism and mutuality**

The notion that the relationship between nurse and patient has distinct elements was supported by the studies of Muetzel (1991) and Ersser (1991). These two studies looked at the relationship with the intent of isolating its constituents and establishing their connection to a therapeutic encounter and outcome. Muetzel compressed her findings into three broad concepts. Her findings about the mutual nature of the relationship have been supported by the writings of Brammer (1988). They both recognise that nurse and patient can benefit from the relationship. Ersser compared therapeutic and non-therapeutic relationships to obtain descriptions of each and provoke reader awareness of nursing practices. These three works legitimised the focus of this study upon identifying relational elements and its comparison of relationships to assist information sifting.

Muetzel developed a model of a therapeutic relationship which graphically demonstrated the connection of intimacy, partnership and reciprocity to the encounter between nurse and patient. Several concepts were subsumed under these headings and the complexity of definition may have precluded use of her model in practice. However, she did recognise the soundness of both nurse

and patient benefiting from their encounter, which she believed occurred through increased self-awareness and healing in each party. This position is supported by the ethic of the "helping" relationship (Brammer, 1988) which recognises that the helping process, aligned to the intent of nursing, benefits the helper. Brammer (1988,20) says that helping improves the self-esteem, awareness and health of the helper and perpetuates the cycle of helping others. These two theoretical positions acknowledge the bi-partisan construction and mutually beneficial intent of the relationship between nurse and patient. They added support for the operational definition and nature of the concept of a therapeutic nursing relationship developed by this study.

Ersser's ethnographic study defined the term "therapeutic" as beneficial. Through contrasting therapeutic and non-therapeutic encounters between nurse and patient, Ersser isolated the elements of a therapeutic nursing encounter. The findings of Ersser confirmed the soundness of phenomenological methodologies and comparative analytical stances in identifying the constituents of a beneficial, therapeutic relationship, as experienced in the real world of nursing patients. His study addresses the cognitive functions necessary to develop such a relationship. Reliance upon higher order thinking for acceptance of his theory as a practical reality, may render Ersser's interpretation perceptually esoteric and somewhat harder to transcribe into practice. However, Ersser's definitions and findings provided support, and supportive evidence, for ongoing studies into the therapeutic nature of the relationship between nurse and patient as found in the real world.

### **Morrison and Taylor - caring and humanness**

The studies of Morrison (1992) and Taylor (1991, 1994) looked at particular aspects of the relationship between nurse and patient. They both employed phenomenology as method and philosophy. The findings centre upon broad ranging concepts easily identified with nursing, primarily: caring, communicating, humanness and ordinariness. Under the umbrella of these concepts, lay distinct nursing activities and functions designed to achieve successful conceptual implementation. This orientation is toward ways of doing enveloped in ways of knowing focused upon everyday nursing functions. This prescriptive style addressed the needs of nurses and nursing to be seen as doers, rather than thinkers, albeit in a caring, communicating, and ordinary human way. The emphasis upon doing, rather than thinking, may also be easily assimilated into practice in which actions, rather than thoughts and thinking, are rewarded. Actions can be done and seen to be done. Thinking requires more subtle forms of assessment. This paradox of concentration with the occupational perceptions of quality care, that is, the doing eclipsing the thinking in nursing practice, continues in current studies.

Morrison (1992) looked at the nurse-patient relationship and its connection to nursing care. He developed a theory of an *interpersonal* relationship between nurse and patient which revolved around the concepts of caring and communicating. For Morrison, caring and communicating were essential components of nursing and the most important facets of the relationship between nurse and patient. Without caring communication, and communication of caring, the relationship between

nurse and patient could not be seen to be nursing. Morrison, through further research and writings, has been able to develop these concepts into learning tools for practice.

Taylor (1991), in one of her earlier studies, investigated the image of the nurse as espoused in nursing literature. She found that the patient was described in terms aligned with human traits and humanity, while descriptions of nurses neglected to address the same human qualities in the nurse. This, she felt, inhibited an effective relationship, the development of which, relied upon the nurse being seen as human. Her complete study, published in 1994, saw her advocate ordinariness and humanness as the exquisite components of a sound relationship between nurse and patient. Taylor concluded that the ordinary, everyday activities of nursing and nursing interaction made the nurse more conceptually "human" to the patient and effected the ultimate relationship.

Taylor's studies, in their recognition of the worth of the ordinary activities in nursing, gave the profession a much needed morale boost. Nursing is searching for descriptions that distinguish its role from that of other health professions. Taylor's study validated the worth of nursing in its simplest form - what nurses do. In Taylor's eyes, patients appreciate the little things that nurses do for them, and applaud the ordinary things that nurses are capable of performing during patient care. Her all embracing concepts do not describe essential elements, but rather allude to ways of delivering patient care to effect positive patient well-being. These actions do involve a conscious effort by nurses to be human in their actions toward patients. Taylor's directives do not require higher-order thinking or superhuman effort and as such, are much closer to the groundwork of nursing practice.

### **The Burdekin Report**

A chance finding of the Burdekin Report (1993) highlighted some of the difficulties of establishing a therapeutic relationship with patients. This government inquiry into the care of the mentally ill focused upon the perceptions of professionals, carers, patients, and their families gleaned from interviews, forums and open meetings. It devoted a small section to the study of the relationship between nurse and patient in psychiatric care settings. There was an assumption that, in this area of nursing practice, practitioners had a common understanding of the workings of a therapeutic relationship, that is, what it consists of and how to effect this relationship with a patient. The Burdekin investigation dashed this ideal. The findings were damning for this area of nursing practice in which the therapeutic nature of the relationship is advocated, supported, and supposedly, practised.

The Burdekin report found that in most instances cited, the relationship between nurse and patient was of poor therapeutic quality and often neglectful of the patient's needs. The therapeutic relationship could be abused when practitioners are ignorant of its essential components. The report did, however, recognise the effects of external influences, such as educational changes, environment, economics and reducing staff numbers, upon the development of a therapeutic relationship with patients whose needs are complex. This report served as a reminder that other

factors external to the nurse, the patient and the relationship can effect the development of a therapeutic nursing relationship.

### **Significance for the Study**

From these fragmentations of theory, experience, observations and insights, was gathered an integrated picture of current nursing interpretations of the relationship between nurse and patient. General consensus on the structure and content of the relationship appeared hard to achieve. Theoretical conceptualisations, perceptions and definitions were varied in nursing literature. Presentation of findings introduced further diversity. Some authors had utilised graphic models to represent and reinforce their descriptions of the relationship. As such, the models provided structural and relational clarity of discovered elements. Others illustrated concepts with data. Both approaches paint a picture of the relationship which could be communicated to nurses. This format conforms with the approaches for presentation of data as modeled by Travelbee and Peplau, while allowing the rich description professed by Colaizzi and van Manen.

The examination of the relevant literature revealed the current trends in presentation of findings, which allowed decisions to be made about data treatment and display of results. The elements of a therapeutic nursing relationship were to be illustrated by data excerpts from nursepatients, nurses and patients. Data excerpts would be referenced using a sequence of interviewee initials, an interview number only if the source was not the first contact, and the relevant transcript page number/s in which the quoted passage occurred. The theoretical description of the concept would expand and explain the relational connection of its constituent elements. This would be supplemented through construction of a visual graphic model which would ease its articulation, foster perceptual understanding and enhance cognitive assimilation of the concept by nurses and other readers. These approaches would clarify the place of the concept of a therapeutic nursing relationship in relation to quality nursing care, both in theory and practice.

This direction cemented the intent of this research by ensuring a constant and systematic approach to data collection and treatment. The selected processes complemented the progress of the research. The journey began through curiosity about differences in practice and a desire to know what was happening in certain circumstances, that is, when a nurse is a patient, and progressed into the practice arena to see, through the eyes of practising nurses and their patients, the relationship 'at work'. Phenomenology lent direction and purpose, a means of answering the questions raised by observation, and extradition of a full description. The understanding gained of these lived experiences would lead to the formation and confirmation of a concept which captures the "goodness of examples" (van Manen, 1991, 218) in nursing relationships, namely a therapeutic nursing relationship, and exposure of its essential elements as perceived by nursepatients, nurses and patients. The true nature of this "new" phenomenon could thus be exposed for communication to, and examination by, nurses.

## CHAPTER FOUR: THE METHOD

The focus of examining the relationship between nurse and patient in two stages was the development of a descriptive, explanatory theory which could be articulated back into practice and ultimately, improve the quality of care afforded patients and nurses through their relational contact. This involved recognition of the relationship between nurse and patient as a complex human phenomenon of subjective and objective components, the need for accurate description of this relationship for facilitation and change of practice, and the relationship's relevance to nursing care and outcomes for both nurse and patient. This complexity demanded an eclectic approach to data collection and treatment, as "no one method ... can ever completely reveal all the relevant features of empirical reality necessary for testing or developing a theory" (Denzin, 1989, 25-6). The two stage structure of this research saw a conglomeration of methods culminate in the revelation of a practice concept, an explanatory model and a descriptive theory.

The method embraced a conglomeration of triads. Information was gathered from three perspectives, by three means, in three settings for collection and collation of a comprehensive picture of the relationship between nurse and patient. Narratives from nursepatients, nurses and patients were supplemented by information, observations and reflections recorded in the researcher's journal, and concurrent literature reviews. Analysis of data employed the methods of phenomenological analysis and concept synthesis coupled with content analysis, constant comparison and contextual analysis to incorporate and dissect all facets of reality depicted by the data. This diverse approach resulted from the multi-dimensionality of the theoretical background, the broad framework of the study and the researcher's need to completely understand the phenomenon under examination through a rigorous examination of the breadth and depth of its being in the world of nursing.

The process was one of "crystallisation", or viewing the world from a variety of angles (Richardson, 1994). Richardson claims that this way of looking at phenomena "provides us with a deepened, complex, thoroughly partial, understanding of the topic" yet paradoxically causes us to doubt what we know (1994,522-3). This 'doubt' saw the incorporation of several means of validating the findings, including participant validation of the researcher's interpretations, an open forum for discussion of the findings, and continuous evaluation and re-evaluation of the findings through reflective writing. Simultaneously, all conclusions and interpretations were critically examined in the context of the available literature about the relationship between nurse and patient. The end result was a "bricolage, a complex, dense, reflexive, collage-like creation that represents the researcher's images, understandings and interpretations of the world or the phenomenon under analysis" (Denzin & Lincoln, 1994, 3).

## **Beginnings**

A combination of phenomenological inquiry described by Colaizzi (1978), framed by the distinct nursing theory of Travelbee (1971), initially directed the study toward a description of the relationships between nurses who have been patients and their caregivers. Unstructured interviews with nursepatients, about their experiences as patients, were tape-recorded. Supplementary data about the participants, information not divulged during interview and the researcher's feelings post-interview were recorded in the researcher's journal immediately following each interview. Application of Colaizzi's analytical steps (Appendix I) saw the development of themes and meanings which described these experiences. These were collated into a comprehensive description of the types of relationships experienced by nursepatients. Constant comparison of different relationships elicited their distinguishing features, and saw the evolution of the concept of a mutually beneficial relationship between nurse and patient, that is, a therapeutic nursing relationship. Content analysis isolated the essential elements of this relationship. Accuracy of interpretation was confirmed by the nursepatients. Although they had experienced this phenomenon of being a patient in relationships with nurses, the concept was limited in its formation, as it reflected only their particular perspectives. Concurrent literature reviews confirmed the complexity of the nurse-patient relationship, the difficulty of describing its attributes, and the futility of prescribing its qualities for practice (Bortoff & Morse, 1994; Ramos, 1992; Wolf, 1986). But these reviews supported the relevance of the elements revealed by data analysis. The concept of a therapeutic nursing relationship was born, but its development demanded further examination and more intensive data collection.

Phenomenological description allows for data collection methodology to be modified (Leddy and MaePepper, 1986) as the analysis proceeds and concepts are uncovered. Concept development moves through phases. Theoretical knowledge of a concept in practice proceeds fieldwork examination of selected cases for empirical validation and culminates in a final analytical stage wherein the concept is exposed in its entirety (Chinn, 1986). The nursepatients had supplied the theoretical framework of the concept. The next step in its development was to determine if this re-conceptualisation of the nurse-patient relationship as a therapeutic nursing relationship existed in clinical practice, that is, between practising nurses and their patients.

## **Extensions**

The method expanded to include the process of concept synthesis described by Walker and Avant (1988). Their stepwise process of concept development through synthesis of all available data bases advanced the research methodically toward conceptual fruition. This extended inquiry was also influenced by the writings of van Manen, as the process demanded reflection by participants and the researcher. It was tempered by the nursing theory of Peplau, as the study focused upon the therapeutic nature of the relationship between nurse and patient. Structured tape-recorded interviews were conducted with nurses and their patients who, together, had experienced therapeutic nursing relationships. Journaling by the researcher was continued as a valuable source of data about the interviews, and means of recording the researcher's responses to information received

(Drew, 1989). Content analysis confirmed the essential elements determined by nursepatients, isolated an additional attribute and further developed the infrastructure of a therapeutic nursing relationship.

Altered methodology perpetuated the what, why and how formulation of inquiry. Content, context and constant comparison analysis of data allowed the burgeoning concept of a therapeutic nursing relationship to be examined in its entirety. Diverse, but complementary, methods generated comprehensive information through examination of the relationship from three different human facets. They directed the study toward meaningful descriptions of personal experiences of therapeutic relationships between nurse and patient, exposed those factors which make a therapeutic nursing relationship, a therapeutic nursing relationship (Crotty, 1996). This eclecticism assisted theoretical description and visualisation through a conceptual model, and the development of a tentative hypothesis which indicates the variables at play in a therapeutic nursing relationship.

### **Eclectic Formulary**

Phenomenology is a research method that recognises human experience and perceptions as valuable sources of information which add to understanding and knowledge of the world (Wilkes,1991; Oiler,1986 & 1982). The method is descriptive, and designed to identify a phenomenon by eliciting descriptions from the people who have experienced the event (Crotty, 1996). It is a way of investigating, examining and capturing in words, a human experience or phenomenon in context with the participants' subjective involvement. "In elucidating some of the features of [a phenomenon] phenomenology helps uncover [its] human meaning" (Kesterbaum, 1982, viii). Nurses and patients are subjectively involved with each other in the phenomenon of a relationship which is developed through its health care focus.

Phenomenological research inquiry enables researchers to engage in a personalised, interactive process with subjects to obtain comprehensive descriptions, and uncover and share the meaning of the experience. It looks to describe the phenomenon through the collection and examination of individual perceptions of human experiences. It is a creative endeavour by researcher and participant to uncover and share the meaning of the experience (Knaak, 1984, 108; Omery, 1983, 50; Davis, 1978). "Phenomenology is the study of essence - what makes something what it is" (Bartjes, 1991). It "prizes differences, variations and struggles for their representation as parts of the whole" (Paterson & Zderad, 1988, 62). A therapeutic nursing relationship is a phenomenon which required examination for its essence and meaning as a human experience within the practice of nursing.

Travelbee's theory of nursing (1966, 1971) recognised the human qualities of nurse and patient. The theory established clear directives for relationship formation which acknowledged the necessity of subjective and objective components in achieving satisfactory outcomes for the patient. For Travelbee, the foundation of a therapeutic relationship lay in finding and sharing the meaning of the

experience of being ill. Meaningful experiences answered the "why" associated with the experience. The concept of a therapeutic nursing relationship has meaning to and for those that have experienced this phenomenon. Examining these meanings exposed answers to the questions surrounding the therapeutic relational involvement of nurse and patient.

Being part of the relationship between nurse and patient is a human experience. The examination of which bares the descriptive values of its participants. Understanding these experiences requires a method of data collection and treatment which validates subjectivity as a way of knowing about the world. Colaizzi (1978) described a method of data collection and treatment which answers the "what" of phenomena, and includes a process of validation and verification of researcher's findings by those who experienced the phenomenon. Descriptive data can be gathered from various sources, including written descriptions, interviews, observation of lived events and imaginative presence (Colaizzi, 1978). Utilising a series of prescribed steps, the researcher was able to arrive at a description of the phenomenon (Munhall, 1994; Knaak, 1984; Omery, 1983) illustrated by themes and meanings.

Using Colaizzi's method, nursepatients, nurses and patients descriptions of nursing relationships were examined for significant statements, clusters of themes identified, meanings formulated, essential structures exposed and a comprehensive description of the phenomenon obtained. All researcher derived interpretations of data are taken back to the study participants for confirmation and evaluation of accuracy. Colaizzi's process lent scientific credibility to this study's collection and analysis of data. Its adoption and adaptation ensured authenticity of description. It provided the researcher with the means of remaining objective within the subjective world of the data, being faithful to the interpretation of the phenomenon by the participants, and achieving an end result - a comprehensive description of the phenomenon.

Concept synthesis (Walker & Avant, 1988) is a creative method of concept development using data based in practice and derived from observation (Appendix II). It allows the researcher to develop a new way of grouping information about a phenomenon by pattern recognition and data comparison. The process is step-wise, with an emphasis on revisiting the steps until an exhaustive data set is collected from all sources connected with a phenomenon. As such, concept synthesis is complementary to phenomenology where "to identify and delineate the essential phenomenon and make sure its description is free of extraneous considerations, the researchers will need to return to their experience many times over" (Crotty, 1996, 175). Analysis is loosely aligned with Grounded Theory (Walker & Avant, 1988) and the outcome is a theory derived from the data. Through application of this process, the concept developed and answers were gathered to complete the "how" component of the concept of a therapeutic nursing relationship.

The process of concept synthesis is central to the development of a theory, particularly that of nursing, a profession still developing new knowledge while trying to maintain its own unique place in



the growing complexity of the health care arena. Concept synthesis is a method of developing concepts by "uncovering phenomena that are embedded in nursing practice and describing and conceptualising where to find these concepts and where not to find them" (Meleis, 1992, 112). The emphasis of concept synthesis upon reaching conceptual cohesion by continuous re-searching of all incidences of a particular concept. Connection of what is seen (or found), to what is known, means adding to existing knowledge of the concept from the participants' esoteric, or private, perceptions of this phenomenon. Thus a full understanding of the concept, its nature and structure, is gained. Concept synthesis goes beyond "the perception and knowledge of the client and provider" to make connections, and reach a level of understanding about the phenomenon, which can be then articulated to others in a meaningful way (Meleis, 1992, 113).

Theoretical recognition of practical concepts is thus empowering for nursing, nurses and patients. The profession's knowledge base grows. Concepts pertaining to, and of pertinence in, nursing are exposed for consideration and possible extension by its practitioners, scholars and researchers. Nurses feel authenticated as nurses and people by the recognition of their ways of knowing about nursing, and nursing care. The process acknowledges the participation of patients in nursing care and confirms the importance of the meanings of their experiences of this care (Chinn, 1986, 1991). A therapeutic nursing relationship was a concept derived from examination of a phenomenon in practice. Concept synthesis enabled the concept to be extended and evolved into a theory for nurses and nursing, and ultimately, patients.

## **ETHICAL CONSIDERATIONS:**

### **Consent**

Written consent was obtained from all participants in this study following a thorough explanation from the researcher. All aspects of the university-approved Informed Consent Form (Appendix III) were read to each participant, who was given time to consider its content and implications before he or she joined the study. Participants were encouraged to ask questions about the project, and the use of any material derived from their contact with the researcher. The right to refuse to participate or divulge information and withdraw from the study or terminate the interview was emphasised as a no-fault decision which could be effected at any time during the course of contact and or interview. Verbal consent to tape-recording of interviews was obtained again prior to every interview. Interviews with nurses and patients in the two hospitals were conducted after verbal and written approval had been granted by hospital management authorities, nursing directors and heads of departments, and their ethics committees. At each visit, the researcher informed the nursing supervisor and manager of the nursing unit of her presence in the hospital. The researcher approached potential nurse and patient interviewees only after consultation with the nursing unit manager. A short explanation of the project and individual participation was given, verbal consent obtained, and a mutual time for interview arranged prior to obtaining written consent.

## **Interviews**

Nursepatients were interviewed in the privacy of their own homes. Nurses were interviewed in the privacy of an interview room. Patients were interviewed at the bedside, at a convenient time, that is, when they were not scheduled for care, were open to interview and could be assured privacy. For those patients in shared rooms, these times varied, and were often dependent upon their roommates having visitors, being engaged in health care activities or leaving the room for treatment. The most preferred time for patients appeared to be during those visiting hours in which they did not expect visitors, as this afforded them company and uninterrupted time to converse with the researcher.

## **PARTICIPANTS**

### *The three groups - selection and composition*

Two methods were used to access participants for this study. Networking and snowballing aggregated the first group of participants. This group of nurses who had been patients could give information about the phenomenon of being a patient in relationships with nurses as caregivers. Theoretical or purposeful sampling of nurses and patients was then undertaken to develop the emerging theory of a therapeutic nursing relationship (Minichiello et al,1995). Sample appropriateness was assured through primary and secondary selection of participants with specific, quality information. All participants were interviewed in depth using the strategies of probing, paraphrasing and direct questions to ensure accuracy of participant perceptions (Minichiello,et al,1995). Each interview was tape-recorded and transcribed verbatim. Each participant completed, and was given a copy of, an informed consent form (Appendix III) covering aspects of rights and responsibilities.

Final sample sizes were determined by data saturation. This was indicated by researcher recognition of repetitive interview-generated information (Morse,1991) from which no new or relevant data was emerging. Preliminary analysis during, and following, each interview assisted this decision by elucidating relational elements, establishing their dimensions, highlighting connections and accounting for variations in definition (Minichiello,et al,1995). Data collection was deemed to be completed when an interviewee began to reiterate information gleaned from previous participants' interviews and further questioning confirmed common interpretations. These pre-selected indicators ensured the collection of a sufficient quantity of relevant data to make sense of the information received from all participants interviewed.

### **Nursepatients**

The criteria for inclusion in this phenomenological study as a nursepatient was that each participant was a nurse who had experienced being a patient, and was willing to talk about that experience with particular emphasis upon personal reflection and critical examination of the types of relationships experienced with nurses as caregivers. The participants had been hospitalised in the immediate past (up to two years prior to interview) for any acute medical or minor surgical procedure involving a

minimum stay of three days. In order to assess the effect of the experience upon individual nursing practices, each participant also had returned to active nursing practice following the period of hospitalisation discussed at interview.

The sampling method was a combination of purposeful and nominated (Morse, 1991). The primary sample of nursepatients began with researcher identification of two colleagues who were good informants (Morse, 1991). They were nurses who had experienced being a patient, could reflect upon this experience, critically examine their responses and reactions, and were willing to share this information in an interview with the researcher. Snowballing added to the sample size, as each participant was asked to refer the researcher to another nursepatient who may be receptive to an interview. This form of nominated sampling relied on participant co-operation, control and selection to access nursepatients who had trust in the researcher and could yield quality information at interview. Six more participants were gained by this method of secondary selection.

Participants were initially contacted by phone, as this was considered a non-confronting, anonymous medium. The researcher introduced herself, explained the reason for contacting the participant, the source of access and the criteria for inclusion in the study. It was explained that the main focus of the research was the participant's experience of hospitalisation and relationships with nurses as caregivers. Participants were told that interviews would be conducted in their homes, be tape-recorded, and take approximately half, to one, hour. Each participant who met the selection criteria was given one week to consider the information before being again contacted, via phone, at a pre-determined mutually convenient time. Following confirmation of participation, days and times for interview were negotiated between each participant and the researcher.

The eight female Registered Nurses in the study met the selection criteria. The minimum length of stay in hospital was three days, with the maximum, for a particular participant being three weeks. All nursepatients had resumed practice following this period of hospitalisation. Participants ages ranged from 29-54 years. They were hospital-trained nurses. Six were also midwives, five of whom had undertaken a course in tertiary education in the past five years. Three had been nursing for thirty years, others had nine or more years of nursing practice. Participants' past practice arenas were a mix of rural and metropolitan health care facilities and present employment was based in rural public and private hospitals and educational institutes. Six of these nurses held current positions either in nursing management, education or clinical nursing. Two had left the profession after the interviewed time of hospitalisation, due to subsequent ongoing illness or injury. Each participant was articulate and willing to talk about the experience of being a patient, thus meeting the criteria for inclusion in a phenomenological research sample (Knaak, 1984).

### **Registered Nurses**

Registered Nurses formed the second group of participants. This was a purposive sample designed to facilitate the development of the concept of a therapeutic nursing relationship which had emerged

from the initial data collected from nursepatients. Participants with specific experiences and knowledge were sought for this sample (Morse, 1991). The criteria for inclusion was participation in, and recognition of, the therapeutic nature of a relationship with a patient. Each nurse approached to participate in the study was given a simple explanation of its purpose and a definition of a therapeutic relationship. This definition was a simple articulation of the explanation given by nursepatient participants as a relationship which was mutually beneficial and healing for both nurse and patient. Nurses who perceived that they were experiencing the definitive therapeutic relationship with an identified inpatient and consented to an interview were included in this sample, as they could provide information which would support, refute or add to knowledge of the concept. Each of the sixteen participants had been working on a medical-surgical nursing ward for three days or more and during this period had continuously cared for the patient nominated as being part of that therapeutic nursing relationship. From the opinions expressed by nursepatients, three days was determined, a priori, to be an adequate period of time for development of a therapeutic nursing relationship. There were fifteen female nurses and one male nurse in the sample. Their ages ranged from 23-44 years. Eight were also midwives. Three were tertiary graduates. Five had undertaken tertiary studies following their hospital-based training. Some had been hospitalised, that is, been patients, previously, primarily for childbirth.

### **Patients**

The third group of participants were patients who were nominated by nurses who identified them as the complementary party in their self-identified therapeutic nursing relationship. This nominated sample accessed a specific group of patients who could supply particular knowledge about their relationships with nurses (Morse,1991), and present a balanced view of a therapeutic relationship. The criteria for inclusion matched that of the nurses. Patients were resident in the same ward for three days or more, and during that time had been cared for continuously by their nurse nominees. Patients were also sixteen years of age or more to give legal consent to interview, able to speak English adequately to respond during interview and willing to participate in the study. The final sample size was fifteen patients of which eight were male, and seven female. They were aged between 21 and 88 years. Two nurses identified the same patient as part of their therapeutic nursing relationship. Participants were contacted by the researcher who explained the research study, the expectations of input and the amount of time involved. Prior to interview, consent was obtained after explanation of the study and its purpose, with particular emphasis upon confidentiality and anonymity, were given to each participant.

### **SETTING:**

#### **Nursepatients**

Nursepatients were interviewed in their homes. This was considered to be a safe environment which assisted the client to relax, afforded privacy and reduced the barriers to revealing the details of the experience to the researcher. The researcher expedited trust by revealing the intent of the research, the conditions of confidentiality and the means of coding information to assure anonymity. Rapport

was facilitated by the researcher being receptive, and non-judgmental, listening effectively in the narrative phase and clarifying meanings for both parties, where necessary. The intimacy of the setting encouraged free flow of valid and meaningful information (Field and Morse, 1985).

## **Hospitals**

From a list of north, central, western and north central Victorian country hospitals available through the Nurses Board of Victoria, four hospitals were chosen at random, by drawing names from a hat, and approached for permission to conduct the study. The researcher was known to the Directors of Nursing at two of these hospitals, but was not employed by of the selected four. Rural hospitals were selected for convenience of access, and because of the researcher's general perception that often these institutions are not included in research studies.

Applications to conduct the study were made initially through informal contact via telephone with nursing administration departments, wherein the researcher introduced herself, the study aims and purposes, and asked for information about conducting research in that particular venue. This was followed by a formal letter, with an enclosed copy of the research proposal, to Directors of Nursing who were asked to forward relevant documentation to appropriate management forums, including ethics committees. Final authorisation for the study came from the hospital executive, through the Director of Nursing.

Of the four hospitals approached, two replied in the affirmative, and became hospitals A and B for the study. Although these hospitals were distinctively different in size, numbers of beds and staffing, each had a thirty bed medical-surgical ward, the staff of which was willing to participate in the study. Hospital A was a small rural hospital where the Director of Nursing was familiar with the researcher, and permission to conduct the research was gained after the procedures described above. Hospital B was a large organisation. Permission was granted after the researcher was interviewed by the Director of Nursing and the Hospital Chaplain to confirm researcher and study bona fide. Verbal assurances were given by the researcher of the ethical and moral intent of the study toward the hospital, its staff and patients, particularly regarding confidentiality and anonymity. After this process, relevant additional information was appended to the original documentation and forwarded to appropriate committees. Formal permission to conduct the research was granted by the hospital executive via letter, and confirmed by the Director of Nursing via telephone.

## **Hospital A**

Hospital A was small in physical size, but had a geographically large health care service area. There were two wards, one acute care and the other, long-term care. The study was conducted on the acute care ward which serviced a mixed population of medical, surgical (including day cases), paediatric and midwifery patients. There were thirty beds available for patient care. The staff on this ward were also responsible for staffing a 24 hour emergency service. In addition, the ward provided palliative and respite care. Some of the registered nurses job-shared ward work and the district

nursing service. Each nurse was responsible for the direct care of an allocated number of patients. Workload was determined by the Ward Manager in consultation with each nurse. It was dependent upon the range of care and skills required by each patient, and able to be given by each nurse. Provision for change of work allocation was built into the system to cater for the individual needs of either patient or nurse. All nurses wrote reports on the patients under their care and gave verbal handover to oncoming staff at the change of shift.

Staff on the ward during the day shift were the Nurse Unit Manager, two Registered General Nurses, one or both of whom were also Midwives, and two State Enrolled Nurses. The Nurse Unit Manager was supernumerary. The evening shift consisted of two Registered General Nurses, one of whom was a Midwife, and a State Enrolled Nurse. In the evening, one of the Registered Nurses was designated in charge of the hospital. On night duty were two Registered General Nurses who were Midwives, one of whom was also in charge of the hospital. There were three shifts in 24 hours. Nurses were allocated shift times according to ward and personal needs, with regular rotation through all three shifts, and were not permanently assigned to particular shifts.

### **Hospital B**

Hospital B was a large organisation of 300 beds, with several wards of designated care. The hospital also offered specialist services which attracted consumers from other health care service areas. The ward population was determined by the type of health care required as patients were admitted into either medical, surgical, midwifery, paediatric, or critical care areas. The study was conducted on a 30 bed medical ward which also provided palliative, respite, long-term nursing, and post-operative care, and for those patients awaiting placement in nursing homes.

The provision of nursing care was essentially through teamwork, with the ward being divided by physical location into two halves. Each half was serviced by a team of nurses, each responsible for the direct care of a certain number of patients, but working as part of a team that serviced that half of the ward. All nurses wrote reports on the patients in their care and gave verbal handover to the oncoming shift to ensure continuity of care. Teams were rotated through the ward halves each 14 days, with provision for change, upon request, to "avoid conflict, burnout and boredom" (as stated by Unit Manager and staff). This process was agreed upon by the ward staff, to facilitate better care as nurses became very familiar with patients and their care in that time. During the day, the two ward teams consisted of two or more Registered General Nurses and two State Enrolled Nurses. The Nurse Unit Manager was supernumerary. In the evening, there were two Registered Nurses(RN) and one State Enrolled Nurse per team, with one RN designated as being in charge of the ward. At night, the ward was serviced by one team, consisting of two Registered General Nurses and one State Enrolled Nurse who was time-shared with an adjacent ward according to workload requirements. One of the Registered Nurses was in charge of the ward at night, although there was also a supervisor in charge of the hospital. There were three eight hour shifts in each 24 hours. These were interspersed with several different time periods of four hour shifts, during the day and

evening, designed to service the needs of the ward at its busiest times and to come in line with budget demands and ward costs. The majority of staff worked a mixture of day and evenings shifts in any one week. The night shifts were permanently allocated to particular staff members.

Each hospital made a similar ward situation available for the study. Access was available twenty-four hours a day, provided the designated supervisor was aware of the researcher's presence within the hospital. The majority of staff were very receptive and interested in the study even when not actively participating. All looked forward to, and anticipated, feedback. This enthusiasm and desire made possible a new dimension in data collection - an open forum feedback process at each hospital with participants and other interested staff invited to comment on the findings. This process was initiated by the researcher, through the Nurse Unit Managers, after analysis of data. Forums were utilised to evaluate and refine the models of a therapeutic nursing relationship developed from and through the findings.

## **DATA COLLECTION**

Data were gathered through a combination of interviewing, observation and literature review (Walker, 1985). To obtain a comprehensive view of the phenomenon of relationships between nurses and patients, three points of view were collected through interviews with nursepatients, nurses and patients. The first collection of data was gathered through unstructured interviews as the researcher was open to the experiences of nursepatients in relationships with nurses as caregivers (Oppenheim, 1992). The second data set came from structured interviews designed to elicit specific information about relationships between practising nurses and their patients. The third opportunity arose through the process and the desire of participants and hospitals for feedback and took the form of an open forum. In each of these stages, the researcher recorded observations of interviewees' reactions and her own responses (Woods & Catanzaro, 1988). Concurrent literature reviews explored the known nature of the phenomenon in nursing and allowed follow-up of ideas and hunches arising from the data sets. In this manner, data collection embraced the principles of triangulation (Minichiello, et al, 1995) to focus the research on reaching a complete understanding of the phenomenon of a therapeutic nursing relationship in all contexts of practice and theory.

### **Interviews**

The what, why and how formulation which drove the method continued into, and formed, the basis of the interviews. Questions were asked of participants in the context of their relational involvement through nursing (Appendix IV). Each interview was tape-recorded and transcribed verbatim by the researcher who interpreted the dialogue. A partnership was entered wherein the researcher and the participant had equal input toward finding and sharing the meaning of the experience. From the perspective of three groups of participants (nursepatients, nurses, patients) and one interpreter (the researcher), a comprehensive picture of the experience of being in relationship with another in a nursing context was elicited. In this way, an understanding of the phenomenon was reached (Knaak, 1984; Omery, 1983) by its articulation among the participants.

### *Unstructured Interviews - nursepatients*

Data was collected from each nursepatient by a series of two interviews followed by a mail-out evaluation sheet. Each nursepatient was interviewed face to face on two separate occasions. The first interview was in-depth and unstructured, and designed to explore the experience of being a nursepatient. The second interview was structured around the preliminary findings and designed to test the accuracy of the researcher's interpretations by following-up emerging themes, examining contradictions and confirming descriptions. It was conducted in each participant's home to protect their "psychological comfort and demonstrate... genuine interest in them as persons" (Munhall, 1994). All interviews were tape-recorded, and each tape coded to ensure anonymity. In the third stage of data collection, participants completed written evaluations. Each was sent, via mail, a composite written account of the interview material, including individual descriptions and tentative findings, and asked to evaluate the contents in the context of their individual experiences of being a patient.

#### The First Interview - Content Specific

The first interview was designed to explore the experiences of nursepatients, elicit descriptions and encourage reflection upon the experience of being a patient while being a nurse. It was in-depth and unstructured. Interviews were approximately one hour in length. All interviews were tape-recorded. Open-ended questions were utilised which centred around the participants' perceptions of the experience of being a patient and their relational involvement with nurses as caregivers. The principal interview question was "Tell me about your experience of being a patient". Encouraging narrative accounts helped these nursepatients to sort through their experiences, develop their own meanings, and gave them a sense of control over the information sharing process (Brammer, 1988). Following this narrative phase, more specific and direct questions were used to generate information about the relationships each participant had experienced with nurses as caregivers.

An interview guide was used by the researcher to keep the interview within the context of what it was like to be a nursepatient in relationship with nurses as caregivers (Woods & Catanzaro, 1988). Each participant was prompted to explore the feelings and memories of the experience of being a patient, expectations of care prior to hospitalisation and personal opinions about the purpose of nursing. All were asked about differences between being a nurse and being nursed. Reflections about personal practice paradigms prior to, and following, hospitalisation were encouraged to highlight differences between their own practices and those of the nurses who looked after them. Participants were asked to describe the types of relationships experienced, look at those qualities which distinguished each type and reflect on the meaning of being a patient for them as nurses and people.

#### Second Interview: Interpretative Accuracy

The second interview was designed for discussion of the preliminary analysis through an individual interview summary. This interview invited comment from each participant and allowed addition, deletion or alteration of the information contained in the initial interview material. Each participant



was encouraged to think about the accuracy of the researcher's interpretations and the summarised information through a process of structured questions related to each individual's experience. The meanings of the experience for each nursepatient were explored in depth through attentive listening to detail and reflective questioning. This enabled the researcher to refine the information into a cohesive whole and extract those elements deemed essential to the formation of a therapeutic nursing relationship between nurse and nursepatient.

#### Evaluation Sheet: Constructive Criticism

A cohesive summary of both interviews was then mailed to each participant who was invited to comment, in writing, upon its accuracy and add, delete or amend any content where they felt it necessary. Without the researcher's presence, participants were able to freely assess the credibility of the final information, and honestly annotate their feelings about the researcher's interpretations of their stories. All eight participants returned written evaluations which had added information and, or, comments about the experience of being a nursepatient.

#### *Structured Interviews: nurses and patients*

Interviews with nurses and patients were structured around specific questions. This method was designed to elicit only descriptions of a therapeutic nursing relationship from the perspectives of both nurses and patients.

#### Nurses

Interviews with nurses were conducted in the ward on which they worked. Both hospitals had a small, informal, private room in each ward set aside for patient interviews, and these were made available for the study purposes. Interviews conducted during the day took place during set patient rest times in the hour following lunch, those in the evening following settling of patients, and at night, after the first round of patient care. Both researcher and interviewee were able to access tea-making facilities which enhanced relaxation. Unit Nurse Managers encouraged participants to use as much time as necessary for the interview, and assured the researcher that there would be no interruptions unless an emergency situation arose on the ward. Being accepted as part of the group, but with a clearly established role as researcher and not nurse (Morse, 1991), and receiving open, friendly encouragement in the pursuit of data, assisted the researcher to engage informants in an honest accurate descriptions of their relationships with patients. Giving information in this safe environment was cathartic for the informants, and insightful for the researcher (Sarter, 1988).

Guided interviews (Field & Morse, 1985) were used to obtain all information about the relationship between nurse and patient in the context of its mutually beneficial and healing nature. Each interview began with the question: "Tell me about a relationship you have had with a patient which you feel was therapeutic for both yourself and the patient". A basic definition of a therapeutic relationship, that is, one that is mutually beneficial and healing for both nurse and patient, was given to each participant, and, in essence, posed the ideal relationship for consideration by these informants

(Schatzman & Strauss, 1973). This definition was utilised to facilitate discernment of a therapeutic relationship from others experienced by nurses in the course of day to day contact with patients. Open-ended questions followed from the given information and allowed each participant to describe the relationship freely and spontaneously. The last question asked of each nurse was to define a therapeutic nursing relationship. This was designed to confirm each participant's interpretation, given the researcher's explanation and their descriptions. Interview length was 30-45 minutes. Use of the same questions at and in each interview obtained comprehensive and comparable data of nurses' perceptions of therapeutic nursing relationships. Each nurse was interviewed once, and then mailed a written summary of the interview transcript for comment.

The second contact was via mail, where participants were sent a written summary of the first interview and an outline of the preliminary findings. They were invited to comment upon the accuracy of the findings and the researcher's interpretations, in terms of the elements present in a therapeutic relationship and associated nurse and patient outcomes. It was felt that this method of contact would afford the participants the freedom to comment honestly and constructively, occurring as it did, without the presence of the researcher, and in the safety and privacy of each participant's own home. All but three participants returned this summary sheet. Those returned contained written comments which were added to the data bank.

### Patients

Guided face to face interviews were conducted at the bedside with patients nominated by nurses. Time constraints meant that patients were interviewed once only, and interview times were kept to thirty minutes or less. The interview began with an open-ended question: "Tell me what it is like to be a patient", and lead on to specific references about the relationship with the nominating nurse. Direct questions, listening skills and clarification strategies gained complete information about this relationship from each patient's perspective within the given timeframe.

### **Forums**

Each hospital expressed a desire for feedback regarding the study and an interest in the ongoing nature of the research. To facilitate their needs and expedite the research, the findings were presented at an open forum held on both wards where data was collected. A group interview of this nature relied on the skill of the researcher to canvas individual opinions and consummate group consensus. It was, however, advantageous. The research findings were trialled for effect on a wider audience. It was time-saving as many participants could be accessed at one time. Objective assessment was provided by those not directly involved in the research process. Exchange of ideas and constructive discussion of the practicalities and realities of the research findings yielded another data bank for analysis. Brainstorming encouraged group interaction and produced a broader description of therapeutic relationships between patients and nurses (Isaac & Michael, 1990). Thus, group interviews assessed the utility of a therapeutic nursing relationship in practice.

Discussion forums were held at each hospital post data collection and multifarious analysis. These forums were open to any interested staff member, including the nurse research participants. Patients who had been participants had been discharged in the interim between interview and the arranged forum dates. Forums were arranged to coincide with shift changeover to ensure maximum attendance. Wards and participants were notified in writing by the researcher. Unit Nurse Managers ensured that notices were placed in relevant areas to attract staff attention.

At these two group interviews, the researcher introduced herself and gave the background of the study. The tentative findings were presented verbally to forum participants who were invited to review the findings and comment upon usefulness of the emerging theory and its diagrammatic model in clinical practice. The presentation was assisted visually by use of overheads. Active participation and discussion by members was encouraged by open-ended questions designed to elicit constructive criticism of the practice model. Forum participants were vocal in their attention to the model and its everyday application in their practice, and in the context of their present area of work. Discussion of the various elements gave valuable data for consideration in the final representation of a therapeutic nursing relationship as a theory and a model.

The open forums were designed to be the third contact point with the nurses who participated in the study. Although none of these participants was able to attend the forums, this was seen as a positive aspect of evaluating the results, as the attendees were not personally involved in the study. Evaluation by nurses who had not participated in the study lent unexpected objectivity to the critique, credibility to the researcher's interpretations and placed forum members' constructive criticism within the realm of everyday practice, as experienced by nurse clinicians outside the study groups. In this way, the model was evaluated as a practical reality, by practising nurses.

### **Journaling**

The researcher kept a personal journal for recording information not obtained on tape at interview. Entries were made at each contact time with participants and organisations. Handwritten records contained pertinent information about location, contact points, and reference criteria. This was supplemented by information gathered before, and following, each interview. The initial process was designed as a focused record of the research process and its participants, and information gathered in this manner was appended to each participant's transcript. It became a valuable tool as the research progressed. Journal entries expanded as thoughts were recorded following reading, and re-reading, of transcripts, and listening to tapes. Handwritten memos were collected into a more formal journal in which connections were made between the data sources, follow up ideas for interviews, and literature searches. Questions to be answered at next contact were recorded. Intermeshing the data sources was enhanced by this continual reflection. Notes were written at any time when appropriate thoughts about any part of the research process occurred - talking, walking, driving and even in the middle of the night when sleep was elusive. 'Dwelling with the data' (Burns & Grove,

1993) became a reality. Through the medium of the journal, the research was motivated, directed and 'kept on track'.

The journal served as an active tool during interviews. As an interview guide, it contained particular questions relating to each participant's biography, and the list of interview prompts. To conserve anonymity, participant's biographies were not recorded on tape, but allocated to journal entries. Individual codes were developed for each participant and each organisation which incorporated phone numbers, dates of interview and a reference area known only to the researcher. Information gathered, by phone and immediately prior to interviews, of each participant's personal geographic and demographic details which were recorded under allocated individual codes. All participants were asked for details regarding their age, nursing qualifications, number of years spent in nursing, post registration education and present position. Nursepatients were also asked about the date, time and type of hospitalisation (private or public) to be discussed at interview, and current health status. Entries were made with the consent of participants, who were informed of the purpose of the journal in the research process, and completed in their presence. The decision was taken not to record any written information during the interviews, due to the distractive nature of this task, and in order to give full attention to what was said by each interviewee. During each interview, the journal was left open and used by the researcher as a visual reference for prompts. This kept the interview focused and ensured exploration of areas particular to the research aims.

Immediately after each interview, in private, the researcher recorded her responses to the revelations of the participants. The journal became a useful record of perceptions and intricate interview details not afforded by tape-recordings, including non-verbal communication, post-interview comments by participants, researcher reactions and impressions, items to look for in subsequent interviews, and follow-up questions. Lists were compiled of particular points which needed further discussion, review, revision, revisiting, examining, and or introducing with the next interview or contact. Missed and important areas for discussion were highlighted for inclusion at this time. Questions about the data were recorded and formed the basis of ongoing investigation through interview, researcher reflection and literature searches. Tentative findings and speculations added to the information pool.

The journal became the link for all processes involved in the discovery and conception of a therapeutic nursing relationship. It was an essential tool for material references and clarification of information during analysis. For example, recordings were made of the observed interactions between nurses and their patients who were deemed to have a therapeutic relationship. Each nurse was asked to introduce the researcher to the particular patient who formed the other half of a therapeutic nursing relationship. This process afforded the researcher an opportunity to directly observe their interactions and reactions when introductions were performed. Short notations were made in the journal about these interactions while the patient's details were being ascertained. This added valuable information which assisted interpretation of data. The journal presented a readily

accessible pathway to the data, a means of building on what was being said by participants, and a way of conceptualising the relationships between the data sets.

The journal also recorded personal observations, notations and thoughts about the research process, the findings and outcomes. It allowed the researcher to identify her beliefs about the relationship between nurse and patient, isolate her assumptions about participant's experiences and the research process, and alter any preconceptions marginalised by the process, but resurfaced by examination of the gathered data. Records of pre-interview feelings, prompts and reminders were compared with post-interview perceptions. Any concerns about the process were reflected upon, and strategies developed to overcome similar problems at next contact. Participants' stories were compared, and evidence of a particularly contrasting, confirming and, or, contradictory nature listed for conjugated review with other data pieces.

Interview is often cathartic for participants, and similarly, journaling afforded the researcher the same release. Entries made following interview expanded to include those made by the roadside on the journey home, at any time that reflection prompted recording, and middle of the night thoughts. Dwelling with the data became a reality of the research process. Spontaneous thoughts became entries for further reflection and connection while re-listening to the tape-recordings. Any emotions induced by the content of the stories were expressed in the journal. At times, participants' stories evoked professional shame in the researcher, while others left her with feelings of pride and a restoration of faith in the connection between the terms 'nursing' and 'care'. This seesawing of emotions also gave hope that the relationship between patient and nurse could be therapeutic if nurses and nursing knew its ingredients and modus operandi. As such, the journal was a motivational source of energy for the researcher.

Journaling opened up new ideas (Bums & Grove, 1993). It developed in the researcher new insights into the phenomenon of the relationship between nurse and patient. The systematic keeping of participant records swelled to encompass the subjective data of the researcher's mind coupled with the objective recording of facts and happenings about the relationship in practice. Re-visiting tape-recordings and verbatim transcripts in conjunction with journal entries lead to a new way of viewing the accounts and the inevitable discovery of 'new' material or confirmation of previously tentative ideas. It reinforced the researcher's role as observer, recorder and faithful interpreter of another human being's experience. The journal facilitated the journey of discovery (van Manen, 1991) about relationships between nurses and patients, and one's self as researcher, nurse and person.

### **Literature Reviews**

The third method of data collection was concurrent literature reviews. This phase was designed to ensure that the stories described by participants and the concept arising from the researcher's interpretation held a logical connection to what was already known theoretically about the relationship between nurse and patient. Consulting the literature for verification of ideas reduced any

bias introduced by participants and the researcher (Minichiello, et al, 1995). Relevant literature was used to supplement the information gathered at each interview and support the credibility of the researcher's interpretations of the data. It enabled the researcher to keep abreast of changes in nursing thought and philosophy regarding the relationship between nurse and patient. Parallel reviews of the literature and data assisted the development of the theory by alerting the researcher to concepts and interpretations relevant to the area of study. It also highlighted areas for discussion within the context of known nursing theory, and uncovered practical applications of relevant nursing theory for cross-comparison.

As a form of cross-checking on the dissemination of the phenomenon, concurrent literature reviews sought to find continuities (Walker, 1985) between the subjective and objective worlds of the relationship between nurse and patient. Careful examination of the literature was made at all times during data collection and analysis to acquire new insights about the phenomenon of the relationship between nurse and patient. It was an effective means to gain additional information that supported, refuted or questioned the research findings. Examining the relationship from the perspective of others who had written about it, experienced and, or, observed it in action, allowed the researcher to differentiate between evidence and inference, and avoid jumping to premature conclusions. It also assured that the analysis was focused and directed. This double-checking of findings with literature was cross-tabulated with the researcher's own knowledge, experience and observations. The concept was revealed as a complete, accurate and factual reality of nursing knowledge, in both theoretical and clinical contexts. Concurrent literature reviews added to the quality of the data by assisting to establish the relevance of the concept of a therapeutic nursing relationship to current theory and future practice. Reviewing the concept within the context of current knowledge and understanding of the nurse-patient relationship maintained conceptual and theoretical coherence in analysis and the process of drawing conclusions from the data (Miles & Huberman, 1984).

## **ANALYSIS**

Analysis was performed concurrently with data collection. It was an eclectic approach, using a combination of methods to thoroughly examine the data (Diagram I). Analysis of the data was triangulated with perspectives presented by researcher journal entries and articles exposed by parallel literature reviews including computer-assisted searches of relevant data bases. Any information given by participants was contrasted and compared with the norms of contemporary perspectives presented by the literature and the supplementary information provided by researcher's recordings of the participants' lives and the contexts from which their stories arose. This enabled links to be made among data, theory, and fieldnotes, and between all three sources of information (Sandelowski et al, 1989). The conglomeration of data was also mediated by the researcher's own reflections on the process of data collection, responses to the stories of the participants, and to some extent, her knowledge and personal practice of nursing (Drew, 1989). Consequently, conclusions drawn from the data were under constant scrutiny for their truthful representation of the phenomenon

Diagram I:

## BASIC STEPS IN DATA ANALYSIS

### FIRST DATA SET

Phenomenology - application of Colaizzi's Steps: delineated -

1. Themes - a description of the *experience*
2. - experiential *meanings*
3. -an ideal *relationship*

Contextual, Constant Comparison and Content Analysis: uncovered and identified -

- a relational concept - a therapeutic nursing relationship
- its elements

### SECOND DATA SET

Concept Synthesis: consolidated the concept through

- confirmation and extension of interpretation and structure
- building and refining of the concept (definition)
- interrelationships and effect of its elements (model)
- description of the process (theory)

and continually questioned for their validity within the context of current nursing practice and theoretical representations of the nurse-patient relationship.

Analysis of the first data set employed phenomenological inquiry (Colaizzi,1978), to uncover a comprehensive description, delineate themes, and elicit meanings. This was followed by constant comparison (Bogdan & Biklen,1992), systematic content (Burnard & Morrison, 1994) and simultaneous contextual analysis (Bryman & Burgess, 1994) to expose the structure of the experience of being a nursepatient, and in particular, explore the relationships between nursepatients and their nurses as caregivers. There was a distinct and logical connection between these formats of data analysis. All used a reductionist (that is, breaking down complex items into simple constituents) mode of approach which looked at succinct sections and descriptions of the experience of patients being in relationships with nurses. Phenomenological aspects of analysis formed a complete picture from piecemeal descriptions. Latter methods brokered this large description down into smaller pieces for ease of understanding. The second stage of analysis incorporated the complementary method of Concept Synthesis (Walker & Avant,1988) with systematic content, contextual and constant comparison analysis to develop a descriptive theory and explanatory model of a therapeutic relationship between nurses and patients.

Each stage of analysis began with reading and re-reading of transcripts to grasp a general understanding of the content and find the meaning of the experiences for each participant (Munhall,1994). The first, and each succeeding, transcript was analysed using multiple methods designed to uncover the general nature and specific properties of, in the first instance, the phenomenon of being a nursepatient, and in the second, the concept of a therapeutic relationship between nurse and patient. The theoretical and investigative framework of the research and the format of the participants' stories kept the focus of the analysis firmly fixed within the research aims.

### **Specific Data Treatment:**

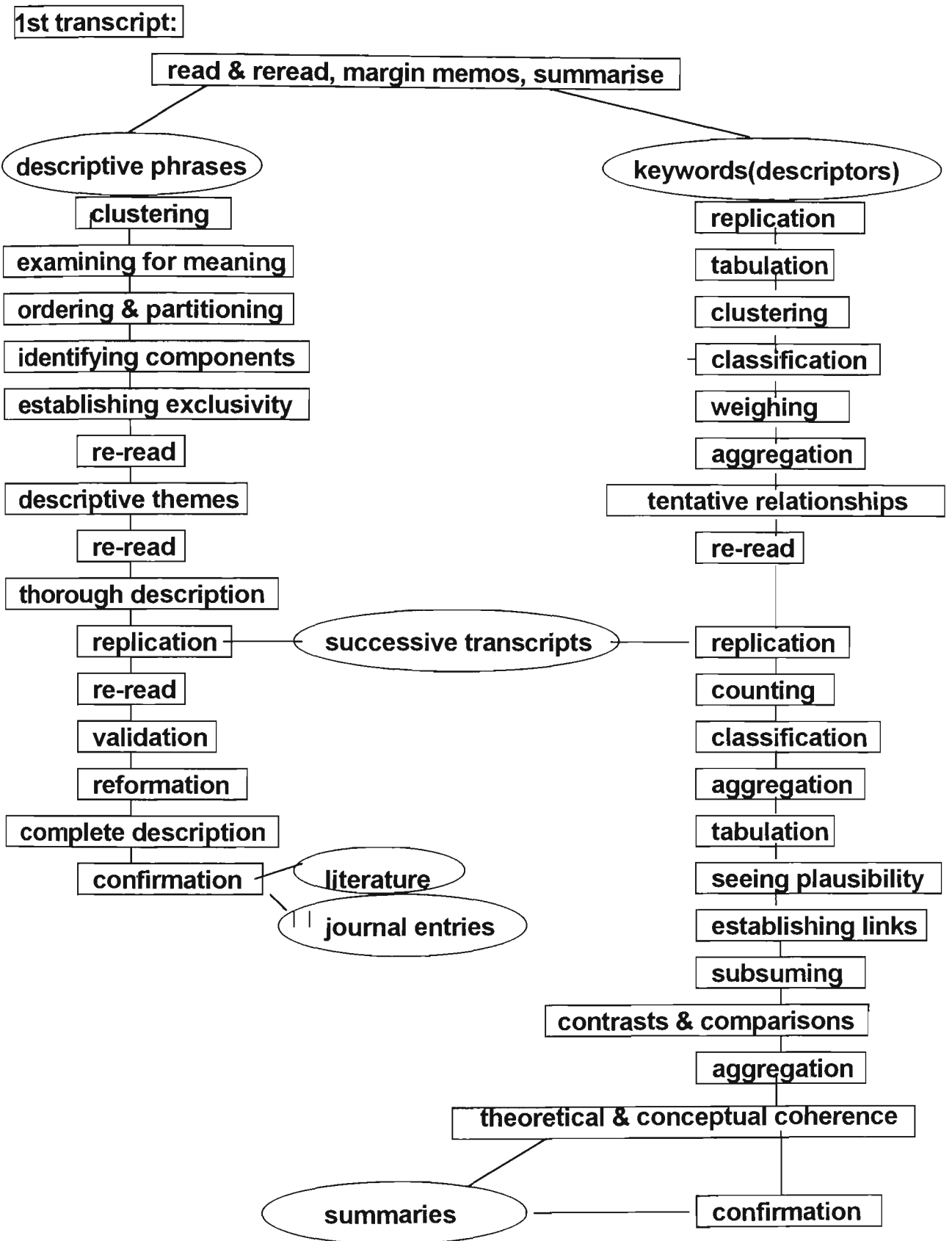
#### *THE FIRST DATA SET* (see Flow Chart 1)

Information given by nursepatient participants was subjected to two processes of analysis. The first was phenomenological reduction, and the second, a combination of content, contextual and constant comparison analysis (Thomas, 1990). These processes were complementary in aim and outcome. Phenomenological reduction elicited descriptive qualities, which were synthesized into thematic statements to paint a whole picture of the experience of being a nursepatient. By "approaching the phenomenon from divergent perspectives, different positions, roles and functions" imaginative variation exposed the essences and meanings of being a nursepatient (Moustakas, 1994). The analytical methods of counting and comparison, between and within the data set, moved these general perceptions toward identification of those specific or particular components that made the phenomenon, a phenomenon.



Following the seven steps outlined by Colaizzi (1978), the first transcript was read and re-read to gain familiarity with the content, affect, and latent and overt meanings of each piece of information about the experience of being a nursepatient (Burns & Grove, 1993). Margin memos noted the researcher's intuitive feelings about the experience (Bryman & Burgess, 1994). Phrases that stood out from the data for their descriptive relationship to the experience of being a nursepatient were underlined with coloured pen (Field & Morse, 1985), then manually listed as themes on a separate sheet of paper. Phrases describing like qualities of the experience of being a nursepatient were clustered together under one theme. Ordering of phrases within clusters, or themes, was based upon the specific meaning ascribed to them by the participant, coupled with the researcher's intuitive feelings noted in margin memos. Partitioning of clusters was made on the basis of the particular property (of the experience of being a nursepatient) which was described by each phrase. This process was assisted by reference to the particular interview question that prompted the giving of information, that is, the specific property that the participant described or was asked to describe when prompted. This process of collation and division by descriptive content determined the exclusivity of each cluster and its belonging properties. The transcript was then re-read. Re-examination of each cluster saw the development of distinctive themes which succinctly described that part of the experience and illustrated its meaning. The transcript was again re-read in the context of each developing theme and its cluster of phrases to determine if, collectively, they represented the whole experience of being a nursepatient, that is, constituted a thorough description of the phenomenon. This re-reading was also used to determine the fundamental composition of the phenomenon. Specific sections of the data relevant to each theme were highlighted with different coloured pens. This colour differentiation meant each section of information was easily identified and organised under the particular theme which best described its connection to the experience. Tabulated information expanded each thematic illustration to reflect the underlying structure of the experience. In all, the themes painted the whole picture of the phenomenon of being a nursepatient for this particular participant.

# FLOW CHART 1



Each new piece of data, or nursepatient story, was treated in the same manner, with an emphasis on locating replication of phrase and property description as per the initial transcript. Most clusters were repeated, while some new ones emerged. This demanded a re-examination of the first transcript to confirm the existence of these different phrases and descriptions. The entire data set was then re-read to view the data as a whole and to determine that there were no negative cases opposed to the determined clusters. Each cluster of phrases was re-examined, reformed and labeled under a descriptive theme. Collectively, these thematic illustrations completed the picture of the phenomenon of being a nursepatient as perceived by nurses who had been patients. The themes, then, had two functions: individually each theme identified a part of the experience of being a nursepatient, and these parts, when organised together, formed a comprehensive description of that experience. The analysis was validated by returning to each participant, asking if the analysis described their experience, allowing them to delete or add any data and incorporating this into the final thematic description (Sarter, 1988; Miles & Huberman, 1984 & 1994). Confirmation was also sought by critically examining any conclusions in the context of objective (and often, subjective) information supplied by current literary perspectives and researcher journal entries.

Inductive thinking (Bryman & Burgess, 1994) and reflection (van Manen, 1991; Schon, 1983), fueled by literary perspectives and personal curiosity, directed the analysis toward identification of the basic units held within this whole experience (Minichiello, et al, 1995; Bogdan & Biklen, 1992). Reading the data had highlighted each participant's use of certain words to describe her experience of being a nursepatient. Many words were common to, and shared by, each description. Constant comparison of data, both within and between transcripts, revealed replication of word use and hinted at the importance of these word elements to the experience and its actual, and possibly alternative, consequences.

Using the first transcript as a model, the application of content analysis in its most basic form - counting - (Bums & Grove, 1993; Field & Morse, 1985) was used to discern the specific descriptors used by each nursepatient to depict particular aspects of her experience. The descriptive words from the first script were listed onto a separate sheet of paper which was then used to tally the occurrences of common words in this and each successive script. Attention to the context in which these words were used, began to lay bare the inherent nature of the experience for this nursepatient. Words common to a particular part of the experience of being a nursepatient were clustered under tentative headings. On returning to the first script, key words used to describe different parts of that experience were highlighted using an individual colour and each page wherein the word/s occurred tagged with its corresponding colour. Each key word was collated into a colour-coded table when transcript reading was completed. This mode of content analysis devolved this experience into essential elements, or components, which formed the basic structure of the phenomenon of being a nursepatient, and exposed individual conceptual infrastructures of that experience.

Linking the origins of descriptors within the experience revealed that the interview questions had prompted the first nursepatient participant to cognitively dissect the experience into distinct divisional concepts, which were descriptively capitulated as "experience", "relationships" and "meaning". The interview prompts had allowed each participant to explore certain facets of her experience in the context of the experience itself, the meanings of that experience, and the relationships formed within, and by, that experience. Prompts and responses mirrored the tentative organisation of descriptors under headings. This congruence saw their usage become the means of mechanically sorting the data and organising the information into meaningful classes (Thomas, 1990).

Again, visual inspection of this initial transcription was made to identify word patterns used to describe the experience, relationships between nursepatient and nurse, and associated meanings for each participant. Key word descriptors that had been highlighted and tabulated in text, were weighed in the context of their descriptive application, then manually listed using the chosen headings of "experience", "relationships" and "meaning". Compilation of descriptors under particular headings identified belonging factors. Organisation and discrimination between descriptors within a heading revealed the first suggestions of the relationship of these factors to each other, and to the experience as a whole.

Each successive transcript was examined for its individual properties under the given headings. Content analysis, or counting, confirmed replication and repetition of distinctive terminology verbalised by nursepatients in their descriptions. Each narrative was then scrutinised for the occurrence of similar word descriptors which further classified the properties or aspects of each grouping, then compared with other narratives, to detect the similarities and contrasts in the perceptions of nurses who had been patients in the context of the three headings. The tally confirmed that each nursepatient had employed certain common words to describe similar aspects of the experience of being a nursepatient. Repetitive and replicated word patterns in each transcript were highlighted with three different colours, one for each heading, and tabulated using the same headings. Words were listed under their peculiar and relevant headings, as per the first transcript, and aggregated by subsuming those words of similar meaning under an umbrella synonym which best described the word pattern expressed by the collective descriptors. Lists of the characteristics of each group were then condensed using dictionary definitions to collate words with common meanings (Burns & Grove, 1993). This assisted the cognitive move from general ideas to specific concepts, as the definitive descriptors became isolating elements for these headings.

Again, transcripts were re-read to ascertain congruence of meaning and substance between descriptions, intuitive feelings, and conclusions. Reading also allowed the researcher to regain a sense of the whole experience for all participants, capture its essential characteristics and rule out any ambiguity of interpretation. The resulting indexes of "experiences", "relationships" and "meanings" were re-examined and perused in the context of outcomes for nursepatients. This sorting action also exposed tentative relationships between words, word patterns and their

descriptions under the relevant headings. At this stage, the sense and fit of the word and word patterns of each heading appeared reasonable, but there was a distinct separation between the value of descriptors under each heading. The general conglomeration of information needed to be more closely examined to establish clearer links between listings and actual experiences (Schatzman & Strauss, 1973). The narrative accounts of each nursepatient were examined to tease out the principal words and word patterns used to differentiate types of experiences, describe differences in relationships and distinguish phases of meaning. Using the participants' own words as labels (Fielding & Fielding, 1986), sub-divisions were created under each heading and appropriate descriptors tabled into each division. The resulting inventory of headings and their elements was manually recorded on three coloured cardboard sheets. These were used for quick reference during subsequent re-examination of each transcript to authenticate the analytical decisions regarding the content of each group. The analysis had now moved from a comprehensive overview of the phenomenon of being a nursepatient to reveal differential factors or characteristics of experiences, relationships and meanings.

Use of headings kept the research in focus and was a constant reminder of the context within which the research was conducted and the part played by its participants. The paradoxical nature of the nursepatient position could not be denied. Here was a nurse who was a patient while simultaneously being a patient who was a nurse. Each interpretation of the data was examined and questioned from the perspective of what it was like to wearing this type of guise *and* to be receiving nursing care. Reading and re-reading the narratives and interpretations continually reinforced this perspective, as the inherent context of this analysis was based in data obtained from nurses who had been patients. The comprehensive description and resultant summaries compiled through inductive analysis maintained the contextual reality of the world of these nursepatients by presenting *their* views of the experience, *their* opinions of relational involvement with nurses as caregivers, and *their* meanings of the phenomenon of being a patient while being a nurse.

Reconciling the analysis with the aims of the research, caused a re-orientation towards a closer examination of the types of relationships experienced by nursepatients with nurses as caregivers. The data subsumed under this base unit was analysed using content and constant comparison methods and scrutinised in the context of relationships between nurses and nursepatients, as perceived by participants. At this stage, the nature of the types of relationships experienced by the nursepatients was clearly evident in the data. Each type needed a label which respected the context from which it came, reflected the feelings of the participants, and by necessity, discriminated between positive and negative relationships. A positive relationship was perceived to be mutually beneficial and healing for both nurse and patient who derived pleasure from the association. A negative relationship was associated with unpleasant feelings and was perceived to be of little benefit to either nurse or patient, and, at times, deemed harmful. These definitions from the data led to the lists consequently being labeled "therapeutic" and "non-therapeutic". The concept of a therapeutic nursing relationship was created.

Consistently utilising the same approach, any givens were compared with the norms of literary representations of relationships between nurses and patients, and examined alongside the data supplied by the researcher's journal entries about the relationships between nursepatients and nurses. Literature reviews revealed comparative and supportive studies which informed the development of the research outcomes. They encouraged thinking, and re-thinking, of emerging ideas within the context of the experience and contemporary views held about the relationship between nurse and patient. The dominance of certain words and themes was confirmed by journal entries about each participant's experience of being a patient and tentative summaries of interview material. Re-examination of the categories, in conjunction with the findings and the entries, lent additional material to each. The use of various data sources lead to constant re-examination and adjustment of conclusions, and ensured the formation of emergent ideas that linked all three (Okely, 1994). Triangulation of data led the way to confirmation of qualities and completeness of description (Bryman & Burgess, 1994; Denzin & Lincoln, 1994; Breitmayer et al, 1992; Kimchi et al, 1991; Denzin, 1989; Fielding & Fielding, 1986; Mitchell, 1986; Walker, 1985).

Each description was collated into a summary which mirrored the aims of the study. The summary was organised using the three predetermined headings: *experience* (of being a nursepatient), *relationships* (with nurses as caregivers) and *meanings* (of the experience of being a patient). Each main heading was expanded and explored by organisation of pertinent descriptors into explanatory subheadings. The experience of being a nursepatient was subdivided into feedback data of the participant's feelings about the experience, personal expectations of care, professional beliefs surrounding the purpose of nursing, and perceptions of the difference between being a nurse and being a patient. Relationship examination was divided into impressions of nurses as caregivers, the qualities of 'better' relationships, factors which influenced the development of relationships, and a list of the elements of therapeutic and non-therapeutic relationships. Meanings were organised into the three perspectives which reflect the complicated nature of being a nursepatient, who is a person, patient and nurse. In this manner, conceptual coherence was maintained for the participants and the researcher.

Summaries were then compared to locate similarities, contrasts, ambiguities and differences between descriptions. Any entries or descriptors that either lacked detail, clear meaning, or adequate explanation by the participant, were marked with an asterisk, and included in individual summaries as questions for discussion at follow-up interviews. To confirm interpretations gathered from the data, participants were asked to explore the meanings of key words they had used to describe their experiences and their relevance to the relationship between nurse and patient. After these interviews, summaries were refined and re-organised. The same methods of analysis were used to critically examine the additional data and reduce the information to definitive lists. Focused revision of lists occurred by collapsing similar terms into clusters. Each cluster was labeled with a matching dictionary-derived synonym which reflected its combined meaning. Listings were reduced

to basic elements. The revised lists were collated into a final summary, which was then mailed out to each participant for verification and evaluation.

In this two stage analysis, a conclusive list of common elements which described a therapeutic nursing relationship evolved. The third review assessed the credibility and formulation of the list of elements which were perceived to constitute a therapeutic nursing relationship. Participants evaluated the list for its content and completeness in relation to their perceptions of an therapeutic event between nurse and patient, and in the context of their own experiences as nurses who had been patients. Information received via return mail was then added to the data bank, and participants' comments were analysed utilising the same methods. This resulted in minor reformulations and reformations of basic data units. Thus the data supplied by nursepatients was utilised to determine the essence of the experience of being a nursepatient, and the structure of a therapeutic nursing relationship, as perceived by nurses who had been patients.

Parallel literature reviews were conducted with data analysis to check for the theoretical coherence of the emerging concepts. This isolated information relevant to the findings, be it supportive or contradictory, for consideration in relation to the questions asked during analysis of the data about the nursepatient experience. It also placed any analytical conclusions drawn about the data into the broader context of nurse-patient relationships, and indeed, consumer-professional relationships. This assured that comparisons could be made about what the nursepatients were saying of their relational experiences with nurses, and literary descriptions given by patients, nurses, theorists and researchers. Computer searches of interdisciplinary literature through the CINAHL database (Saba, Oatway & Rieder,1989) highlighted new nursing studies and developments concerning the nursepatient relationship. This, together with literature through available the non-nursing computer data bases of Psychlit, Medline and Eric, (Saba, Oatway & Rieder,1989) confirmed that any competent consumer-professional relationship was based upon certain elements which were co-dependent. This legitimised the emerging framework of a therapeutic nursing relationship.

The eclectic formulary of analysis revealed the phenomenon of being a nursepatient, the dominant concept of a nursing therapeutic relationship and its basic structure. It exposed the common and diverse factors in what it was that the participants were saying about the experience of being a nursepatient. In conjunction with reading of the entire transcript and the researcher's journal entries, listening to the corresponding tape-recordings several times lead to complete understanding of the experience from the nursepatients' perspectives and acknowledgment of the associated emotions inherent in this experience. The analysis was re-focused upon the experience of being a nursepatient in relational involvement with nurses as caregivers. In this way, themes and meanings emerged from the data to complete the description of the experience from the perspective of nurses who had been patients, and complement the structure of the concept of a therapeutic nursing relationship.

This type of process-driven analysis delivered a comprehensive picture of the structure of a therapeutic nursing relationship as described by nurses who had been patients. This research, conducted from a phenomenological base, recognises the subjectivity of the collected data and acknowledges that, because it investigates human phenomena, the research can never be complete (Colaizzi,1978). The matter derived from such an analytical framework is thought-provoking, particularly in its generation of new ideas and directions for the relationship between nurse and patient, and suggestions for further, and future, research. The idea of a therapeutic nursing relationship in this particular context is incomplete. Descriptive analysis saw a definition burgeon from the data and open new visas for examination within the concept. As predicted, the phenomenon had been described and examined for its meaning as a human experience within nursing, but the concept needed further development as a practical utility for nurses and nursing care.

More information needed to be found to confirm, or refute, the practical relevance of the concept of a therapeutic relationship to nursing practice. Analysis had raised several questions: 'Does a therapeutic relationship occur in practice?', 'How frequently?', 'What factors enhance its development?', 'How do nurses and patients feel about being involved in such a relationship?', 'Are the elements expressed by nurses and patients compatible with each other, and with those of nursepatients?', and 'Where does this all sit, or fit, within existing practice and theory?'. A therapeutic nursing relationship was an extreme outlier of the first set of data, having occurred only occasionally for some of the participants. The "lack of fit" of a therapeutic nursing relationship within the experience of nursepatients, lead to the quest for more data collected from a different perspective - that of practising nurses and their patients (Bryman & Burgess, 1994). This foray could be likened to a primitive form of theory testing (Fielding & Fielding, 1986).

#### *THE SECOND DATA SET* (see Flow Chart 2 ).

The second set of data was formed by collecting information from nurses and their patients who had experienced a therapeutic relationship, that is, examination of selected cases. Analysis consisted of the process of concept synthesis as described by Walker and Avant (1988), and close comparison of data items within this set, and with that of the first set of data. Analysis was analogous to the methods of systematic content, contextual and constant comparison analysis. Again, it occurred simultaneously with collection. The specific criteria was to look for and examine in context, any variations, differences and similarities within, and between, the data sets in their reporting of the nature of a therapeutic nursing relationship.

All new information was discerned for its value in relation to what was already known about the concept of a therapeutic nursing relationship, revealed by the previous data and contemporary literature. Again, the data set was complemented by researcher journal entries, and all conclusions confirmed by participants (Miles & Huberman,1994). Serendipitously, a fourth bank was added to this data set by the hospitals' desire for feedback through a forum group discussion. This approach



## FLOW CHART 2

Each transcript:

read & re-read

summarise - key words

tabulated

variances, differences, similarities

no negative cases

establishing relationships

identification of factors

+ literature reviews

congruence

+ journal entries

+ evaluations

confirmation

+ focus groups

additional empirical evidence

replication

establishing links

building a logical chain of evidence

validation of conclusions

conceptual & theoretical coherence

theory

incorporated a healthy critical thinking approach to the data engendered by the very eclectic nature of its collection and completed the synthesis of the concept of a therapeutic nursing relationship.

### The process

Concept synthesis (Walker & Avant, 1988)(Appendix II) is a strategy based on observation and evidence gathered in clinical experience and used constructively to build knowledge. The process involves cyclic, interchangeable steps to develop a concept into a descriptive theory through examination of its components. These qualities are then loosely classified into categories which are examined for the presence of an hierarchical structure which establishes relationships and distinguishes levels of importance between, and within, the categories. From these categories, an operational definition is derived which describes the concept and facilitates its communication to others. Validation of the concept occurs through constant examination of the data in the light of all other forms of information, or evidence, available about the concept. This involves literature, field studies, research findings, recognised authorities, and participants. When no new information is forthcoming, data saturation is reached. The concept is then able to be described in a theoretical definition inclusive of its attributes (Walker & Avant, 1988). The application of Colaizzi's steps in analysing the first data set was complementary to the first five steps of Walker and Avant's process. Translating and incorporating their process into the research analysis meant an extension of the first analysis into a more complex re-examination of the data in relation to all other sources of information. It recognised that therapeutic relationships between nurses and patients are possible, and explored other data sources to determine those qualities which make this relationship different to others. Thus, both sets of data were analysed in a syntax of processes which verified the concept of a therapeutic nursing relationship.

### Actualities

Transcript data were initially read and re-read, then summarised into pertinent phrases and key words, which were highlighted, labeled and the appropriate segments of data tabulated. These sections of data were examined visually for similarities and differences among their descriptions, that is, within the data set. This also established that there were no negative cases in these new narratives. Certain elements were linked together in the descriptions which gave a clear indication of their interdependent relationships within the concept and the outcomes of its utilisation in practice (Field & Morse, 1985). Comparison of variances between the two major data sets occurred when key words from this data set were cross-referenced with those elements listed by nursepatients. This revealed the constant constituent elements of a therapeutic nursing relationship and was concomitant with the derivation of an exact listing of factors identified in, and by, both data sets. This list was then examined in conjunction with researcher observations and elements mentioned in literature as being part of an effective nurse-patient relationship. Data summaries were returned to participants for confirmation. The analysis was validated by allowing each participant to comment upon the description and having them delete or add any data and then incorporating this into the findings. The ultra-refined list of elements were placed within an explanatory model to clarify the

meaning and boundaries of a therapeutic nursing relationship. The model simplified the information by placing the elements of a therapeutic relationship into a logical sequence of events for ease of interpretation. The findings were presented to group forums for evaluation and feedback. This empirical evidence from non-participant practising nurses, facilitated weighing, clarification and refinement of the evidence. The predicted incidence, in practice, of a therapeutic relationship was borne out by nursepatients, nurses, patients and group forum members.

This consistent assemble, present and repair strategy assisted the analysis in three ways. It built a logical chain of evidence to support the concept as a practical reality, established the links between the elements in the context of what is, what is known, and what had been experienced by participants in nursing relationships, and determined the fit of the concept within existing theory of the nurse-patient relationship. Conceptual criteria were identified which clarified the meaning, and defined the nature, of a therapeutic nursing relationship in everyday practice. Extending the range of data to encompass all available viewpoints, cemented the conceptual and theoretical coherence of the analysis (Miles and Huberman, 1984) and confirmed the validity of the conclusions drawn from the data. All elements of data were then synthesised into a theory which described a therapeutic nursing relationship, its attributes and their relationship to each other within the concept.

#### **Trial of computer-assisted analysis:**

Analysis of the second data set was designed to be supplemented and assisted by the use of the computer program: NUD.IST (Richards and Richards, 1991). This package processes non-numerical and unstructured data in qualitative analysis through indexing, searching and theorising, but its effect on the analysis was negligible. It involved considerable time and effort to become familiar with the system which added stress to the process of analysis. Despite having access to the program, the manual, the writings of software creators (Richards & Richards, 1991) and other authors' interpretations (Minichiello, et al, 1995; Fielding & Lee, 1991), the program was a paradox. It presented at best, unnecessary repetition of the work of analysis (Cooke, 1992) and, at worst, an extension of data treatment by the demands of its coding (or indexing) system, which smacked of grounded theory which, albeit qualitative, was not complementary to the processes of analysis already undertaken by this researcher.

It was envisaged that this computer package would assist in, and hasten, confirmation of the elicited elements, however, in this capacity its use was limited. Granted, more familiarisation with the package may have facilitated the quick return for which this researcher was most hopeful. In this researcher's understanding, the researcher has to decide *a priori* indexes, then set about searching and theorising using the capabilities of the computer package. All the difficult indexing, searching and theorising had been performed at this stage by the researcher's active visual and manual engagement with the data. An attempt at establishing a database using this package was disappointing, as it involved re-working and re-analysing data with which this researcher had already become very familiar.

An initial search yielded support for the indexes (or elements), but supportive data extracts were limited in volume and often completely out of context, which did little toward enabling firm conclusions to be drawn about the selection of elements which constitute a therapeutic nursing relationship. The physical limiting size of a computer screen and the restriction of the number of window interfaces it can engage, reduces visual contact with the data in any context, and for this researcher, made connecting one area to the other more difficult.

In this researcher's estimation, the package has value for those yet to perform the type of complex analysis which had already been undertaken, but in this instance, removed the researcher so far from the data that she was not dwelling with it, but dwelling *on* it. This time was better spent continually and consistently manually interacting with the data transcripts, tapes and participants. Laying out various hard copies of text dialogue manually, and sequentially checking each page against the other, afforded this researcher continuity of analysis and a firmer belief in any conclusions drawn. This process facilitated imagination, which is a necessary ingredient of qualitative analysis (Okely, 1994) and formation of words which described the meaning of the experience for its participants. Manual analysis complemented inductive reasoning, as it allowed this researcher to read between the lines and build an understanding of what has been said by the participants (Minichiello, et al, 1995). It enabled this researcher to stay close to the data and "have a feel for that data which can only come from processing that data by hand" (Isaacs & Michael, 1990).

## CHAPTER FIVE: FINDINGS

The exploration of various perspectives led to a number of findings. Nursepatients presented a description of their experiences of being a patient, which were devolved into themes and meanings. Reductionist examination of the relationships experienced by these nursepatients revealed the essential elements of a therapeutic nursing relationship. Expansion of the sample to include the vistas of practising nurses and their patients confirmed and expanded the range of these essential elements. Further exploration, examination and reflection resulted in the fruition of the concept of a therapeutic nursing relationship, formation of its representative model, and the development of a theory which collates description into meaningful definitions for nursing.

### THEMES

To elicit a description of the phenomenon, nursepatients were asked to explore, and reflect upon, the experience of being a patient, and their relationships with nurses as caregivers. The narratives painted the whole picture of the experience of being a patient, which was clearly expressed in eight major collective themes. These were: lasting impressions; expectations of care; opposing perceptions; removing control; devaluation: being made to feel different; the good, the bad and the ugly: relationships in action; caring care: extraordinary care; and, ending discord: that one *really* good relationship.

#### **Lasting Impressions:**

Being a nursepatient was not a satisfactory health care experience. It was broadly associated with negative images of nurses and nursing care, and, for some, largely unpleasant memories of being a recipient of nursing care. Perceptions were formed by involvement with, and observation of, attending nurses' actions and interactions. Nursepatients' recollections of hospitalisation were intertwined with their perceptions of a certain lack of quality and quantity in the care received by themselves and their fellow patients.

Memories were actively associated with vulnerability, sadness, conflict and despair, regarding their treatment as a patient and a person. They felt "cheated" as patients as their care did not fully embrace and exhibit the caring concepts espoused by nursing as a profession. They thought that they would be accepted as patients, but often found that their dual identity of nurse was the dominating factor for care decisions. One nursepatient wrote of her feelings of

"powerlessness and frustration [because] staff misunderstood [my] condition and feelings ... which resulted in vulnerability, depersonalisation and the loss of many so-called friends [among her peers] ... the only way they understand is when it actually 'happens to them' " (mm3:2)<sup>1</sup>

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<sup>1</sup> Interviewee, interview number, transcript page. See page 53.

Nursepatients wanted to be active participants in the process of nursing care, but were more often excluded. They perceived that their needs would be considered in the formulation of plans and outcomes, but their viewpoints and input were not always solicited by their caregivers. They often felt de-humanised and de-personalised, particularly when their admitting condition was the focus of interest and care. For one nursepatient, hospitalisation was a nightmare of questions and uncertainty as her condition and circumstances of treatment were unusual, and apparently novel to the staff:

"My nursing assessment was done prior to the staff meeting me, knowing my diagnosis or even my age ... [they were] not even aware until admission why there was a need for the treatment. I was the one 'We don't remember what's wrong with her' and we have asked her a hundred times, and we still keep getting confused and don't know what is going on"(sp24).

The continual questioning did little toward building her confidence about impending and ongoing care.

The experience of being a patient was not always a pleasant recollection for these nursepatients. Feelings of helplessness, frustration and powerlessness were reinforced by caregiver attitudes and approaches which stripped patients of their rights. One nursepatient found her own frustration and anger exacerbated by her inability to act as an advocate for herself and fellow patients:

"One dear 83 year old, she was really ill, she had a roaring temperature, and she felt so unwell. This wench came in and said "You should be sitting out of bed'. [The patient] said 'I don't feel well'. She said 'You will get out'. She was cruel. And if I wasn't able to turn off, I reckon I would have snotted her!" (jb14)

Two nursepatients openly stated that their feelings of unpleasantness were heightened by fears for their safety, having been the recipients of some "incompetence" during their hospitalisation. One had to point out to staff that her intravenous site was inflamed before they would consider a change of location, as:

"They were putting it in at the site, rather rapidly and not in enough volume of fluid, I would think, and neither did my vein!" (lh3)

Another experienced a respiratory arrest due to insufficient care of an intravenous line which was administering continuous narcotics for pain relief. She said:

"In my point of view, the quality of nursing today is not satisfactory, in the sense of 'That's near enough'. 'She'll be right' ...[There are] too many unexplained errors" (Jb3:1)

These two nursepatients endured extra pressure by having to maintain a preventative "close watch" over all procedures and techniques following these episodes.

There was an assumption that the poor performances of some caregivers would have implications for the nursepatients. One nursepatient stated that, because of the standard of care she, and her

fellow patients, had experienced, she "felt ashamed to be a nurse" (sp15). This shame was of a professional nature, as she felt that the care experienced would be assumed by her fellow patients to be common to all nurses, including herself. She felt obliged to defend herself and her profession to other patients, even though the care in action did little to support or reflect her protestations and convictions.

Nursepatients anticipated that they would feel "at home" during hospitalisation, but were lonely, and felt, alone. They were critical of the lack of time spent with them by nurses as caregivers, and the excuses given for restricting contact times with patients. "The bookwork" or being "too busy" were common reasons. In the face of the nursepatients' knowledge of the clerical demands upon nurses, the former appeared inadequate. Knowledge of the ward gleaned through informal contacts with other patients and personnel, asking about individual workloads of each nurse, and observation often repudiated the latter claim. One nursepatient remarked that she knew that these excuses were not feasible, for she had seen a number of empty beds in the ward, and the volume and pace of traffic past her door belied the ward being busy:

"they weren't exceptionally busy, so I know there was no physical reason why they couldn't have spent just a little more time with me, and helping me to do things for me that I really needed them to do" (dc2).

This lack of credibility in explanation did little to change the impressions of care gathered by the nursepatients during their hospitalisation.

### **Expectations of Care:**

There were three common personal expectations about being a patient. The first concerned holism and whole person care. The second was patient-centred care. And the third centred around the notion of being seen as a person, not a nurse. Nursepatients felt uncared for, and discriminated against, as both a patient and a person, when their expectations were not met.

Each nursepatient had a personal philosophy of nursing which reflected the principles of holism. A common perception was that intelligent, contemporary nursing meant caring for the whole person in mind, body, and soul. It was anticipated that their nursing care would be orientated toward care and consideration of the whole person, as a physical, psychological and social being. But they found that the nursing care was largely confined to physical aspects. It was not holistic, and only rarely considerate of their psychological and emotional needs. As one nursepatient said:

"They [the nurses] did the mechanical things. But they did not really want to know me as an emotional, psychological human being....just looked after my physical needs" (dc12).

Another remarked that:

"They weren't bad nurses, it is just how people come across ... technically, they were probably top nurses, but it was just ... *I know there is more to it than that*" (ms37)

Patient-centred care was associated with holism, and rooted in the notion of the patient as *prima facie* in the construction of health care delivery:

"The patient is the centre, should be the centre of care, but often when you looked at a hospital, you would think that the patient is often incidental, and more often than not, the care isn't centred around the patient ... where I think it should be" (mv12)

Nursing under this ethos validated the rightful place of patients, and by correlation, that of nurses, within the health care structure, for "if there wasn't a patient, we [nurses] would not be needed, would we?" (ms37).

These nursepatients expected to be cared for as people with health problems. For five nursepatients, declaring their occupation on admission forms held no special significance. They felt it was of no consequence in their present situation. They did not see that being a nurse would make any difference to their care. Three nursepatients did not disclose their professional occupation for personal reasons, primarily because of their higher positions within the nursing hierarchy. This, they felt, may have influenced health care agencies to give them "preferential" treatment in comparison to other patients in the ward. All of the nursepatients wanted acceptance as people, and assumed that they would not be seen as nurses. They wanted to be nursed like any other patient. The rationale behind the decision of disclosure or non-disclosure of occupation, was based upon the nursepatients' collective need to be perceived primarily as a patient.

Nursepatients who disclosed their occupation were often initially greeted by each successive carer with "So, you're a nurse". Those admitted to the hospitals in which they worked, found that they were forcibly isolated from the rest of the ward by being placed in a single room, thus setting up their status as different from that of other patients. Others reported being placed in rooms furthest away from the nurses' station:

"You would get put in a room and it would seem you would always be in like Siberia. I used to say that I'm always stuck down in the last room in the ward and they never get that far down the passage to see you" (jb6)

Those who did not admit that they were nurses were often serendipitously 'discovered' by their use of certain words, making their beds with mitred corners, understanding of nursing jargon, or asking to make a cup of tea in the ward pantry. One participant's occupation was uncovered by her doctor who, at the nurses station on the ward,

"demanded loudly to see *his* matron...and came striding down the corridor calling out 'My matron! Where is my matron?'"

until he found her (dw11).



## Opposing Perceptions:

Nursepatients saw themselves in need of supportive, understanding care. They were more concerned about their illness and prognosis to give much consideration to their nursing knowledge. A participant reported her anguish over not being able to reconcile nursing knowledge with her medical condition:

"even though you are in the nursing profession, because you are so consumed with this pain, and your whole life is distorted, you can't think along professional lines...you know...what will I do, how will I handle this...it just totally takes over your life" (mm11)

For the nursepatients in this study, there was a clear line between personal needs and professional knowledge. However, despite a division being seen by nursepatients, the situation was not as clearly drawn for their caregivers. One nursepatient found that she had to assume responsibility for her catheter care once the immediate post-operative period had passed:

"I had to clamp my catheter off *and* release it ... they were inclined to leave me to do that instead of doing it themselves, or supervising it...and if I emptied it, I would fill in the Fluid Balance Chart myself, and no-one followed it up" (mv18).

There was a general feeling of disappointment in the nurses' nonchalant approaches toward caring for patients who were nurses, and with the assumption that nursepatients would be able to, or even want to, perform their own nursing care much sooner than other patients. Some were angry that parallels could not be made between the levels of support afforded other patients in efforts toward self-care and the nursepatients' own cases.

Other nursepatients felt that they had been inadvertently placed, by some caregivers, into the role of performance or competence critic. This image was cemented by certain caregiver behaviours which involved making comments about being watched during certain procedures, actively seeking validation of competence, and sometimes, avoidance of providing direct care to the nursepatient by delegating certain elements of care to the most senior nurse on duty. One nursepatient stated that she thought that this was a common assumption, as:

"some of them express[ed] the feeling that the nurse who is a patient will be measuring them up all the time ... when you are a patient, and if you are sick, you don't really give a damn whether the comers on the bed are done the right way ... If a nurse is helping you to have a shower, or getting out of bed, or sitting on a pan, you are not really measuring up or doing an assessment of the way in which the nurse is helping you get out of bed ... I don't think I have ever been conscious of thinking to myself, this nurse is not doing this the right way. I have never been aware of assessing them whilst they were doing something for me, but there appears to be that feeling, at least in some nurses' minds, that that's what you are doing if you are a nurse who is a patient" (dw21)

Other nursepatients felt that they had been judged by their peers and found wanting because they had joined the ranks of the sick. This was particularly obvious when the nursepatient's condition was work-related. Caregiver attitudes were very obvious to one nursepatient:

"They treated you as though ... as if to say ... nursing staff should have more brains than this, you know, to be landing in hospital all the time, and they just treated you like a malingering back patient, and if you had to have drugs of addiction ... well ... it made it worse ... they don't want you to get addicted to it ... and I said, I don't either!" (mm,1:10)

These types of responses from nurses as caregivers made the nursepatients feel vulnerable, afraid and often, embarrassed.

There was a general feeling that nurses as caregivers assumed nursepatients were manipulative because of their knowledge of the system. Any protestations of pain and efforts to procure analgesia were often treated with suspicion. For one nursepatient, several re-admissions for the same condition led to caregiver disbelief of her level of pain, denial of pain relief and condescending receptions by staff:

" ' Oh, you're just tense', they'd say ... and this one nurse who absolutely tore strips off me ... she said 'You *can't* be having Pethidine *every three hours!*' I just looked at her, I couldn't answer her. I just burst into tears ... and that was not even 24 hours after I got back from theatre ... and [after being] in and out of hospital ... the attitude of the staff [was] 'oh, no, not you again!' ... and I said, yes, but I do not want to be here, all I what is for this injury to be fixed, I can't live my life like this!" (mm4-5).

Nursepatients were often assessed and reassessed by different nurses before any medication was given. This reinforced one nursepatient's perception that "nurses would be thinking, 'God is she genuine, or is she not?' " (jb17). They perceived that other patients were offered analgesia at regular intervals, while they were not given that same privilege:

"They would pop in and out to see other patients [about pain relief], but they never, very rarely did they ever [do that for me] ... I don't think that they made time because they knew I was a trained nurse ... I felt that they thought I would have known [when medication was allowed]". (jb32)

Perceptual incongruence about nursing care delivery extended into explanations for delays or gaps in care. Nursepatients all set out to be understanding of the demands on their caregivers. This was a common scenario:

"I would only ring [the bell] if I was really desperate ... you don't like to ask ... that did not worry me at first ... but the nurses don't seem to ask you ... [and] nobody would answer your buzzer ... you would hold out and hold out for a pan ... you would wet the bed if you didn't have a good bladder" (jb2:1-2)

Nursepatients were made to feel as though they should understand the inherent day to day difficulties of nursing, because their occupation exposed them intimately to the demands of the job. In the words of one participant, nurses

"assume that you know ... [about routines] when I said that I didn't ... looking at me really startled, and saying, 'What do you mean, you don't know? You're a nurse, aren't you?' " (dw7).

The nursepatients did not feel that this assumption was fair, because they were patients now, not nurses. They had assumed that they would be treated as patients. They were often hospitalised in centres with which they were not familiar, and for conditions which lay outside their areas of expertise.

One nursepatient commented:

"Even the likes of a pan, they would come in and say, 'Well here you are', and put it on the edge of the bed, and you might be in traction, and you would have to get yourself out of the pelvic traction [to use it]! Meal trays were another thing ... they would leave it on the trolley at the end of the bed ... and how [in traction] are you supposed to get that trolley up there, cut up your meal and eat it! They would not take any notice, just walk away! I used to think that they think I don't need the care because I should know better [than to expect it]...I used to think a lot of things ... you lay there for a long time ...You have a lot of time to think about things" (jb5).

The nursepatients all felt that they should not have been judged as nurses, for

"It is really important to listen to your patients, and not allow your judgmental feelings to be obvious, cos, let's face it, we all have judgments about people, but as a nurse, you have a responsibility not to let it get in the way of care" (dc23)

Nursepatients perceived themselves primarily as people whose circumstances made them patients. Having nursing experience and knowledge was secondary to their preoccupation with receiving professional care to amend their altered health status. They saw their wishes as compatible with those of other nurses and the health care agencies in which they sought care. Many of their caregivers perceived them to be nurses who were patients, and placed them into inappropriate realms of self-carer, assessor and malingerer. This perceptual incongruence led to feelings of frustration, anger and resentment. Unfortunately, nursepatients' occupations did appear to set them apart from other patients in the eyes of the nurses who looked after them.

### **Removing Control:**

Nursepatients wanted to participate in their nursing care as much as they each believed that they, as patients, were able to do so. They shared a common belief in emancipatory health care which would afford them joint responsibility and participation in discussions, decisions and actions concerning their nursing care. They saw their care evolving through interventions arrived at by communication and consultation with their nurses. However, they did not experience this level of control over their

nursing care. Their nurses as caregivers assumed, often denied and, or, actively removed control from the nursepatients. They did this by a variety of methods, including minimal communication, rule reinforcement, distancing, environmental restraints, restriction of choice and information embargo.

The nursepatients felt that the nursing care they received was almost always delivered superficially, without concern, consultation and, or, confirmation with them about their deeper needs, feelings or thoughts. These were not solicited by nurses, and modes of communication did little to encourage disclosure:

"They did ask me about my pain, of course, but then they never really took it any further to see what else was going on ... yes, and I guess, perhaps also they thought that I might volunteer that information, but I mean, sometimes you don't feel like doing that unless someone takes the time to talk to you and find out what is happening ... [they] were just popping in and out and talking generally ... if other people are talking to you of inconsequential things, you tend to stay on that same level of talking, you know, things that don't really matter... and then the nurse would leave the room and that would be the end of the conversation, so you never really got any deeper with anybody else" (lh4-7)

and:

"We never got beyond those very superficial sorts of things ... and no-one ever said to me directly 'How do you feel about this?' ... I probably would have said 'Bloody awful!' ... but nobody ever said that to me directly" (dw30).

moreover:

"It was a big rush in at pill time ... you know ... 'do you need anything for pain' ... then a big rush out ... so there was no stopping for 'how are you feeling today', 'is there anything you need', 'do you want to ask any questions' ... that sort of thing did not exist." (dc3).

which led to:

"If you wanted anything, or asked for anything, you felt it was a real effort for them to get it for you ... and ... if there was [sic] two of them making the bed, they would not be talking to [me], but [to each other] about what they did last night, what they were going to cook tonight or what they were going to do on their holidays" (mm39)

The nursepatients felt that they had little power over any aspect of their care:

"When a person comes in as a health care consumer, health professionals immediately take ownership of them, and lay down all the rules and say, 'You can do this, but you can't do that' and make decisions for them instead of asking them what they would like, or what they want" (dw19)

Another who wanted to take her child into hospital with her, but was unable to do so because of staffing:

"I found that side of it depressing ... you couldn't just go and do what you wanted to do when you wanted to do it ... it was restrictive in the sense that I could not have [my baby] with me, although I could see the point, because there was only one nurse on [duty] on the evening and at night ... so it was a really frustrating time" (lh18-19)

Rules were blatantly reinforced through adherence to pain regimes:

"They would look at their watches and say 'It's only three hours and fifty-nine minutes since you had something' ... but then it might take another half an hour before it finally came, so you were losing all the way, you would be losing out" (jb1)

and visiting times:

"It really gets up my nose, because if someone has traveled an hour to get there, then this keeping them outside, you know, and saying it is not quite visiting hours yet, you can't go in, is just ridiculous ... I think that the nurse has a lot of power in organising [this]" (dc35)

Thus nursepatients perceived that control of their health care lay with the nurses:

"When you are the nurse, you are in control, whereas when you are the patient, you are not in control, someone else is" (ms29)

A nursepatient talked of spatial and circumstantial reinforcement of control. She was confined to bed and found that her caregivers:

"At all times, were looking physically down on me ... when they continued to stand, as they did, that also removed that sort of individual equality thing that you have if we had been the same relative height ... also being the person 'done to' certainly removes your power base even if you are not willing to give it up ... just by being in the position of having something done [to you] removes your power base to start with" (sp26)

The carers were perceived to be free agents by virtue of their physical health and freedom of action as nurses. Nurses were seen to have a legitimate access to the ward, while patients who were told that they could and should walk, felt restricted:

"They say walk, but where do you do you walk? There is nowhere to walk, where do you walk? ... but up and down the passage, and you feel like you are peering in everyone's room ... that is something you don't think about when you tell people to get up and go for a walk" (ms4)

Nurses were able to remove themselves from the patient's immediate environment at any time, by either simply walking away, going to attend to the next patient or moving on to the next part of their daily routine:

"If you are the nurse, and you don't like, or feel comfortable with a patient, you have the ability to leave. Whereas when you are the patient, and that is particularly the problem ... you don't have the ability to control the nursing staff that come in ... or go out, at all" (sp22).

Withdrawal of self as carer was seen as the epitome of control, as in most instances, nursepatients were unable to physically move out of the bed, room or ward to actively retain the physical presence of the carer. It was felt that this gave the carer the ability to be able to choose to care, or not care, for their patients' needs, but that the patient had no means of redressing this situation:

"Nobody came back to see if I had voided ... sometimes I would have to ring the bell three times [emergency signal] with tears streaming down my face ... and they would not come near me!" (mv18).

For a nursepatient confined to bed, her lack of control was overwhelming:

"In the particular circumstance that I had, I felt that I just did not have any control. Unless they [nurses] were willing to come in and sort of look after me, then there was nothing else I could do ... I felt lost (dc5)"

Nurse caregivers who exercised control in this way made the nursepatients feel extremely vulnerable and powerless, for they

"would have to wait until someone came into the room to ask for something ... and even then you would have to wait ... it was given when it suited them, not when the patient requested it" (mm7).

Their feelings of lack of control were heightened when it came to receiving information about their hospitalisation, nursing care and outcomes. Nursepatients felt that they were not given sufficient information about their illness and treatment to understand what was happening to them. Any information given was neither conveyed in a manner designed to increase their knowledge nor to enable them to make informed decisions. Information was often given in a blasé manner and based upon the caregiver's interpretation of what a patient needed to know. This was felt, by each nursepatient, to be an unfair appraisal of their needs as people and nurses. Illnesses experienced by nursepatients often fell outside their own personal practice arenas, and this created knowledge gaps for them. One midwife, facing surgery said:

"I did not get any information about going to theatre. I did not know when I was going to have my pre-med[ication]. If you know what is going to happen, it is not so scary when it does. But I found that I had to ask for all that information. It was there, but nobody told me" (dc37)"

Another, whose area of practice was gerontology, was not informed that she was not receiving pre-medication prior to surgery:

"the only thing that changed dramatically from what I was used to, and that I didn't like, was that they don't pre-med you at all ... and I had to wait until 2 p.m., and I did not have a pre-med ... you are very apprehensive...they sort of tell you to have a shower and get ready, and that's about it ... and the anaesthetist said 'What do you think about not having a pre-med, and I said to him 'Well, I nearly got up and went home - changed my mind and went home ... I can't see a reason for not giving it" (mv4-5).

The theme of removing control was succinctly expressed by one participant who reiterated the feelings of all nursepatients when she said:

"You realise that you are really at the mercy of whoever is looking after you, when you are being nursed" (mv27).

The general consensus of nursepatients was that removing their sense of control increased their feelings of frustration and powerlessness, which, in turn, inhibited participation in their own health care.

#### **Devaluation: being made to feel different:**

The nursepatients perceived themselves as being treated somewhat differently or being made to feel different from other patients. They attributed this to being nurses. In their experiences as patients, nursepatients saw instances of differences in care and caring in the approaches, responses and reactions of their caregivers. Nursepatients compared their care to that given to other patients. They observed the interactions of nurses as caregivers with other patients. There were noticeable differences:

"They did not have the normal chatty conversation with you that they might have with the person in the next bed ... they did not really want to get close to you or they did not really want to know anything more about you, knowing you were a nurse was enough to put them off ... it was almost as if there was a wall up, and so not being treated like a human being, but perhaps not being treated in the same manner that the next person might be ... even though I had a private room, you could hear what was going on next door. We shared a bathroom, and you know, it was no effort for them to help this person, you know, go to the bathroom and say 'Is everything all right?' and 'Press the buzzer when you are ready', and all that sort of stuff ... whereas when I needed to go to the bathroom, I was just expected to go ... even though I had a sore tummy and everything ... 'Oh, well, you know where the bathroom is' ... that was the attitude. Nobody really wanted to help me because they assumed that I would help myself. It seemed that the woman next door got more offers of assistance than I did" (dc28-9)

There was a general feeling of disappointment among the nursepatients in the level of nursing support offered to them as patients. They recalled feeling "isolated", "alienated", "confined" and "excluded" from the rest of the ward by the actions of their nurses as caregivers. Very little encouragement was given nursepatients to mobilise and socialise with other patients in the ward, which denied them the opportunity to join patient to patient support systems. Many of the nursepatients came to believe that it was inappropriate for them to go outside of the immediate room, as "you were in that room, and that's where you'd stay ... it was more like a jail, I think!" (jb11). Other patients did not appear to be restricted in their movements. In essence, each nursepatient felt alone in her experience of hospitalisation and nursing care.

Devaluation of the nursepatient, as a patient and a person, covers a gamut of feelings associated with being made to feel different, difficult, dehumanised, labeled, and, or, a number or object rather than a person. Most nursepatients expressed feelings of being de-personalised:

"You felt as though you weren't a human being, you were a number. You weren't Tom, Dick or Harry or Mary or Mister or Missus or anything! You were in room five and you were *'The back'*. One staff member came in and said 'How's the back lady today?' I reckon I cried more times than I didn't. I hated it!" (jb4)

Nursepatients deplored this attitude, where:

"The patient is not a human, just an object ... they tend to sort of treat you like a number... [and] because your confidence has been squashed by this incident all the way along, you just felt as if you just weren't capable of making the right decision" (mm41).

Others talked openly of labeling. One nursepatient spoke of being called "just another malingering back patient" (mm39). After disclosing her occupation during admission, a nursepatient found that this information was relayed immediately to other nursing staff:

"She obviously thought it was important to warn the others that I was a nurse ... as if it were a forewarning, you know, 'This one's a nurse, she'll be a troublemaker'. Whereas you don't normally go out and say to your co-workers when you are a nurse, 'Oh, did you know Mr. Smith was a bricklayer' ... I mean (laughs) ... it's of no significance ... [but] if they see it necessary to go out and tell their colleagues that you are a nurse, then it is of some significance to them, and not necessarily a positive one. It's a form of discrimination against me ... and in another way, it was a breach of trust" (dc26-7)

Another, felt that her nurses had found it:

"easier to label the patient as difficult or different than to spend that little bit of extra time to try and find out what it is that is making him or her act that way" (dw39).



Nursepatients felt alone in their illness, their care and its outcomes. These feelings can be experienced by a patient who is not a nurse, and may be evoked by many things, including the strange environment of hospitals, threat to self-concept and fear of the unknown. But these patients were nurses. They were familiar with the cultural environment, the roles, the expectations, the system, very often the procedure, often the caregivers, and sometimes, the place.

Nursepatients were made to feel different to other patients by the actions of their nurses as caregivers. There were distinct differences in the levels of attention and involvement given them and other patients. Nursepatients attributed these variances to the only singular thing that they perceived made them different to other patients, that of their occupation as nurses. This was felt to be an imposition, for these nursepatients believed nursing, as a profession, advocated impartial, non-discriminatory care for *all* its patients. They did not believe that they should be exceptions simply because they were nurses. Being devalued as patients increased the loneliness and unhappiness of the nursepatients. This coloured their perspectives of caring. Recounting their experiences cemented their residual feelings of negativity, unpleasantness and dissatisfaction with the experience of being a patient.

### **The good, the bad and the ugly: Relationships in Action:**

In the context of the relationship experienced between nurse and nursepatient, three types were described: the good, the bad and the ugly (or "awful"). Nursepatients believed that most of their nurses as caregivers underestimated the importance of the relationship between nurse and patient to perceptions of quality care and patient outcomes. They were looking for a relationship which met their expectations of care, and unfortunately, this was a rare occurrence. This is sweeping, but not damning, because a relationship is a reciprocal affair. It needs to be worked at by both parties. Illness and its associated lethargy may explain a patient's inability to have the necessary energy and enthusiasm to give to relationship development, but similar reasons do not excuse nurses from participating in a relationships with patients.

#### *The Good*

This was a functional type of relationship wherein nurses appeared to genuinely care for the patients, the work, themselves and the profession. The nursing care was more patient-centred. In this relationship, the nurse gave more time to the patient as a patient, was friendly, and communicative. The nurse was a clinically competent caregiver who followed through with promises and requests, making the nursepatients feel that they were "in good hands". There was some sharing of personal information between nurse and nursepatient. This added to the perception that for patient care, at least, this relationship was more holistic:

"... because you have shared some of your life with them...they are actually looking at you as a whole person ... someone who is a human being as well, and that cheers you up, that is nice..."  
(dc42-3)

Nursepatients felt involved in their care because their input was encouraged, and their opinions, valued. This added to feelings of self-control and enhanced self-esteem.

### *The Bad*

This relationship saw relational disunity between nurse and patient. Nursing was directed at the condition rather than the whole patient. Nurses did not want to become involved with their patients at any other level than that of deliverer of care. Nursing was seen more as a task:

"It is very task-orientated ... and that is what it is ... ultimately they just perform their duties and that is, more or less the end of it. They just do the job, got on with it, and at the end of the day went home ... it has just become a job, and that is the easiest way to perform it" (lh12).

These nurses were perceived to have had a vested interest in the social and financial aspects of being employed as a nurse, and their behaviour indicated that they would not:

"spend time with the patients, talking to them and working out whether they need to be counseled or talked to about something, they are off talking to each other instead ... and if there were two of them, they would come in and say hello, giggle to each other and walk off ... they were only here for the money, the money, that's what they were here for" (mm44).

The behaviour of nurses indicated that they held a poor opinion of the nursepatients, and consequently, their interactions lacked depth and understanding. Nursepatients often felt that they were a burden for the nurses who professed to be caring for them. This was eloquently expressed by one nursepatient who said:

"It was just the feeling that if you wanted to burst into tears, that that will cause the nurse who is looking after you to run away, then you feel as if you are a bit of a burden, a bit of a pain in the neck, and not as strong as you should have been, and I don't think that you should have to wear that as a patient" (dc36-7).

In a "bad" relationship, nurses did not appear to be in touch with the nursepatients as patients or people. Nursepatients were exposed to nurses who were professionally proficient, efficient and officious, or worse, "those that were blasé" (ms7). Both approaches led to deficiencies in the personal aspects of nursepatients' care. Attempts to form a more personalised relationship were rebuffed neatly by caregivers who effectively controlled the nursepatients' input by not stopping to listen to requests. Holism was not a tenet of these relationships. The relationship was superficially beneficial because, in most instances, nursepatients went home physically improved, but emotionally traumatised. Three nursepatients whose physical care was not followed up during hospitalisation, because their nurses as carers were not sufficiently interested, were forced to pursue the matter with their own physicians until it was resolved.

## *The Ugly*

This is the antithesis of the meaning of relationships. Patients were secondary to everything else in the nurses' lives. There was no effort made to get to know the patient as a patient, or a person. Care was "careless and slap-happy" (mv6), directed from a distance, and often, not delivered at all. Communication was not open and honest, and did not always succeed in conveying information or increasing a nursepatient's understanding of what was happening. Patient input into care was minimal, neither encouraged, nor solicited. Nursing assessments were carried out infrequently, thus changes in health status were not always readily detected and plans not altered to accommodate new developments. Nursing care was often decided in isolation from the nursepatients and did not always achieve the desired result for either nursepatient or nurse. This was the worst type of scenario for one nursepatient who, during her hospitalisation, was unable to form any effective relationships with her caregivers. Despite being severely disabled following surgery:

"I was left to my own devices, as far as hygiene goes - with two limbs in plaster - I had to struggle to wash, toilet...getting on and off the pan, and clean my teeth. Then [later] getting in and out of bed. They [nurses] tended to think that because I was young, I could do it - without help ... I wasn't desperate for them to be interested in me as a person ... just be sufficiently interested to understand my physical requirements...and what they had to do ... and I did not really feel that I got that much ... I did not really feel that I was asking much ... and I did not even get that much, at all" (sp24)

For this nursepatient, procuring early discharge from hospital was preferable to remaining in this precarious position of foisted self-caring.

### **Caring Care - Extraordinary Care:**

Most nursing care and relationships with nurses as caregivers were described by the nursepatients as "fairly ordinary" and routine. Care was seen as extraordinary when nurses as caregivers were perceived to *want* a better than good relationship with their patients. Unfortunately, this was a rare occurrence for the nursepatients in this study. When an extraordinarily pleasant, positive, satisfying and complementary relationship between nurse and nursepatient occurred, it stood apart from all other relationships. Reflection upon the qualities of this relationship saw it held up as the 'holy grail' of nursing care, for which they, as patients and nurses, had been searching from day one of their hospitalisation. Nursepatients were looking for a relationship equal, or similar to, that which they, themselves, had been part of in their own nursing practice. When this did occur, it was a one-off situation in which the nurse as caregiver was perceived to hold a similar philosophy and practice paradigm to that of the nursepatient. This relationship was more than a combination of physical and psychological care. It was a meeting between two people who shared the same beliefs about nursing and caring. The relationship enriched both nurse and patient and was expressed in different terms by each nursepatient:

dc:

"Caring in a way that is giving of one's self, like sharing yourself as a person, not just as a technician or somebody that has to do

things for you. But, being, allowing yourself to be part of that relationship with another person. It won't always gel, there will always be two personalities that don't necessarily get on well ... In most situations, if you are just yourself and who you are, that immediately allows the person you have just met or the patient that you have just admitted to gain that trust almost straight away, because you are not trying to be something else. You are who you are and you are chatting to them as you. So I think that caring is the sharing of one's self and being willing to be part of that person's need by offering yourself as the person who will do it for you if you require it..."(dc42)

ms:

"You just felt confident and trusting with them...just a difference in approach and attitude ... nothing to do with their nursing techniques, or anything like that, it was just an attitude I suppose, and the way they spoke and you just felt that you could trust and had confidence in them ... and explained things more and spoke about what they were doing and why ... oh, it's just a feeling ... I don't know ... I can't put it into words ... *you just seem to know* ... you know that they know what they are talking about and what they are doing ... they are not all gush and no brain ... it [was] insight and instinct" (ms21-2)

ms:

"You were on the same wavelength with them ... it was just a feeling that you have that they understand and you can talk to them more than you can to someone else ... perhaps confidence and trust ... I sort of felt that I could rely on what they suggested or that I knew that they would look after me properly".(ms6)

dw:

"The ability to see the patient as an individual and it is really of no significant who you are or what you do ... the ability to empathise, to take a risk, commit or contribute some of yourself, putting the patient first, not being afraid to stand up for what you think, and being able to argue in support of what you think as an advocate for the patient" (dw25 &40)

jb:

"They had time for you. They would ask you about your family, they would find time to talk to you ... and they would tell you some things about them ... these are the little things I can remember ... one girl was renovating a house, another was having twins ... talking about these things stops you thinking about yourself ... we were like a family ... another one, she was good ... She was really interested in ... me and would always come to me and ask me lots of things about me ... she wanted to know everything about me ... she must have just clicked with me somewhere along the line..." (jb12 &43)

lh:

"He would take more time over his day to pop in an question me, and see how you were really going ... I was appreciative of his care ... I think he probably took the time to talk to me ... to see what was happening and how I was ... he probably tapped a bit deeper than the others and yeah, I did appreciate it as it gave me an avenue ... an outlet ... I suppose" (lh6-7)

mm:

"You would get the odd one who was good. Like the one, the one little one that came in. And I mean, she fixed you up, washed you and did your pillows and you felt as if you were floating on a cloud. She just had the right touch and everything" (mm40).

This relationship was a positive, interactive, better than good union of nurse and patient. Nursepatients felt that nurses who engaged patients in this type of relationship saw the relationship as an important part of nursing care and as a means of achieving positive outcomes for the patient. Moreover, these nurses genuinely appeared to like the patient as a person. These nurses were receptive and perceptive, demonstrating empathy and sympathy for the patients in their care. They had and practised good communication skills, including listening and talking. They provided accurate and appropriate information. Nursepatients felt involved in their care, without having to be formally asked to participate. These nurses problem-solved with their patients, and supported their decisions. They gave the nursepatients control and maintained their self-esteem as thinking people. This type of caregiver was naturally friendly, open-minded, honest, trustworthy and reliable in all aspects of the relationship, from first meeting until termination. They were happy in the work, and with themselves.

#### **Ending Discord - that one *really* good relationship:**

A "really good relationship" was described as a union in which there were mutual benefits and satisfactory outcomes for both nurse and patient. It was an extension of the extraordinary relationship into the sphere of concrete evidence of the quality of the care, caring interactions and relationship formation. As a relationship, it reconciled all other relationships, making up ground for discrepancies in care and open displays of non-caring attitudes. This relationship really made a difference to nursepatients' perceptions of their treatment by nurses and their long-term feelings about being a patient. Other less caring nurses behaviours were overshadowed, but not forgotten, by exposure to that one "really good relationship".

When describing a "really good relationship", nursepatients often referred back to their own practice for validation of their ideas, and their description reflected and contrasted with their own experiences as patients:

"They have got to come across ... as though this is the only patient on the ward, and while I am here with that patient, my whole attention, you know, time, is devoted to him, while I am here with him at this moment ... a patient can see straight away if you don't give two hoots about him ... there is the natural ability to gain people's trust ... and you would have to love your nursing career, and love caring for people, and get some sort of significant satisfaction from helping ... seeing that patient walk out the door, or knowing that you have contributed to the comfort of that patient's dying" (mm29-30)

and:

"You are keener, and more enthusiastic too, to do more, and therefore at the same time, become more involved ... take the

time to establish a link ... because you [the patient] would definitely know which ones to relate to, you would probably be happier being nursed by such a person because you would have a better communication with them, and therefore you may feel freer to expound to them whatever was worrying you, which in some ways would be therapeutic ... cos if you did not have that trust, in that person's either confidentiality or their abilities or their willingness to listen to you, you wouldn't get off first base ... the purpose of nursing is to provide the atmosphere or environment which is conducive to healing ... which would not only cover physical aspects, but also emotional" (lh13-4).

Reference to certain attributes was common:

"She [sic] has got to know what she is doing for a start off. She has got to know her capabilities. She has to know what is *really* wrong with the patient to help that patient get better. And just plain commonsense will get her a long way ... you do not learn unless you do your theory, but you can pick up a lot of commonsense answers. It just comes natural. It should just roll off. I mean if you have that caring attitude, if you really want to be a nurse, you will be a bloody good nurse ... your patients mean a lot to you. You have got to love, and just be yourself. Be natural. You learn it from a book [in the beginning] but you learn a lot from yourself" (jb23-4)

and:

"Irrespective of who they are [or] what they have wrong with them, that as an individual you respect them, and that as an individual, you are really no better or worse off than they are. You may have more knowledge in a particular area, but then patients have knowledge in other areas that is just not evident at the time ... and to listen, be it something fairly insignificant or of major importance ... just to listen and make a response to what they are saying. If you can't actually do something at the time, explain why ... rather than just say no. Then if you say, ' will come back and do that later", then to actually come back, and do it! To not come back and do it, is to lose whatever relationship you have started to build up ... and to say sorry when you have to" (sp14-5)

A "really good" relationship was often seen as 'daring to be different':

"As a nurse, I was always getting into trouble for I used to include the patients and ask the patients what they wanted and how they felt. When I was doing mid[wifery], I used to throw the baby up on the mother's stomach and immediately count all its fingers and toes, and say its balls are in the right places or whatever... my instinctive thing was that the mother wants to know that it is all there and that it's all very well to hold this red screaming thing up and say 'Isn't it wonderful. You have a boy' and then you throw it in the cot in the corner and it is another hour before the mother gets to hold it or see for herself that it is all intact, so I just used to do it first. That used to get me into trouble" (dw11-2)

and making a difference:

"The experience you have as a nurse with someone in your care is beneficial to them and to you ... it's supposed to be a positive experience, and it can still be positive if the person dies ... you ... make sure you're in tune with the person's needs ... by being caring ... listening ... making sure you're in tune with their needs and those of the family so that you can act in a positive sort of way .... that experience they have together is as beneficial as possible or as they can make it" (dc13-4)

Descriptions were often voiced in the 'should' and 'could' mode:

"You have got to really want to work in that area and like it ... if you are not going to like it, you are not going to treat [patients] the way they need to be, *should* be treated" (ms40).

This suggested that there was a strong moral obligation for practising nurses to provide this type of comforting relationship for the patients in their care.

In order to name this "really good" relationship, each nursepatient was asked to summarise their ideal experience in words which described its nature and effect. They described the relationship in terms of its positive, pleasurable and satisfying effects, and the competencies of the nurse who developed this relationship with patients. This relationship gave both nurse and patient pleasure, through reciprocal, caring interactions. The nursepatients felt cared for and about, as people, patients and nurses, and looked forward to each interaction with nurses who offered this type of relationship. They believed that this feeling was reciprocated by the nurses whom they perceived enjoyed greater work satisfaction through this interaction.

In this type of relationship, nurses were seen to be able to marry personal qualities and professional competencies to effect and affect positive patient outcomes. Nurses exhibited a high degree of skill in delivering truly holistic nursing care which matched the needs and perceptions of the patient. They were able to alter the environment to suit the patient's needs and not kowtow to the demands of other nurses, the ward or the hospital. Nurses capable of forming a "really good" relationship with patients had a physical presence which lent security and confidence to the nursepatients. In the words and eyes of the nursepatients, this one "really good" relationship could be seen to be mutually beneficial for nurses and patients, and conducive to healing in mind and body. A relationship of this nature and calibre was considered a therapeutic experience, evidenced by better patient outcomes and quality nursing care.

The concept of a therapeutic nursing relationship originated from nursepatients' descriptions of "that one *really* good" relationship. A therapeutic nurse-patient relationship is a two party affair which is energised by both parties. It is an intangible, malleable, reciprocal entity which develops between nurse and patient. It evolves from essential qualities of relational involvement, but appears to be

dependent upon personal attributes present in the nurse and the patient. For both, it involves a willingness to enter the world of another and the ability to see the relationship progress toward a mutually beneficial outcome. It appears to be important that the nurse is perceived to have a commitment to doing one's best, both personally and professionally, to set things right for the patient. This working essence is instantly recognisable by those looking for it in a nursing relationship, and its present assures that both nurse and patient benefit from their association.

### Summary

Nursepatients' impressions of their relationships with nurses as caregivers were largely unpleasant, unsatisfactory and negative experiences. Their expectations of care did not always match those of their caregivers. Nursepatients felt that their care did not embrace the holistic, personalised and patient-centred ideals espoused by nursing theory. Nursepatients were rendered powerless by the actions and reactions of their caregivers. Nursepatients believed that they were discriminated against by nurses as caregivers. They felt isolated and lonely. All of these feelings were attributed by nursepatients to the complexity of the position where, for some caregivers, the patient's occupation appeared to have equal import to nursing needs. Quality care and caring was dependent upon individual nurses whose distinctive personal and professional beliefs allowed them to incorporate the patient's social data into the nursing care to enhance relationship-building with patients. Consequently, relationships were diverse. Some were perceived to be good, others bad. Lack of regard for the psychological care of the patient rendered a few relationships negligent of holism. Examination of these relational varieties exposed, for the nursepatients, those essential elements of an effective working relationship, described as "that one really good relationship". Reflection revealed the speculated and actual outcomes of such a relationship for both nurse and patient. This relationship was perceived to benefit nurse and patient through process and application. It held healing properties. The terms, "a therapeutic nursing relationship", encapsulated these definitions and outcomes for further examination as praxis.

### **MEANINGS**

The experience of being a nursepatient has three facets of meaning - professional, personal and experiential. As nurses, being a patient meant really understanding what it was like to be a patient and to receive nursing care. They could now honestly say to patients in their care that they knew exactly how it felt to be a patient. Personally, the experience of being a patient meant that each nursepatient developed an acute awareness of the effect of power differentials in professional relationships, and the importance of self-esteem building strategies for patients to be assertive, confident individuals. As nursepatients, the meanings were highly individualised, varied, and linked to the paradox of being neither patient nor nurse, but both.

The experience of being hospitalised had definitive meanings for each nursepatient. In the context of relationships, the essential feeling was that of disbelief. Nursepatients could not believe that such an experience had occurred for them. They looked to themselves for the answers and found none.



There was a common belief that their type of experience was a rather unique, highly individualised event. Each sincerely hoped that this would not happen for them again, and that the types of relationships they had experienced were not commonplace for all patients. This was reinforced by personal examination of their individual practices as nurses which exposed concrete evidence of professional paradigms and personal beliefs that were contradictory to those experienced. Upon reflection, there was tangible evidence of the effects of their care in the form of positive feedback and thanks from the patients to whom they had been caregivers.

The experience of being a patient made these nursepatients feel different in a situation where they did not want to be seen as contrary cases. They did not expect to be perceived as "different" patients, but the actions and reactions of nurses as caregivers set them apart from other patients. They felt deprived of the essential activities of nursing care generated through the nurse-patient relationship because the nurses as caregivers, in most instances, withdrew from close contact with them and denied them participation in the relationship. These nursepatients felt that their rights as people and patients had been emotionally violated and that they were powerless to change the immediate situation.

For the participants, as professionals, the experience of being a patient meant a re-examination of their own practice and ways of being in relationships with patients. Personally, being a patient meant that each participant made some decisions about future hospitalisations, involvement in nursing care and nursing relationships. As nursepatients, there were some definite aims regarding health and well-being.

#### *Professional Meanings*

Professionally, the experience of being a patient for these nurses meant confirmation of their own practice beliefs that the patient is central and equal to the nurse in a relationship, and that such a relationship assures quality outcomes for both patient and nurse. Their experiences afforded these nurses an added means of communication with patients through recognition of a shared experience, that of being a patient. This sharing of the nurse's personal experience assisted patients to understand their own experience of illness. The nursepatients felt that sharing experiences enhanced communication, legitimised personal knowledge and validated self-worth within the nurse-patient relationship. The experience of being a patient extended learning about ways of being in relationships with patients which could then be applied to their own practice. There was a determination that the non-therapeutic relationships they had experienced would not occur for the patients whom they cared for in their day to day practice. There was an acceptance that a therapeutic relationship was more productive for patient, nurse and health care outcomes.

#### *Personal Meanings*

For these nursepatients, the meanings of the experience were influenced by the strength of emotions associated with the experience of being the patient component of a nurse-patient relationship. A

clear picture of what they needed to achieve in relationships with nurses emerged from discussion and reflection of the experience. The nursepatients resolved that the next hospitalisation would see them being a very different type of patient. They were determined to be more assertive, confident and vocal in their nursing care. Each would exercise more careful choice in future health care provision to ensure that it matched personal needs. This included health care "shopping" in order to make an informed choice. As future patients, the participants were determined that they would achieve therapeutic, partnership-orientated relationships with nurse as caregivers.

### *Experiential Meanings*

Meaningful feelings about the relational involvement with nurses as caregivers centred around issues of wellness, control and disclosure versus non-disclosure of professional status. There was a definite aim for the nursepatient to keep well, and well away from health care facilities in this capacity. These nursepatients wished to have more control over self and well-being, to be able to express feelings and demand change in relationships with caregivers. The ultimate response being the knowledge that they could, and would, discharge themselves from the care of those perceived to be unsatisfactory caregivers. As one participant stated:

"If the standard of care was low, because I knew what had to be done and that I could do it better at home, albeit with help from friends, I would go home and do it" (sp,10).

Nursepatients were indecisive about disclosing their professional status when next hospitalised. The decision, whether or not to tell caregivers that they were also nurses, appeared to be dependent upon each nursepatient's perceptions of the type of relationship being offered by individual caregivers. There was a strong suggestion that revealing, or concealing, professional status during hospitalisation rested entirely with the nursepatient, and would only either be done under the nursepatient's terms, or not at all. As patients who were also nurses, the idea persisted for each nursepatient that professional status did have some influence on what had happened to them during hospitalisation. There was a general belief that being a nurse had made a difference to the nursing care received, because being a nurse was the only factor which made these nursepatients different from other patients.

### Summary

The experience of being a patient was seen as an opportunity for personal and professional growth. Professionally, the experience for these nurses meant confirmation of their own practice paradigm that the patient is central and equal to the nurse in a relationship which assures a quality outcome. The experience gave them an added means of communication with patients in which the sharing of a personal experience may assist patients to find meaning in their own illnesses. Their knowledge of the lived world of the patient complemented their knowledge base and nursing practice. As professionals, they were assured that, for the patients in their care, there would be no repeat of the nursepatient experience of nursing relationships.

Personally, the experience meant that, as people, the nursepatients had formed a clear resolve to be different next time, that is, more confident, more assertive and exercise more personal control. They would make careful choices in future health care provision to ensure that selected institutions held a philosophy that matched their personal needs, that is, they would make an informed choice in health care. Each nursepatient was personally determined that each future hospitalisation would see them achieve relationships with caregivers which were more attune to that "really good" relationship with its essential elements

As nursepatients, the meanings were influenced by the strength of emotions associated with the experience, and were strongly conceptualised expressions of that experience. These included: wellness, a determination to keep well and "well" away from health care facilities in this context; control over self and well-being in such a way that allowed expression of feelings and condoned demands for changes in relationships with caregivers. For some, the ultimate display of control was the ability to discharge oneself from the care of those perceived as unsatisfactory caregivers. One dilemma remained, that of disclosure and non-disclosure of professional status. This remained a contentious issue, despite personal resolves. There was a strong suggestion that occupation would not be revealed on admission forms. The nursepatient would personally choose whether or not she revealed or concealed her occupation, based upon her perceptions of the relationships that could be developed with caregivers. This dependence was based on potentials which were expressed as: if the relationship was perceived to hold the potential to be a "really good" one, then disclosure of occupation would not be a problem, but if the reverse were true, then nursepatients would go to great lengths to conceal their occupation.

## **ELEMENTS**

Comparison and reflection upon the types of relationships experienced by the nursepatients elucidated the properties of a therapeutic relationships. Descriptors attributed to that "one really good relationship" were compared with other words nursepatients had used to describe their experiences. Reflective discourse differentiated certain qualities or values. In a good relationship, some properties were present, in a bad relationship, one or two, and in an ugly relationship none, or very often the antithesis, of all the desirable properties of an effective working relationship. In a mutually beneficial and healing relationship, vis-à-vis therapeutic, all elements were present. Nursepatients had mused that these desirable elements were present in that one really good relationship, assisted it develop effectively, and made it unique in their memories. It stood alone by virtue of its collated properties which were not present in other relationships. The thirteen elements of a therapeutic nursing relationship were perceived to be: communication, interchange, equality, support, safety, knowing, liking, closeness, consent, perceptiveness, trust, contentment, and satisfaction. The concept of a therapeutic relationship included working definitions of these elements and reflected the nursepatients' perceptions of what constitutes effective, holistic nursing care.

### *Communication:*

Communication between nurses and patients was perceived to be most effective when it took the form of open, appropriate, informative and interested interactions. There was an emphasis on talking and listening by both parties, each of whom must be willing to participate fully in the dialogue. The nurse needed to be sensitive to the patient's needs and aware of the conversational context. The patient was perceived to be very receptive to changes, in both verbal and non-verbal communication, that may indicate that the content was being altered according to the nurse's interpretation of the patient's comprehension. Withholding information was seen as the antithesis of a therapeutic relationship. Reciprocal interest in each other as persons, patients and nurses was productive to developing an effective working relationship.

### *Interchange:*

Interchange facilitated a therapeutic relationship. Interchange was a deeper exchange of information than was imparted by mere dialogue about the health care situation in which both nurse and patient found themselves. By engaging in this more meaningful interaction, nurse and patient began to form an appreciation of each other's parts in the relationship, and moved on toward a union in which responsibilities and roles blurred and crossed-over. This interchange of positions within the relationship meant that nurse and patient reached a deeper understanding of each other as people, and nurses, and patients. The exchange between nurse and patient of knowledge, feelings and experiences on an interpersonal level increased the acceptance of each other's being in the context of nursing care and clarified expectations of the relationship. Most of the nursepatients were hospitalised for illnesses which lay outside their own particular area of practice speciality. Explaining what they did, and or did not, know about the present situation, identified needs and added direction to the relationship. Being honest was an important component to their well-being, and the nursepatients expected a reciprocal quality in the nurses who looked after them. Admitting knowledge deficits was considered to promote learning for both nurse and patient. Exchanging feelings added a personal touch to the relationship and was closely tied to raising confidence levels concerning the care, the treatment and the outcome or outcomes. Learning from, and about, each other by sharing past experiences united nurse and patient. In this sense, in a therapeutic nursing relationship, nurse and patient were perceived to be one entity, not two.

### *Equality:*

Relational and situational equality of nurse and patient was an vital component of a therapeutic nursing relationship. The relationship was seen as an equal partnership wherein nurse and patient each had a fifty percent ownership entitlement. All facets of the relationship were shared between the partners. There was an acceptance that each partner knew the other well and was capable of "bearing the load" if one of them was unable to do so because of circumstance. This in no way undermined the authority or power of the other, but recognised the present need for dependence. There was mutual respect which extended to an appreciation of each other's ability and wishes regarding the experience and the relationship.

### *Support:*

Nurse and patient supported each other in a relationship based on and in credibility, commonsense, adaptability and competence. Both nurse and patient were considered to be credible authorities of self, needs and need-meeting strategies. The patient brought personal aspects to the relationship; the nurse, the professional aspects. However, each recognised the reverse in each other. Commonsense was the directive force within the relationship and the logic behind the decisions made. Both nurse and patient were adaptable to situation, circumstance and each other's feelings and wishes. The whole structure was a malleable, non-rigid association. Professional and personal competence within the relationship was an expectation and a recognition of attributes which are distinctly human, that is, a thinking, caring person concerned for and about the welfare of an other and one's self. The nursepatients were afforded relief by the giving nature of the relationship and the knowledge that another human being was available to them at and on such a level of involvement.

### *Safety:*

Physical, psychological and environmental safety was tantamount to feeling secure as a person and a patient. The nursepatients had to feel safe in every aspect of their hospitalisation. Physical safety encompassed those things done to the body, including basic needs such as warmth, cleanliness and diet, and other higher needs such as attention to detail with procedures and treatments, privacy and giving of medication. Psychological safety was the knowledge that discussion subjects were not confined to the present, but included any matter affecting the patient or nurse, with respect for the individuality of the participants. A safe environment was a conglomerate of physical and psychological. It was an overall feeling that one was protected and sheltered from harm without being compromised.

### *Knowing:*

A therapeutic relationship is one in which nurse and patient know each other well. This knowing is multi-faceted. It includes professional and personal knowledge of each other as people capable of feeling, thinking, controlling, desiring, anticipating and expecting certain returns for participation. It involves both nurse and patient knowing the physical condition, the associated feelings, the origins of thinking, the focus of control, the object of desire and the anticipated outcome or outcomes. It requires some skill to put what one sees with what one knows and follow pathways that seemingly lead nowhere. Being together throughout these journeys enhances understanding of each other in the relationship. This assures continuity of care and brings security to the relationship when either party is absent.

### *Liking:*

Liking each other began as a superficial entity. It meant that nurse and patient accepted each other within the relationship and respected each other in the circumstances that had brought them together. When liking reached a deeper level, it meant that nurse and patient liked each other as people. Anything deeper than this was considered to be unprofessional and overstepping the

boundaries of care. Liking each other eased rapport and made the relationship enjoyable. There was a strong suggestion mutual liking accelerated the formation of a therapeutic relationship.

*Closeness:*

Closeness was associated with a feeling of intimacy with each other. The very act of delivering nursing care was perceived to be of an intimate nature because of its association with bodily functions, but these nursepatients also felt that closeness on a more emotional plane was important. The two were considered to be synonymous to a therapeutic relationship. One participant felt that in a close relationship, "You [the patient] could tell them [the nurses] anything, and that they could tell you anything" (ms,7) in full knowledge that it would enhance the care given to each other within the relationship. In this context, advocacy flowed, because the two were co-conspirators in a relationship directed at health and nursing care.

*Consent:*

As each party in the relationship knew the other well, there was control and freedom. This seemingly paradoxical working relationship developed through mutual consent. There was control, as each person knew what was happening and why. Decisions were made in full knowledge of the situation and with the consent of each other. There was freedom to say exactly what one was feeling, and an expectation of an interested listener. The relationship was one of balance, achieved by contradiction of opposites.

*Perceptiveness:*

Each person showed sensitivity to the other, demonstrating insight, empathy and sympathy according to each other's needs within the relationship. Being able to perceive the other as an active member in the relationship acknowledged the importance of each to a therapeutic relationship.

*Trust:*

There was an expectation for both nurse and patient to be honest, reliable, responsible, confident and committed to the relationship.

*Contentment:*

There was pleasure within the relationship and with the care given and received. The relationship was relaxed and comfortable for both nurse and patient.

*Satisfaction:*

The process, relationship and results satisfied the feelings, removed the doubts and validated the self worth of both patient and nurse.

## **Confirmation and extension of elemental properties**

Now that the elements were exposed, it was essential for the development of the concept that the ideal of a therapeutic nursing relationship, described by nursepatients, be investigated as a practical reality. The thirteen elements represented the views of these nurses who had been patients, but not necessarily those of practising nurses and their patients. Extension of the sample to include descriptions of therapeutic relationships in practice confirmed the thirteen elements and supported the addition of another factor to which nursepatients had alluded, but largely not experienced as patients. These descriptions of a therapeutic nursing relationship as experienced by nurses and patients were highly individual. Some narratives placed more emphasis upon certain elements than others. However, these additional stories did confirm the existence, in practice, of a therapeutic nursing relationship, and establish its links to quality nursing care for both nurse and patient

### *NURSES' PERSPECTIVES*

Nurses' descriptions of therapeutic relationships embraced the thirteen elements espoused by the nursepatients in this study. Nurses talked of communication skills, exchange of personal and professional knowledge, feelings and experiences, equity between patient and nurse in a relationship and the importance of mutual support. Safety was described on three levels, emotional, environmental and physical. Nurses felt that it was important to get to know the patient as a person and for the patient to know the nurse as a professional and a person with a life outside nursing. Liking was a common notion for precipitating a therapeutic nursing relationship. The relationship between nurse and patient was considered to be a close association between two people who worked together and trusted each other to achieve common goals. It was essential for nurse and patient to be perceptive and sensitive toward each other in their relational contact. When these elements were present, the relationship became one shared between nurse and patient which assured both more satisfaction and contentment than a relationship formed through circumstance. Nurses also described in detail, a fourteenth element - that of camaraderie and its essential belonging to a therapeutic relationship between nurse and patient.

#### *Communication*

Nurses' descriptions of therapeutic relationships experienced with patients focused upon having, and using, good communication skills to develop a greater understanding of patients needs. One nurse commented that she had developed a therapeutic relationship with a client who was somewhat "hostile" and resistant to nurses approaches by persevering:

"I sat with her many times and talked to her, and usually start[ed] off talking general things instead of [her condition] ... I used to ask her about 'How is home' and 'Where do you live' and 'What sort of work do you do' ... a lot of other nursing staff had told me that she was very uncommunicative and that she doesn't talk and you know, but I found that I got through to her by introducing other subjects other than just [her condition] and the hospital. And I was able to talk to her" (is,1).

Another spoke of the importance of talking while performing nursing activities:

“When we trained you learned to talk to the patient when you were doing things ... I don't think they [patients] minded ... I think it probably made them feel more comfortable. I think that if you are talking, even if it is just making jokes or discussing what is going to happen for the rest of the day, makes them feel more comfortable ... it was better if you were talking” (jc,3).

Non-verbal communication was just as important to establishing a therapeutic relationship with a patient:

“There was one gentleman who was palliative care, a single gentleman, who was petrified of dying ... but he wouldn't communicate to you verbally, he would, when you walked into the room, he would just put his hand out ... so I would spend every spare moment I had in there with him and we would just sort of hold hands ... not a lot of verbal communication, just a lot of eye contact and holding hands ... he was such a gentle person that I don't think he would stand up and say, ' Hey, I don't want to be alone'... when you first held onto his hand, he was usually very tense ... and within minutes he was more relaxed” (jh,1).

Looking for an area of common interest outside the nursing and health care needs of the patient was important in building a relationship. Having "something in common" allowed nurses and patients to develop a deeper level of communication through which full expression of the patients' nursing needs could occur. Conversing with patients was made easier by having something in common, that was not nursing, health or hospital focused. It gave nurse and patient a link, or a tie, through a shared interest. One nurse found talking about her children a good starting point:

“I tell them the ages of my children and they find that all so interesting and I'm someone who has another life besides nursing, and I suppose that makes them talk about their other family members and where their lives go”(ls,6).

This shared interest in each other's lives assured nurse and patient of being able to initiate a conversation or discuss this interest every appropriate contact point. Each party in the relationship appeared more human. By clearly establishing a life interest outside nursing care and hospital, both nurse and patient were able to humanise the titles afforded them by circumstance.

### *Interchange*

Nurses and patients who were willing to honestly exchange their knowledge, feelings and experiences quickly developed a therapeutic relationship. Most nurses felt that they were able to establish a better relationship with patients if rationales were supplied with actions, because “you have to tell them what you are doing and why you are doing it”(jc,6)

Keeping explanations simple and appropriate to the moment was essential:

“Explaining what is likely to happen to them during the day, step by step as you go along ... how they might feel, that it is normal to feel like that, how they might be feeling, let them know that if they are not happy they can let you know and tell you that they are not happy” (fm,1).



Allowing patients to speak about their feelings was crucial to understanding each other as people:

"I talked about what had happened to him so far, about the operation, you know, how he felt about the operations, without putting words in his mouth. I got him to relate to me what the doctor had said about the results of the operation, and what they said to him and how much he believed of that ... I sort of just threw the ball back into his court all the time to let him speak and I think that just allowing him to air it, he sort of came to terms with [impending death]" (md,5).

Exploring feelings was important to developing trust in a relationship:

"If I can tap into that, and get them to talk about it, or what their past experience was, I find that that helps to build their trust up in me, cos they have just shared that with me ... I don't come in with any wonderful answers, but I find that if people can just talk about those past experiences, then that helps the present moment" (so,2).

### *Equality*

A therapeutic relationship developed when a nurse and patient had an equal share of the relationship and an equal footing in the decisions made within that relationship. Equity was closely connected with closeness, trust and support:

"Professionalism ... has to be balanced with treating [the patient as an equal] ... not talking down to that person, but treating that person as fellow human being ... and we are there together and we are going to travel this road together, and ... I will be there supporting you and ... that is how trust comes"(so,2).

This particular element was also dependent upon the nurse being able to convey equality to the patient through manner, approach and actions. There was an assumption that patients saw the nurse as a knowledgeable professional who was more human and natural toward them than most other health professionals. One nurse described this as:

"A matter of *not* having that aura that I'm the Sister and you're the patient and you should feel that I am controlling you in this environment [but] you can have input into your care so that patients are aware of what is going on and what their care is going to be and that we are going to do that now" (ls1).

### *Support*

Nurses felt that they should support patients as people with rights to self-determination. A nurse told of a patient scheduled for surgery whose husband died. A decision was made for the information to be withheld until after the surgery:

"I felt that you could not let her miss going to the funeral because of the surgery! ... it was her choice. Well, they told her and she discharged herself and went home to the funeral ... I am glad I spoke out, because it should not have been [their] choice ... [nurses] speak up for patients if they don't want to ... or are ignored ... you are the go-between for the patient ... it is an important role for nurses to tell the patients that they do have a choice and that you will say something for them or even if they want someone in [to support them], then you can make it a lot easier for them" (rd,3)

Nurses could overcome patient loneliness, as “that nurse relationship can make them feel a little bit as though they are not so alone” (ah,2).

Support was connected to friendship:

“Hopefully, as a nurse, you are there prepared to be their friend and to interact with them, but if they put up barriers and you know that they do not want that, then you don’t force it” (sj,4).

and closely aligned with physical presencing or “being there” for the patient:

“You have to be there for the patient, and if it means staying over [finishing] time, well, that’s it, you have got to be there for them and you have got to be their advocate” (sd,7).

and it meant psychologically tuning in to the patient’s unspoken needs:

“I like to think that I will always be there to listen and to learn and to, especially, pick up on the things that they might not say, but do want or need ... and basically, a support for them while they are in need” (nb,4).

### *Safety*

Nurses felt that they must always maintain a professional concern for the well-being of patients, and project a friendly, pleasant demeanor. Maintaining social etiquette by introducing one’s self at the beginning of shift and saying good-bye at the end, was perceived to assure the patient some security:

“You might only have a quick chat at the start of the shift [but] it makes them feel ... important and like they are cared for in this strange environment [and] because there are so many people popping in and out, at the end of the shift, I will go in and say “See you later” ... I won’t just disappear” (Ah,3).

It appeared important to nurses that they greet all, and particularly new, patients with a “pleased to see you” attitude and a smile of welcome in order to dispel patients’ fears of strange surroundings and feelings of personal inadequacy in a hospital environment.

“When people are in hospital they are anxious, they are frightened, they are in a new environment, and I feel that as a nurse, you have to really make them feel welcome and make them feel that ... that this is their second home away from home if they are sick or if they are not well ... and to really make them feel comfortable. You should not make them feel as an intruder or that sort of thing” (ia,2).

Making the patient feel at home was a common theme. It was perceived to be an important aspect of hospitalisation which encouraged patients to maintain, as near as possible, the normal functions of their daily lives. When patients felt part of the ward, they were more relaxed and comfortable about what was happening to, and for, them.

“They are not afraid to ask, no matter what it is ... you know, they might want a cup of tea every hour or want you to sit with them ... so it is like a home away from home for them” (jt,7).

"You knew what he liked, what he drank ... you just knew his routine ... cos everyone has their little ways, and it helps if you know them too ...it was like his home away from home" (cb,2).

"When people are in hospital, they are anxious, they are frightened, they are in a new environment and I feel that you really have to make them feel welcome and make them feel that this is their second home from home"(ia,2).

"If they are a long way from home... and understanding that being out of their home territory can be a bit traumatic for them at times ... make them feel a bit more at home [in hospital]."(Ah,2).

Safety was also assured by attention to smaller details in the physical environment surrounding the patient. These actions increased a patient's comfort:

"[At night] I pull the curtains across so that there is not so much light from the exit signs. I explain to them that they are going to hear noises and what these are ... make sure their call bell is handy and [tell them] they can ring for anything" (jh,4).

Psychological safety was associated with "telling the truth" and "being honest" with patients. Nurses were well aware that patients can detect falseness and, that if circumstances prevented social pleasantries, it was best to be honest about what was happening on both a personal and a professional level. Honesty was an essential attribute for increasing a patient's level of confidence in a nurse:

"Look, I really think that most patients expect it anyway, but I think that they feel ... safer ... that at least they know that she is going to tell me the truth ...so she must know what she is doing" (jh,4).

Safety was associated with displaying competence:

"You have got to convey that [so that] they feel confident with you looking after them. You have got to be competent. You have got to show that you know what you are doing ... so that they feel confident and happy. I think that that reduces their anxiety, if they feel confident with you there ... explaining what is going to happen ... how they might feel ... getting out of bed... pain" (fm,1-2).

Added to this was the observations of nurses who saw that being able to again care for those patients who returned to the hospital, reduced patient anxiety:

"It seemed to make so much difference to his whole perception of coming into hospital. It took away a lot of his fears, I think, to see a familiar face, you know, somebody who would know him and understood him. From the patient's point of view, it was very good for him to see a familiar face ... they are at ease and I think it is because they know that person, so that makes a big difference" (md,7-8).

Another nurse spoke of the similarities between being allocated the same patient for several consecutive shifts, after days off and on re-admission:

"They come in to the same familiar faces ... they look out for you and they are relieved if they have got you again ... If you have shared some intimate time with them, then they start to open up more. If you can help resolve their fears and worries, then its does help the healing process... and I am sure that it does aid their recovery ... [you get to know a few well... and some don't want to go home later!]" (cb,3).

One nurse talked of patients who had traveled long distances for their health care and lacked frequent visitors:

"Patients often get out of their comfort zones [with hospitalisation] ... it is probably important for this type of patient [that] they have someone they can sort of [relate to] ... a familiar face first thing in the morning ... someone they can talk to ... a bit of friendliness" (ah,4).

Measures to increase patient safety were broad:

"Making a noise, laughing [lets] patients know that you are there. Another thing that patients ask is 'Oh, who is going to be here tonight?' I think that some think that when we knock off at 9:30 there will be no-one here. I say, such and such a nurse is on and often they will ask, 'Is Sally on tonight or Joe Bloggs on tonight? Oh, good!' They begin to build it up and to feel a securer now. You know, little things like ... the buzzer, a box of tissues and water by their bed ... it is such an insecurity to be old and frail and not be able to go to the toilet and not to have a buzzer to call anybody ... it does really count ... it is security... I would not like to be lying in a bed with my arms crippled and not be able to get a pan or call anybody. You don't want to *have* to call over to the next lady and say 'Excuse me, can you...' And I always make sure my bed areas are always clean and neat ... cos lying there and seeing a mess would be the worse thing ... I would want to get up and clean up" (sd,8-9).

### *Knowing*

Knowing the patient was important to developing a therapeutic relationship. Most nurses recognised the need to get to know patients on all levels of function as physical, psychological and social human beings in order to deliver holistic nursing care. There was a clear link between knowing the patient well, and responding appropriately to their behaviour with their families and other health care providers. One nurse narrative concerned a patient who was dying and did not wish to discuss this with her husband friends and doctor. It was important for her to maintain a certain attitude toward people other than nurses. Knowing the patient was tantamount to understanding the context of this happening:

"[She was] the strong one in the family and they looked to her for those day to day things ... she was always the brave one ... I think that in this relationship that she was the one 'who wore the pants' and made the decisions ... and I think it was a release valve for her to have someone to whom she could say 'It's not working ... I'm not getting any better ... I'm not coping' and she never said that to other people. Her visitors would always come and say that she looked so well and that you would never think that she had cancer. And you would be thinking ... 'Well, she just had so much morphine and she is not in pain' ... and she never let that on" (jk,1-4).

Continuity of care assured greater knowing of each other:

"I prefer, if possible, to continue on [nursing] the patients I have had previously. You get to know them better, they get to know you better. I think it is much more satisfactory for them and me. I think you know where you are. You know what the patient is like, the patients know you and you can develop a relationship" (fm,2).

As did familiarity, because:

"A lot of people, especially in small communities like this, really like continuity of care and they like to see a face that they know, that they can recognise and the family like to see that they recognise [because] it takes away a lot of ... fears ... because you know them ... a bit about their personality ... their support people, their partners, their families, and that seems to be as important to the family as it does to the patient ... it just seems to put them at ease. I think they feel less threatened by the environment and what is going to happen to them ... if they see a familiar face" (md,6-7).

Knowing the patient was intertwined with giving quality care, especially to the very ill and the dying because:

"The only patients that you get to know very well [particularly while on night shift], and vice versa, are the ones who are very sick and you spend more time with, and often those are the ones who die ... so you can give them a peaceful death" (jt,1).

The elderly also featured:

"At the start of the shift I like to sit down for a few minutes [with each patient] and really find out how they are ... so that you eventually get to know them so they feel comfortable with asking you things ... cos a lot of older folk here won't ask ... you *know* that they will lie awake all night with chest pain because ... they still think that they are bothering you ... they will give up [asking] if you don't listen to them" (ah,2).

The focus of this knowing of another was, however, limited to what was considered to be appropriate to know at a nursing level. Each nurse personally discerned a level of involvement attuned to patient care:

"There is a lot of different nursing practice being carried out. I think individual nurses are different [especially] when I think of the mix of us here. Some people don't really get involved. It is still very ... physical care ... I think we really need to get to know our patients and stick by them" (Ah,3).

Although getting to know the patient as a patient who is a person appeared to be a primary concern, there was a deep sense of avoidance of becoming too involved and knowing when and where to draw the line regarding personal input. Over-involvement was perceived to lead to high stress levels and possible burn-out. Many nurses described a past instance where a desire to be deeply involved with a particular patient had led to personal distress, for example:

"It has taken me a lot of years [of nursing practice], a *lot* of years to leave things behind when I leave the hospital. A long, long time ... I have trained myself to do that ... otherwise I go home and I lie in bed and worry about and think about a patient and wonder what I did and did not do ... once I had a little girl in here and we sent her off to another hospital [100 kilometers away] and I actually went to that hospital the next day to visit her [the family were surprised] and it was at that point that I realised that I was taking time away from *my* family and getting a little too involved. A phone call would have done that [time]" (md,9-10)

Involvement could be tailored as one nurse recounted:

"I remember one patient I nursed about a year ago, again from the Wimmera, and he had cancer and was in remission. He lived on the way to my in-laws and I was able to call in and check up on his progress. It was good to be able to call in and see how he had progressed. With these sort of patients, they can take a little more out of you because you get that little bit more involved. It is nice when it happens occasionally, probably not all the time" (aH,6).

Both nurses professed that this hindsight about acceptable levels of involvement had enhanced their personal and professional growth, and that they were now more able to care as nurses for patients.

### *Liking*

In a therapeutic relationship, liking each other was essential to relationship formation:

"cos if you don't like someone then you don't lend yourself to being a confidant ... you tend to make excuses not to risk any more [contact] ... you just move away..[but with those you like] you feel comfortable ... you can talk about anything ... you would have a laugh ... and they feel comfortable with you" (jk,3-4).

"Rapport" and "clicking" were frequent terms that appeared interchangeable with liking. Nurses used any of or all three words to describe the scope of personal feelings involved when nurse and patient had developed a closer relationship. Qualifying statements for this relationship were that nurse and patient were "getting on well" and "confiding in each other". Clarification of the meaning of these words often imposed a degree of difficulty for the nurses, who found it difficult to articulate precise, discriminatory definitions. Differences in meaning and use were exposed by taking time to reflect upon examples of each. Rapport was something that had to be worked at by the nurse, while "clicking" could occur immediately upon contact of a nurse with a patient:

"Some people, just like out of hospital [socially], you click with straight away, other people take more time ... to get to know ... I like to take a bit more time to get to know these people and their care. (cb, 6-7).

Rapport was a tangible entity which developed as nurse and patient became more familiar with each other, often through seeing each other as friends working toward a common health goal. As such its orientation was probably professional recognition of an effective relationship between nurse and patient:

"It is having time to build up a level of trust and establish a rapport ... giving that person your sole attention ... showing that person that you respect them and treat them with respect, and I don't talk down to them ... you communicate on a level that is more or less equal, but at the same time I am still aware that I am a professional person and I need to act in that capacity because after all, they are dependent on me being efficient at my job *and safe*" (so,1).

One nurse recounted her experiences with palliative care clients in the community:

"I do a lot of palliative care and I find I really enjoy that and I get a really good rapport with those patients, and I find I really click in with these people so well and they ask me questions [that they don't ask other nurses]... and I keep them informed. We had a lady ... for four months ...

on a syringe driver so she required a registered nurse every day and I work three days a week [and went] to this lady ... but I think that you have a rapport when you walk in the door and they have the kettle boiling when they see it is you that pulls up, and you are instantaneously a family member and you are pulled into the family and you are part of the family ... which is really good ... I just get in there " (Is,2-3).

Rapport was enjoyable:

"There is nothing better than coming to work and building up a rapport with a patient or patients ... you go in and think 'I am going to see such and such ... we've had a great couple of days' ... its great to see them again" (sd,11).

Clicking was a more intangible, "gut feeling" that the nurse experienced about the patient, as there were "some people you have just got a sort of chemistry with ... they just gel with your sense of humour"(cb,6-7). Clicking was a non-verbal recognition of each other as compatible people. Clicking was seen as reciprocal: "You just knew that you were going to get along from the first moment you met"(sd,11). Clicking was also rewarding:

"Often you gain so much it is worth what you have to go through to pursue a sort of relationship while they are in here ... getting to know them and what they go through. There are always a few that just don't click with you but, often you get those ones that really do click and they are very special and you go out of your way to look after them and give extra special attention to them ... they are good to communicate with and develop relationships with and care for" (nb,2).

With either entity, there was immediate liking between nurse and patient, and mutual recognition that the relationship would be therapeutic, functional and self-limiting:

"You really do need to click with patients to be therapeutic ... there are times when you have clicked with a patient and the patient does not want to go home ... I mean it is sad in a way to loose touch with some of the people that you do look after, but that is the way it is. They come in, they get better and they go home and that is what we are here to try and get them to do ... [through] a therapeutic relationship" (nb,4).

### *Closeness*

A therapeutic relationship was perceived to be a closer connection between nurse and patient than a mere professional association of two people. There was more caring, sharing, intimacy and person to person closeness in this relationship:

"There were things that she would not mention to her husband that she would talk to us about ... the doctor would come in and she would be very positive to him ... yet she had all these fears that she would talk to us about ... I think the main thing was that we were there, so she should talk to us ... the nursing staff were the only ones that she talked to about her future ... she did not even tell the doctor that she was scared ... you get to know what they are going through" (jk,1-2).

Mutual crying in times of trauma, death or birth was a sign of nurse and patient togetherness:

"I think it shows that you care. You have become close enough to the situation that you have been touched by it and you care ... that it is

special for the parents and the family ... it is their special occasion ... and they very frequently cry [and you do too]" (fm,6).

Closeness was associated with intimate knowledge of the person's needs and wants, and involvement with their families:

"You knew what he liked, what he drank, and his routine too. I think that helps if you know their routine, cos everyone has got their little ways ... we sort of went through the things that he went through too, you know, with him getting worse, just going through all that and getting close to the family and the children ... you really felt for them all ... they got to know you well and they opened up to you too ... you ... spend time with them [and] get emotionally involved ... it is never a simple case ... medical patients ... they have so many problems"(cb,2).

"To just sit down and spend time conversing [evokes closeness] ... she was telling me all about her family and her life and what she was planning to do. She was organising her will and all of that and who was - the grandchildren would get this and that ... I had time to sit and hold her hand ... it was what she wanted to " (Ah.1).

Being closer to each other meant that both nurse and patient took an interest in each other as people:

"Over the years I have discovered that the ones who make the effort to get to know their nurses [you get closer to] and the nurses become fond of them and they put a bit more into being there and their relationship with them. They and their families do greet you when you walk in and take the time to get to know you ... to know your name and they greet you by name ... and say 'Hello S. How are you today?' ... because they know your name it makes a difference to looking after patients. Actually you do give them a bit more care and attention ... we talk a little bit more ... because they sound a little bit more interested in the nurse looking after them" (sj,2).

"The interest both parties show in each other and each party remembers what the other person tells them ... like the patient will remember that you said that you had the next day off and what you are doing, and they will inquire about that" (nb,2).

Keeping confidences was part of being close to each other:

"If family members ring up and want to know certain things, I tend to put them through to the patient so that they have confidence in you and that you are not going to spill the beans or that the whole community is not going to know what they are in there for. It helps build their confidence ... that you are going to tend to their needs as much as possible without breaching that confidentiality and everyone knowing about it" (sd,4).

Closeness meant a special kind of friendship:

"We were becoming emotionally involved, but it was still nice. I guess there is nothing wrong with being sad or upset when someone you begin to care about dies. But perhaps it was easier for the family and the patient that we were becoming friends and that he would die in a friendly



sort of atmosphere. Hopefully, as a nurse, you are prepared to be their friend and to interact with them ... and they interact with you ... and talk about their world and you ask a few questions and they ask some back ... because we had this relationship and we were becoming friends, it was easier to do all those things and more that he did not ask for or anticipate ... it was a two way thing" (sj,4-6).

As nurses:

"You tend to discard the barrier and become more of a friend and you hope that that is an aspect of the relationship that they grasp and enjoy and look to ... that they would have had that friendship [from nurses]"(ah,4).

And:

"One of the things that you can offer them is companionship and ... the opportunity to sit down and talk ... to vent how they are feeling ... and you are an outsider who can sit down and listen [with] and objective view ... helping them, sort through their own emotions and feelings and conflict and how to cope .. it is a sort of open-ended relationship (nb,4).

The context of the relationship was a focal point of the nurses' descriptions. There was respect for a relationship with a patient developed for professional reasons, and an assumption that the relationship based upon a need for health care would remain within the confines of the institution.

The relationship was seen as:

"A different sort of relationship to a friendship you develop outside the hospital. There are sort of limits and bounds that you have to, or that you do, stay within cos of the environment you are in ... [which is] basically, a support for them while they are in need" (nb4).

Nurses often stated that it was possible to see the patient outside of the hospital because patient and nurse often lived in the same locality. It was mutually acknowledged that, outside of the hospital, the relationship was a more of a casual acquaintance type of social connection in which the intimacies of hospital life as nurse and patient were forgotten, but the involvement of two, as people, was not. One nurse mentioned that it was nice in this more social "how are you" mode of contact to "catch up" with the patients that she had nursed and to find out what had happened to them since she had cared for them as patients. One nurse remarked that seeing patients outside of the hospital was therapeutic for her:

"They see that I am doing the grocery shopping just like they are and they will stop me and say 'I'm doing this now and I've this and that'...they tell me what they are up to with their lives and I find that really quite positive for them and for me too, because I know where they have headed ...and I never stop them from talking to me" (ls,6)

Some nurses professed to feeling embarrassed about meeting patients in the street, mainly as they had forgotten the patients' names. They often bemoaned their lack of recall, until later reflection made them realise that their names, too, had obviously been forgotten by the patients. All participants found that these "outside" connections were pleasant, undemanding interludes that often left them feeling better about themselves and the world around them.

## *Consent*

In a therapeutic relationship, consent was tacit. Nurse and patient shared decision-making and supported each other in the process without having to verbally agree to this arrangement. Both respected each other's abilities to work in unison toward the best possible health care outcomes from their relational connection:

"It was just habit in the end ... you knew that she wanted it that way and she would often say [so]" (jk,4).

Both nurse and patient responsibilities overlapped in this situation:

"One of my ladies was down here today getting her own pan and I said 'You don't have to do that, I will get it for you'. She said that I had enough to do and that she was capable of getting it herself" (jc,5)".

Consent meant accepting the patient's views and values and working with them:

"I have a special relationship with a patient with HIV. We sit and talk openly about death and his funeral... and each patient approaches their own death differently and I think you have to be there for how they want it - you don't put your own values onto them. You are there for how they want to approach, you know, their own death" (md,3-4).

The self-limiting nature of the relationship was also tacitly acknowledged:

"I was happy to hear her story and see her, but she will go out the door tonight and I may not see her again, and that is all right (fm,4).

An important part of consent was patient advocacy, that is, supporting patients' decisions regarding medical treatment:

"A special relationship I had recently was with a lady who decided not to have any active treatment. She really thought things through ... but the doctors would come to see her and talk around her. So I spent time with her talking to her and then explaining to medical staff that she had spent a lot of time thinking about it, and that it was an informed decision, and supporting her in her decision which was what she wanted" (Ah,1).

procedures:

"It is good if you can speak up for them ... [especially] with a procedure that is going to be done and they do not want it" (rd,2).

and their families:

"Because I knew how she felt, I found it quite easy to say to the family, that they had to sit down as a family and conference as a family ... and decide with your mother ... cos one section wants active treatment and the other wanted withdrawal of treatment, so there was real conflict of interest there with the family, with the mother. I said 'What does she think about it? Have you discussed it with her?' And there [had been] little discussion with her, I knew"(md,3-4).

## *Perceptiveness*

Nurses were perceptive regarding patients' unspoken needs and utilised this knowledge in care planning:

"It is just something that you sense, just the way they look at you and you get a sort of feeling if the patient appreciates some silly jokes or whether they just want the facts, or whether they want you to stay around and help them out or whether they want you to leave them alone. It is something that you develop as sense. You have really got to be aware ... I think ... because if you don't have that awareness, you can miss a lot with your patients. Then again you will get two people in the same, similar situation and because they are different people, they will be totally different in how they react and what they require from the nurse-patient relationship. So you really have to be adaptable and be able to get in there and work it out yourself. Not necessarily with the verbal information but with the non-verbal communication that they use and often information from family and friends. I think one of the things we tend to do as nurses is when one person has looked after a patient and made a generalisation, and we come to handover and that generalisation is stated, we have got to be aware and not go into that room with that generalisation on your mind. Like this patient is difficult - then you are going to expect that patient to be difficult and you will make it difficult for then not to be difficult. You have really got to go into each new patient with a fresh mind and a new attitude" (nb,5-6).

Perceptiveness was coupled with awareness of the total person inside the patient:

"There are so many cues that people give out that we miss on simply because we are trying to plan our day's activity. I think as I get older I am more aware of those cues ... I have got more perception of what people might be saying under[neath] what they are saying" (so,3).

Nurses utilised this perceptiveness in several ways - to effect change:

"She was an educated woman. She did not like people telling her [what to do] and she did not want people to think that she was hopeless or that she was not capable ... I just had that feeling ... so I gave her a lot of praise and told her she was managing well. And I used to give credit where credit was due ... for encouragement and to make patients feel good, too" (ia,2)

"Sometimes instead of running off to get morphine or pethidine, sometimes the mere fact that you stop and you talk almost takes their mind off the pain and their need for analgesia is not as desperate ... sometimes its is just a feeling that 'Gee, I wish I had more time to spend with that person' ... Maybe it is a subliminal message that they are giving that they really want you to stay there and talk. Maybe it is not a lot of specific things that they have said, but more a thing that you are sensitive to or that you are aware of." (so,4).

to do that little thing extra when it was needed:

"Doing something for them ... like getting them a cuppa and they say to you that you are too busy, and turning around and saying that you are not too busy makes them feel good ... even if it was something simple like getting a cup of tea or sheepskins for their backs, positioning for comfort ... when they know you are busy" (sd,5)

"Lots of little things - their hair - some like their hair set sometimes and blow-dried and chasing up little things that they have to organise in their

own home, letting people know that they are in [hospital] or just going and ringing welfare and organising services to stop ... and transport home" (cb,4).

to reduce anxiety:

"Another man I have today is going for X-rays and he is aware of what time those X-rays are so that he is not sitting around thinking 'Well, when am I going to go for these X-rays and what is going to happen when I have had them done and does that mean I have got to wait to see the doctor?' ... I never make it so that they know nothing and I know everything" (ls,1&4).

and to respond appropriately:

"It has tied in very much with my own spiritual growth as a human being and has helped my ability to nurse people that [sic] are dying and sort of accept [death]... death does not scare me any more [and I can] be more useful as a nurse to meet their holistic needs other than just their clinical and comfort needs" (md,3).

"You have to interpret each patient, because every one is an individual. You can take one look at them and know [what they want of you]" (jc,6).

"You have got to sort of tune in and pick up on their vibes and the aura around them, as to how they are feeling to be able to react to them and if they do just want to sleep, then it is no use being effervescent around them - when they just want to relax" (sd,1).

"Because they are so sick, it is often 'Leave me alone' and you will find that as they get better, feel so much better in themselves, they are just a different sort of person ... especially the young pancreatitis people that come in with alcohol problems...sometimes they are so obnoxious when they come in and you find that when they improve and get better medically, they seem so much better in themselves and they are much easier to look after"(jt,6).

With perceptiveness came empathy, which was qualified by statements such as:

"Putting yourself in their shoes ... what would it be like if it was me ... just what you would like and expect people to do to you" (Ah,2).

"It probably hurt like anything getting out [of bed] the first time [post-operatively]" (Jc,7).

"I think the main thing is to be really therapeutic, you have to put yourself in that bed and you have got to think, 'Here I am, what would I be feeling?' Because I think of the things my mum went through when she was in hospital, I think that you begin to think in that mode ... and you sort of tend to think well, if I was in your shoes, what could I do for me to make me feel better .. you know, how would I feel if I was in this position - lying here and having a catheter put in - and what I could do to make it a bit better - so it is not so embarrassing" (sd,5).

"Another important thing is that you put yourself in the same situation and the same sort of person, you know, what sort of things they would be going through as [compared] with what you would appreciate yourself. If I feel that I have met someone with whom I have an empathy, you are sort of on the same plane, the same wavelength and you know how each

feels and what they want and when they need it .. and you know you are going to get along well" (nb2 &5).

Empathy was intertwined with sympathy:

"It was a little of feeling sorry for them ... having some understanding of those people ... you feel a bit sorry for their circumstances or what happened to them here with the complications ... they are very attached to their home places and don't cope very well out of them ... if it was me, how would I cope in those circumstances?" (ah,3).

### *Trust*

As the relationship between nurse and patient developed, so did trust in each other as partners in health care:

"After about two days, I found that I was able to tell her anything and finally she accepted the fact that I was there to help her and not to intimidate her or harass her with things and not to make her feel as though she was not capable ... of looking after herself"(ia,1).

"The first thing is that you introduce yourself and have a little chat with them and make them feel comfortable and establish a sort of relationship on name basis, what they like, what they like to be called, what they are in here for, what you are going to do for them, and your name, and that they can call you whenever they like. It is not always said explicitly like that, but you get that across to them and get them settled in comfortably so that they can trust you ... and if they develop that trust in you then they are more likely to have a therapeutic relationship with you. Some people are more willing to trust than others ... some you approach more slowly [to gain trust]"(nb,5).

"I felt that they had some trust in me when they got to know me better ... continuity and them feeling comfortable with you"(fm,1).

Trust was aligned with honesty of self, capabilities and prognosis:

"I think that they feel more comfortable because they can trust you, because you have been honest with them"(jh,4).

"I think they like it if you are really honest with them because they know where they are at"(cb,1).

"You always give them an answer to what they want to know, so that they know where they are heading with their care"(ls,1).

"To know what you are on about and if you don't know, for example, about medication, then to be honest with them and say 'Look, I don't know about this one but I will look it up' and to go back and tell the patient. If you say you are going to do something then do it. I think that you've really got to carry through with what you say ... because they will remember it all the way otherwise. To follow things through builds their confidence in you"(sd,3).

"I find that I can be very honest with them and their relatives ... when they ask what I think I can be more honest with them ... you can relate to them, you can talk to them, you can tell them, you can plan with them ... its so much easier to be honest with them about what is happening ... I would feel more comfortable about telling them 'You are very ill, and we can do as much as we can to make you comfortable and to keep you free of

pain, but you are a very ill person'. I have not come across a situation where they have had an apoplexy about that! It is almost as if they say "I know that I am an ill person' and they sort of respond to the reassurance and the honesty that you give them"(md,4)

Respect facilitated trust:

"What it is that builds that trust up I think, is showing that person that I respect them and treat them with respect ... being there together ... I think that is a very important part of meaningful relationships with people. If you can't trust them, then you cannot begin to establish a relationship. I take the time to understand... to tap into that and get them to talk about their past experiences and I find that helps to build that trust up in me cos they have just shared that with me"(so,1-2).

Respecting each other's privacy regarding the intimacy of the situations in which nurse and patient interact was important in developing trust:

"They see you in here as a professional and someone they can trust ... because you are the nurse, they say things to you that they probably would not say to someone else ... because you see them day in, day out, you see them in pain, and you see them on the pan"(jk,2).

### *Contentment*

When nurse and patient were attuned to each other's needs, contentment followed:

"He was not going to die there and then, it was just that he wanted some one to sit with him. That was just what he wanted. They must be more comfortable because they do not have to worry, because they know their needs will be met ... if they have got a nurse who is looking out for them or if they get along well with them, and they are not frightened to buzz if they want a drink or if they feel cold ... they might get better quicker ... they have only got to ask and you do it ... they are not afraid to ask, no matter what it is"(jt,3).

"I felt that they were both at ease with their situation and that their questions had been answered"(ls,4).

Contentment was reciprocal:

"I think it was just their acceptance of me ... I suppose they looked at you in that special way, you know, 'He knows a little bit about us' and show that interest in me ... perhaps it was just the interest I was taking in them"(ah,2).

"The fact that they would smile and you only have to walk into the room and they say 'G'day S., how are you today?' You know that sort of thing all helps cos you begin to think we are beginning to build up a rapport ... and you get those comments like 'It is nice to hear you laughing... we like that ... we know someone is here'. The patients will pick it up and it is great."(sd,7-8).

"I am sure that it makes their stay in hospital a lot more pleasant too. It must be their personality that they are pleasant and they are willing to give a little bit of themselves and get so much back in return and they give so much to other people too"(sj,6).

If the relationship was a comfort to the patient, then:

"You know when they start smiling and maybe in turn they might ask me about me and where I came from and you know that they are relaxing when they start to ask questions"(ja,2).

"It would make it a more positive experience for them ... it won't alleviate their pain and discomfort, it won't take it away, perhaps it may reduce their perception of what is going on, the pain, and make it a more pleasant experience for them" (so,2).

Contentment was ongoing and could be renewed on next admission, relieving anxiety and assisting recovery:

"I think it is those same patients we have been having for years that I see that happening with ... coming into hospital is not such an ordeal for them ... they are sort of excited to see us again and they can tell you where we left off, what their family is up to ... and I think that that aids their recovery, too"(cb,2).

### *Satisfaction*

A good relationship was satisfying. Rewards could be subtle or obvious:

"I guess they made me feel a little bit special. They made me feel good. I think it was because they gave something back. They appreciate what you do for them. And I think sometimes there are subtle threads - that perhaps they are similar people of similar backgrounds and perhaps similar interests that you have. You really feel that you have done some real good for them and they have done some good for you ... it certainly gives you a lift ... that is therapeutic ... if it is helping [others] and you. You feel appreciated, and [the patient] feels people are taking an interest in them" (ah,1&5).

"I felt proud that I was able to break through that barrier that she had when she first came in. And I felt good. And in fact she did write a very good thank you note ... and she made sure that she sought me out and thanked me personally and she said that she was very grateful for all the help I had shown her and she was a happy lady ... when she went home ... I was quite happy that she had gone home happy and I felt that I had done something [for her]"(ia,1).

"They do take an interest in you so that means that they do think about you and vice versa. You are not just the nurse who is on at night ... and ask did you have a good sleep and what did you do on your days off. That is a bit of positive feedback. I think you know yourself when you have looked after someone really well. You don't need them to say anything or they don't have to write a letter to the local paper or write a thank you note ... yeah, you know what you have done yourself."(jt,4).

"I always felt that there was peace and harmony ... there was no friction ... there was no thing undone ... It was as though I had achieved a lot ... thinking I was not unfinished ... I felt that they were both at ease with the situation and that their questions had been answered ... I get positive feedback cos when I see them up the street, they stop you and say" (ls,3-4).

"It was a very rewarding experience for me ... and to be with them ... I found it a very giving experience on both sides ... I felt that there was a

real bond around both of us ... and that made us feel very much that we were both getting something out of it ... I feel that I can contribute”(md,3).

“There might be something little that you did for them that you know, just by giving them some pain-killer, they might say “Oh, that was the best sleep I had at night , thanks to you’ ... I think that helps too when you know you have been appreciated”(rd,2).

“I feel good if I can get my work done to my satisfaction and have the patients happy and in no pain and knowing that I have told them everything I can ... if they have been unable to feed themselves and they suddenly are feeding themselves ... they have not been walking and I get them walking ... even if it is just two or three steps ... it is something toward their rehabilitation or home plan”(jc,5).

“The little ‘thank you’s’, and ‘you have been really good, thanks very much, don’t give up your nursing’ ... that sort of thing I think is positive feedback ... and in what they give you - ‘Here take this box of chocolates home’. You always share them because you have all shared in the care. I really love my nursing - really enjoy it - I think once my interest had begun to wane, it is time for a change, or get into a different area or to move on. When the patients appreciate [you] it gives you a bit of extra warmth and you are happy with your work”(sd,5&11).

“It is the continuity you have with the patient ... I get that satisfaction seeing the job right through ... it is nice to get a positive response because it is something positive to you and something positive towards your hospital and they would not come and say that if they did not like what the hostile had done for them ”(fm,1).

“Being thanked for doing things [is good]. I think that we are all human and it is nice to get feedback to say ‘Hey thanks for doing that or thanks for looking after me, it has been great’ ... You can make their day ... make them feel better ... about themselves. I think that we should reward them as much. I think we should be thanked too.”(cb,5-6).

### *Humour*

A sense of humour was important for the development of a therapeutic relationship. Nurses felt that patients appreciated smiling, laughter and joking. Each nurse was aware of the appropriate use of each and one nurse stated that it was still possible to enter the room of a dying patient and smile as “you adapt your smile to meet the situation”(cb,6). Others remarked that the patients did not want nurses to be glum all the time, and enjoyed hearing nurses laugh (sd,9). Good-natured bantering between nurse and patient enhanced the relationship by exposing the person behind the label, thus humanising the connection. Appropriate use of humour enhanced a sense of sharing with each other at a personal level, and was perceived to assist the health status of the patient and the nurse:

“I like to make them comfortable and feel at ease - their morale is lifted and they feel energetic as well - a joke or a laugh - I think that if they have a laugh too, it lifts up their spirits a bit and makes their day and hospital is not so bad after all”(ia,4-5).

“I just felt comfortable with her - you could talk about anything and she seemed to be relaxed and you could have a laugh”(jk,2).



"Mrs. D said 'Oh, I am going to feel awful ringing the buzzer, if I have to use a pan' and I said, 'Oh well, I will offer you one all night so you don't have to ring the buzzer and feel bad!' I think they like a few laughs, too" (rd,4&6).

"I think even if you are talking even if it is just making jokes [about] what is going to happen, it makes them feel more comfortable"(jc,3).

"A sense of humour - to be able to joke with them - a smile makes all the difference. For me it really works ... I am still happy in my job and my patients are still talking to me and laughing with me" (sd,3&11).

"I like people with a sense of humour - it helps get you through these [difficult] times"(cb,1&7).

From the descriptions given, another important element of a therapeutic nursing relationship was emerging - humour or *esprit de corps*. Nurses felt that patients respected them professionally, and yet needed to know the person behind the label in order to enter a closer, more personalised relationship. Laughter, joking and bantering seemed to be precursors of a therapeutic relationship.

### *PATIENTS' PERSPECTIVES*

The fourteen elements described by nursepatients and nurses were reflected by the stories of patients. Patients' descriptions were basic explanations of the properties of therapeutic relationships they had experienced with nurses. Echoing the comments of nurses, patients also reported that a mutually beneficial and healing relationship was usually only experienced with one particular nurse of the many with whom they came in contact during hospitalisation. This one therapeutic relationship, however, had the ability to make patients feel special, tolerant of the different types of relationships developed with nurses and more accepting of the treatment given them during the course of their stay in hospital.

#### *Communication*

Patients saw communication as a primary nursing function and nurses proffering conversation to patients as a means of comfort:

"General comfort ... that you in yourself are just generally feeling OK ... to make sure that you are not in pain ... they also come in and chat which can help distract you from wallowing in your own self-pity or it can be just a total change of focus in the day"(cs1).

"They come in and chat to you and see if you are all right and comfortable and in any pain"(rd.1).

Patients also appreciated the nurses' workload:

"They talk to you. They keep you company if they have nothing to do" (lh,1).

"Sometime, when they have time ... cos this [ward] can sometime be very busy ... when they have the spare time, they are very nice to talk to. And when you are upset, they put you right again"(kr,1).

"They see that you are comfortable and how you feel" (hp,1).

The subjects of conversations between nurses and patients ranged from social pleasantries to particulars of the patient's condition:

"There are a million subjects you never really get involved in in your normal life ... from 'how comfortable the bed is' to 'gee whiz, with all the antibiotics you have been giving me I have developed thrush, and I've never had that before!'... so there a lot of different things to talk about" (rz,2).

"We just chat ... we have a bit of a chat about this and that ... you know, what's going on and the weather "(fd,1).

"They explain everything to you and that's great"(mp,4).

Patients found it easy to talk to nurses as:

"You can always find something to talk about with [nurses] ... you get visitors and they are sitting here for hours on end and you are trying to make conversation ..there is nothing going on so you have nothing to talk about"(mg,2).

### *Interchange*

Patients felt appreciated as worthwhile contributors to their care when nurses encouraged them to talk about their feelings and knowledge of their situations and responded to them as people and patients:

"Right from the word 'Go', they have been sensitive to how I feel about my own operation ... sensitive and thoughtful enough to say 'Are you fully aware of everything that is going to happen?' So they would give me the whole picture of what was going to happen and not leave out [the details] cos sometimes it can be those tiny details that can leave you feeling distressed" (cs,2).

"[Nurses] are more open-minded and they don't have to give an opinion, you know what I mean? They just ... maybe a few things go through their minds ... but they are more open-minded to what you have got to say about yourself ... Nurses are the only ones who actually listened [to me]"(ab,2).

"If you have really been down [sad], you can speak to them and they know, and they are good to you. They come in every two hours and check their patients and if you are awake, they say 'What has happened? Can't you sleep? Perhaps you have something on your mind - something that is worrying you?' And I can talk to them"(kr,3).

"They take an interest in you and ask you about your social life and it does leave you feeling as though someone cares - you know, someone is interested in me!"(cs,4).

### *Equality*

Patients liked to be treated as human beings, not numbers or conditions. They expected nurses to be professionals who used their people skills to add a personal touch to patient care:

"She is also the type that [sic] relates ... on a more personal basis ... you are not treated as just another person who has come in - you are a person with feelings and it is OK to own your own feelings"(cs,2).

"They treat you as a person ... not as a number ...there is not one that [sic] ever talks down to you. They all seem to meet you on the same level ... you feel that you are an equal"(es,1-2).

"Although they are very much on a professional level, they would also come back down to your basic everyday human level ... just be an everyday person with you and not be a Miss Superior 'I'm a nurse" sort of approach"(cs,2).

### *Support*

Patients believed that nurses offered them support in many different ways, particularly with activities of daily living that they were unable to perform independently:

"They had to be there to sit me out on the toilet and pop me back into bed. They were always there [for that]"(rd,2).

"The way they have got to look after you - a bloke's lying in bed, helpless half the time and they do every mortal thing for you. Even wipe your bum! They are worth their weight in gold! The moment you press the buzzer, somebody is here ... on the spot!"(hs,2).

"You ask them if they can do something for you and they are glad to do it for you"(fd,1).

"They help me out of bed ... help me to the toilet ... they have done all that I have asked them and a lot more!" (kt,1).

"Nothing is an effort for them ... I still say they should be paid twice as much"(es,2).

"You ask them if they can do something for you and they are glad to do it. Never a problem or any questions about it."(fh,1).

One patient equated support with advocacy:

"I was in pain. I was told, like over three days, by three different doctors, and they all said that it had nothing to do with the kidney infection, but that was where the pain started! The nurses were the only ones who actually listened to that [which] made me feel a lot better. They reminded me to tell the doctor ... cos I was really worried ... they were there all the time .. I know that they are busy and sometimes I get sick of bothering them, but they don't mind being bothered. They listen to things that you don't have time to tell the doctor forget to tell the doctor and they take note of that and remind you when the doctor is there, which is really good cos I forget - as soon as I see a doctor I forget what I was meant to tell him"(ab,2).

Other patients spoke of being compensated for loss of independence by nurses' actions:

"I have always been independent ... and now I am relying on so many people and they have been wonderful"(fd,4).

"To be a patient is to be totally dependent upon other people... to do things for you and help you. It can be frustrating when you can't get up and do things ... [nurses] tend to do just about everything for you - they support you - and help you physically and emotionally"(cs,1).

Another saw nurses as the 'humanising' feature of being in hospital:

"They are nice people and they don't mind having a bit of a chat or asking ... that can comfort you so much"(kt,3-4).

"They are really motherly and sisterly"(ab,3).

### *Safety*

The presence of nurses assured patients physical and emotional safety:

"She even walked or helped push the trolley down to theatre with me and I was laying there with my legs totally shaking - literally shaking up and down off the trolley - just the reassuring firm hand on the shoulder and the 'I will see you when you get back' left a good feeling as you were about to approach the unknown [which] builds that security"(cs,5).

"I was still like under the anaesthetic and had had an injection, and was on the verge of being possibly sick. I was pretty groggy and shaky, so they were there with the dish, ready and waiting! If I needed them, I only had to buzz and they would have been there! They were really good for the first night that I was here - in all the time making sure I was all right. Now they check on me when they pass through, which is really all I need now."(rd,2).

"You only have to press the buzzer, and, bang! - they're there. They're there!"(hs,1).

"It makes you feel a little more secure if you know there is someone around that can help you."(lh,3)

"They make a lot of noise in the office - they talk a lot. It is nice to know that there is someone handy when you are not feeling well. Nothing is a trouble to them" (mp,2).

"They just keep popping in and out all the time ... you know they are there if you want them, which is lovely"(fd,3).

"When it was J...'s face that appeared, I would feel immediately reassured ... reassured by her presence, being there"(cs,3).

Safety and security made the patients relax and feel at home:

"It makes you feel more homely" (kw,2).

"It makes you feel as if you are at home getting looked after"(mp,2).

"It makes it good because they [nurses] are here - just the same as home, more or less, that's for sure"(hs,2).

### *Knowing*

Knowing each other as people connected by circumstance closed the gap in the relationship of nurse to client:

"When she come back on [duty], she goes 'Oh, and how was the kids next time you saw them?' and things like that, and the fact that she remembered certain things that I had told her and she would bring them back up in conversation again has just built up a sound relationship"(cs,4).

"The time I spend with nurses, they all get to know me ... The ones that show concern about me as a person and ask me things too ... and get to know you in time ... sometimes you have got to wait a while, and you don't realise til after that they have been stuck up in [another department] ... they always tell you why you have to wait"(fh,2).

"One of the lovely nurses bought in a little book she thought I might be interested in reading ...out of the blue she came in when she was heading for home the other day and she said 'I bought this up for you. I thought you might be interested in this and knowing the type of person you are' and I said I would be [interested]. You get to know them very quickly and they possibly get to know you very quickly too."(fd,2&3).

Patients who remembered nurses from previous admissions felt secure in their knowing:

"F... has nursed me before. Because I know her, she's not a complete stranger ... it is important to be comfortable with them [nurses] so you can sit there and talk to them and explain what is going on"(lh,3).

"The first time that I came in ... the fortnight before, there was quite a few of them on and they know you .... 'You've been here before' and 'Seen you before' ... they have all been very kind ... you feel looked after."(mp,2).

### *Liking*

When patients were able to develop a rapport with their nurses, liking each other as people followed:

"For some reason I just completely 'clicked' with J..... right off, She was the first nurse that I saw when I arrived and her approach was very caring and very sensitive one and I think that really helped me build my confidence in her and above any of the other nurses. I would look for her first ... she had taken down my history ... prepared me for theatre ... and when I came out of theatre she was here and took me through those first vital hours when you come out and are not so with it"(cs,4).

"He is really warm and he is always joking and I thought I heard him singing today"(ab,4).

"It is important to like the nurses and they to like you too. You feel very much at ease. If you don't like them, you can't talk to them."(hp,3).

Reliability and stability of action and manner endeared nurses to patients:

"..their manner and the way they go about things. They are in first thing and late at night and they are still just exactly the same - never grumpy - it is wonderful"(fd,2).

"... when you are self-conscious, they help you and don't take any notice ... and they seem relaxed which makes a difference"(hp,1).

"Just her manner ... there is just something about that girl - nothing is a trouble to her, she never gets put out ... very attentive ... If I asked her to do anything, she would do it."(kw,2).

"Some nurses can leave you with a feeling that wow! they are wonderful, and they are there whenever ... at the drop of a straw, the second you ring the bell, they are there, they are helpful, they just ask what you need and they will respond"(cs,1).

### *Closeness*

Patients who perceived that they had a close relationship with a nurse, saw their relationship as more of a friendship than a professional liaison:

"You have your special nurse .. they treat you sometimes a bit better than some will ... you feel that little bit better ... you feel proud that you have someone that sticks to you ... you get on good. Just like friends and that is why they are special"(kr,3).

Closeness meant that nurse and patient were confidantes:

"I felt that it was OK to tell her anything - anything I was feeling, thinking, whatever!"(cs,4).

Friendliness was important to patients:

"People [nurses] are on a much friendlier level ... they don't rush in and out ... you don't feel that you are another dog in the kennel ... they talk to you and your own feelings count"(cs,3).

"[Nurses] are very friendly which makes me feel better in myself ... it makes a difference .. it perks you up.. which is good ...they are really interested and inquiring all the time"(fd,1 & 9).

"They are very friendly which is good ... makes you comfortable [to] say how you feel"(hp,1)

### *Consent*

Adequate explanation pre-empted consent to treatment:

"They explain why they are taking blood and testing your urine and ... why it had to be done. Otherwise I would be still mystified. I would still be wondering"(fd,6).

"I think I must have been the first woman he had ever washed ... he asked me if I wanted a woman to do it ... I told him I was just the same as he was and not to take any notice ... just to do it like you do yourself"(hp,3)

Displays of nursing competence and caring, saw patients consenting to nurses entering their private worlds of thought:

"There are personal points that you are feeling within your body at times and it is not always easy to talk about, [but] J... built that security that it was OK to tell her anything I was feeling or if there was any pain in any where that would probably be a strange place ...it was OK to tell her. I was relieved to see her face and to know that she was here and in control of the situation. And I felt that it was OK for her to check it out too - to me that was an important part [of the relationship]"(cs,4).

"I did not want to have my leg off, and they [nurses] convinced me if I did not, I would be in a lot of trouble ... so with that gone, it [gangrene] will not be sneaking up my leg. A couple of them talked to me about how I should have another couple of views, and they said it would make my life a misery if I did not have it done ... I was worried about what I could and could not do. The woman from the artificial limb people came to see me and she has an artificial leg too! So I have seen my leg out."(kt,2).

Working with nurses was beneficial to recovery:

"You come into hospital to be cured, and it depends if you are reasonable enough with the nurse, [then] she will be the same for you. If you be nasty and sometimes very bad, as patients sometimes do, the nurse still does her [sic] best, I would say, to a certain point. I would do the same if I was in their shoes. Somebody might think that this [viewpoint] is too tuned to the girls, but you have to have patience, and I think you [the patient] may have to change your mind, too, how you speak. I mostly go along with the nurses. It is no good being awkward to them, because [it] makes it very hard for them to do their job. They say you have to do something and she can help you, but you have to help you too - you have to try your best, and if you don't, it is no good to them or you"(kr,2).

### *Perceptiveness*

Patients were able to identify certain qualities which made their relationships with nurses therapeutic:

"She is just super-caring and very sensitive to how .... I am feeling and just that extra careful way when she knows that you are in pain ... and I guess for me, when I am teary. I guess they are that extra sensitive - 'what is it? Is there anything in particular that [makes] you teary?' ... Just prior to surgery I was a total bag of nerves and they were aware of that and did everything they could to reassure me that 'You will get through it OK' and they are going to do this and going to do that and reassured me every step of the way which I found to be a bonus, a total bonus. Rather than leaving me [to] just sit there and start sweating it out, they kept coming in - 'Are you OK? Any other questions?' - and the continual interaction was good .... made me feel comfortable"(cs,3).

"Nurses are pretty special people and I'd like to think that the majority of them have that ability to develop relationships and that that is part of the process of being a patient any way. There's that one relationship with the doctor and [another] with the nurse, as far as getting in and on with the regime of hospital. The nurse is charged with knocking down those barriers [when] the patient is not responsible themselves"(rz,3).

Patients were aware of the demands placed upon nurses:

"My job probably parallels that of nurses ... the job role was much larger than just being a supervisor. I was the psychologist and the someone to cry on the shoulder and someone to sort out all their problems and manage their finances and give them good advice and advice that worked .. developing that relationship is the secret of it all... whether is it a five minute or a five week one. Nurses aren't superwomen. They can only react to the feedback they're getting from the patient."(rz,2).

"They are pretty busy and they keep on the move here all the time, [but] they look after you well ... no matter what you ask them, they just do it, no matter how tired they are - they must get tired. They are going all the time"(mg,2).

"They, I mean nurses, are here to do for you ... they do what they can, don't they? ... they are not at your beck and call all the time"(mp,2).

"Nothing seems a bother to them. I would not have their job for all the tea in China."(es,1).

After experiencing being nursed, and observing nurses at work, some patients had changed their opinions about nurses:

"I expected to have to ring all the time [to get attention] but I don't. They just come in and ask you... to see if you are comfortable ... I can't do nothing for myself ... they ask you if you want to be helped .... oh, you feel at ease [here]"(hp,2).

"My normal opinion, my original opinion, was that if you said 'Can you do this nurse', they would say, 'I'm too busy, be back later', or something like that. But they are not. They just don't mind. They just put themselves out to help you. That's good."(kw,3).

### *Trust*

Patients felt that they could trust nurses because they were professionals. Trust in the nurse as a person developed as the relationship progressed and the nurse displayed competence in nursing skills and the ability to maintain confidentiality:

"I totally trusted her with giving injections. I felt quite reassured just by her presence in doing whatever - the sponging, the changing and whatever - she was very caring and very sensitive"(cs,4).

"It is a level of trust, really ... its part of the charter of caring for people ... but one of the secrets is to develop that level of trust so the patient feels comfortable with any of his [sic] requests. It's half the battle, I suppose. To be comfortable with them, I would imagine, from my side of things, to not hesitate to say this [intravenous line site] is hurting the back of my hand and things like that - to ask questions"(rz,4).

"They are good at their job and they can comfort you so much. It is nice to have someone you can trust."(kt,2).

Honesty was bound into trust:

"I like to be told straight forward answers to my questions then you know there are no secrets being hidden ... the nurses I have come across have come straight out and told me the answers ... you can sort of tell if they are not telling you everything [if] they have to think about what they are going to say ... but not F..., she gave me a straight answer"(lh,4).

"The nurse said to me 'You know that you are going to burst the stitches in you eye again if you start coughing. I said, 'All right, that is the last cigarette I'll have'. I have never had another cigarette since and that is over twelve months ago. Well, it was true! I knew it myself. It only needed her to tell me" (es,5).

"I ask straight out. I want to know the truth. When you are relaxed with them, it helps a lot. It makes you feel really good [when they tell you the answers]. If you ask the doctor and he won't tell you, you feel frustrated and you think to yourself that they must think you are stupid"(hp,4).

"You can ask questions and they will give you an honest answer. You are not in the dark. You get told. I need to know what is going on. They are fiddling around trying to make me better. I am content to let them do it."(mg,3).



### *Contentment*

Patients expressed pleasure in their relationships with nurses with whom they had found comfort and felt relaxed:

"The continual interaction ... made me feel comfortable for after surgery when I would be totally dependent upon them to do everything for me. It did give me a more reassured feeling that when I went down [to theatre] that afterwards things would be OK"(cs,3).

"The marvelous thing that they do at night, when you are sleeping, they creep around and whisper in your ear. They do not bellow out and wake everyone [else] up"(hs,3).

"I was quite content for them to whatever they wanted for me. It does not bother me. I am thrilled to be here and to have them do what they do for me. They are very caring, very compassionate and very, very caring. When I come back from [the tests], they ask how I got on, and was it difficult, was it traumatic. I know it has to be done. They are just really interested and inquiring all the time - it makes all the difference to how I feel about it"(fd,6).

"It is a reassuring role that they play - 'Oh, yes, things are proceeding at the right pace'. Reassuring people, I guess. I suppose then that you can ask questions like "Is that normal? Have you heard of that happening before? They definitely do make it easier for patients to cope in hospital"(rz,3).

"It is lovely to see a cheerful face, even if you are in pain or anything. When they brought me up here on Monday, this nurse who came up with me gave me a kiss and a cuddle and said that she hoped she would see me again, which is good. It is nice - it gives you a lift"(kw,4).

### *Satisfaction*

Patients who were satisfied in their relationships with nurses found:

"It excellent to be a patient with good nurses - it will be hard to leave and go home. I have always said that nurses earn their money. They do. Too right. They have got to put up with old fellows like me!"(kw,4).

"It puts a bit of humanness into [the situation]" (rz,3).

"It is really good, it's not like being in hospital. It's a happy place. It's not a down place. It was a good break for me."(ab,4-5).

"I just can't get over the attention and service you get, It is absolutely wonderful. I can't complain about a thing"(fd,1).

Good relationships with nurses were beneficial to patients:

"It lifts you up. You can be down in the dumps with pain and that and they sort of lift you up. You feel a lot better."(kw,4).

### *Humour - smiling - joking*

Patients liked to discover humour in their situations. They enjoyed nurses who approached them with a smile and were willing to engage in good-natured banter:

"I enjoy having a joke with the nurses - it improves me"(kt,2).

"I have a bit of fun with the nurses. A sense of humour is good, providing they know their job. One of the nurses sat up quite late last night making little ribbons cos it is St. Patrick's Day. She said, 'Will you wear a ribbon?' I said I would not wear one, but I was pulling her leg - I've got it on!"(fh,2).

"All I want to do is sleep and they keep coming in and waking me up all the time (laughingly) - to do my observations!" (lh,1).

"They always have a smile on their face"(hp,1).

"Last night there were a few who were coming in and they were making a few jokes ... to have a laugh over something, you can relax and it helps to break those barriers"(cs,2).

"I think that they would have to have a good sense of humour to be a nurse. I think laughing is good for you. I laugh a lot at home, so it must be good for you"(mg,4)(es,1).

One patient laughingly recounted his experiences with nurses:

"As a patient you lay there and think - I wonder if they have tried this or if the doctor has thought of that, or maybe it is this. You can ask the nurse and most of them say 'God, I don't know!' (Loud laughter). This morning one of the comments was that "You may be going on long-term antibiotics" I said, 'Well, that's something to look forward to, isn't it?' "(rz,2).

Another recalled being engaged in lively conversation with nurses:

"There were three nurses in here and they were laughing and carrying on when my daughter came in. She said, 'What, are you having a party or something?' and I said, 'Yeah, grog tum!' I like a bit of a joke. It freshens you up. It makes you feel more homely. If they have a joke, they tell me. I have a bit of fun, only acting the fool. I think it keeps them going and me going too. They could have a real crook day and a bit of a stir up here and there makes them laugh and I think they are better off. And me too, if I can have a laugh, it's good. I think it means everything if you can get along well with the nurses"(kw,3-4).

For one patient, humour reduced the level of embarrassment in a particular situation:

"I am not allowed to go to the toilet. I have got to use one of those pans, and I have never used one of them before in my life. I said to the nurse that I was going to be a nuisance tonight cos I have to ring the bell and you have got to bring one of those pans, and she said "Don't let it worry you, we have got so many that ring the bell for nothing' and she said that it was most important for me to ring. But that she would beat me to it - 'I will come in and say 'Do you want to use it?' It made me feel great. When I had to ask for one this afternoon, I thought, 'What will I do?' She just said 'Put your legs up' and I said, 'Am I going to do it all over the bed?' And she laughed and said, 'No, you won't!'. It was fine."(fd,4).

In another instance, this patient bantered with nurses about her continual stream of visitors:

"They see the visitors I have - which is quite numerous - and they are always slinging off - you know - 'You are the only one who has rooms full of visitors all the time' and that sort of thing. And even when they brought the stretcher in at lunchtime, they said, 'There are always women in here!' I don't mind, you take it as it comes"(fd,5).

### *Overview*

Patients' viewpoints of the relationship were fundamentally related to their feelings about their caregivers. They looked for a nurse who could relate to them as people, and who was not "grumpy" or "moody". These latter factors were, to patients, the most important indicators that a nurse was not interested in either them and their needs, or, more particularly, his/her work as a nurse. Perceptions of nurses' attitudes therefore dictated the terms of a relationship developed by patients. Patients were acutely aware of who would willingly offer them the type of care they desired, and actively sought out those nurses for "better" care and attention. Nurses perceived to not want to offer more than an impersonal, or professional basis only type of relationship, were requested, by patients, to perform purely physical nursing functions, and no more. The nurses who were perceived by patients to be more open in their approach and more friendly toward the patients were treated differently. They were engaged in more meaningful communication, given more personal, physical and social information from the patient, and asked to meet the patients' whole needs. Although it was important to patients that their physical care be delivered competently, each looked for more than this in a relationship with a nurse. Companionship and understanding were equally important considerations to enable patients to feel comfortable about having the physical care of their bodies performed by another, albeit, a nurse. Patients felt that they were better able to express their feelings in the safety of a close relationship with a nurse, particularly about, and during, the performance of more intimate bodily functions.

Each patient liked to feel appreciated as a person with a problem. It was perceived to be a deep affront to patients when they were ignored, treated as object rather than person, referred to as a condition rather than by name, and when their treating condition attracted more interest than they, themselves, did as people. There was a sense of ownership about a nurse perceived to be more personal in delivery of care, "good at the job" and adept at developing relationships with people. "My nurse" and "there's the one that looks after me" were common comments. They looked forward to their contact times with particular nurses and often those working specific shifts. Night shift workers were considered by most patients to be very different in their approaches to patient care. These nurses were perceived to make available, and take, more time to talk to patients troubled by personal concerns or fears about prognosis and outcomes. Nurses working at night were seen to be more relaxed and less concerned about the administration of the ward.

Patients felt that often nurses forgot the requests made of them by patients. This was not perceived as an insult, however, as the patients had had clear perception of the workings of the ward, and very often the hospital, and could excuse this lapse in behaviour with "they were very busy", "there are

other patients here in greater need than me", "the phone was ringing and ringing", "they had to attend to emergencies" and often in a whispered tone "someone died here last night". The patients very often could not see what was happening outside their rooms, but could hear the pace of the activity and conversational tones, and were thus very receptive to the atmosphere and events of the ward. In a therapeutic nursing relationship, the patients felt an instinctive trust in their nurse or nurses. They knew that they would be given a truthful explanation for forgotten requests, and that these would be followed up when time permitted.

Patients felt that a hospital ward was rather like a "home away from home" when they developed an effective relationship with a nurse. They were, in the safety of this relationship, able to do and say most things that they would at home, with no fear of reproach or reprisal. The relationship "normalized" a different physical environment. It was possible to relax and feel more comfortable about the physical surrounds and develop a sense of wanting to expand personal horizons to areas outside the room. Those patients able to ambulate felt free to explore the ward area and interact with other patients, while those confined to bed encouraged conversation with those able to walk around. Patient to patient support systems appeared to develop fairly quickly, perhaps because of the shared experience of being patients. Patients actively protected each other's welfare. In the presence of effective nurse and patient relationships, patient support systems expanded to include the nurse, or nurses, involved. Patients became nurses' advocates and defended them against adversity. In this situation, patients shared their life experiences with nurses, offered them advice and gave them emotional support. This sharing experience with other patients and nurses appeared to enhance a patient's sense of belonging.

Patients liked nurses to smile and be happy. If they could often hear laughter in and around the ward, patients felt cheered and somewhat better about themselves. "It lifts you up" said one patient. Hearing conversation, noise and laughter assured the patients that someone was near which heightened their sense of security. They knew that someone would be available to meet any emerging needs. If the ward was quiet, most patients appeared to assume that the nurses had left and often rang with a minor request to check that a nurse was present. This supports the notion of "physical presencing" as described by nursepatients. In this instance, wanting a nurse was an express desire for comfort and reassurance which could be given by the nurse's physical presence, and is not opposed to the nursepatients' reference to removal of physical presencing as an element of relational control.

Patients perceived that a friendly relationship with nurses was more possible if the nurses were capable of appreciating a joke or good-naturedly taking "a good ribbing" about themselves as nurses and, or, people. Sharing jokes with patients meant that the nurse was the epitome of a "good sport", and very human. In patients' quests for a closer relationship with nurses, joke-telling was an important compatibility assessment tool.

The social boundaries of the relationship were respected by the patients. Patients were aware that a relationship with a nurse would be short-term, that is, not lasting or being "forever", as the very nature of their contact confined the connection to the hospital environment. This did not, however, mean that the relationship could not be renewed on the next visit to hospital, be it as patient, visitor or outpatient. Because of the locale, it was possible that many patients may see particular nurses outside of the hospital environment. The relationship, in both instances, was expected to be more casual and social, rather than professional and personal. Patients professed that they may not be able to remember the nurses names if seen outside the hospital, but considered it bad manners not to acknowledge each other as former partners in health care.

#### *A Fourteenth Element: Camaraderie*

Descriptions offered by practicing nurses and their patients of instances of therapeutic relationships confirmed the thirteen elements described by nursepatients. Each highly individual story contained reference to these qualities, and to another characteristic of a therapeutic relationship which had been alluded to by nursepatients, but perhaps, was largely missing from their experiences. This element revolved around humour and good-natured 'kidding' which occurred when nurse and patient reached a deeper level of connection in their relationship.

"Camaraderie" was the label chosen for this element because this word embraces all its descriptive qualities. The participants perceived camaraderie to be of particular value in developing a therapeutic nursing relationship and all participants believed that it was equally important to patients and nurses in the formation of an effective working relationship. Its defining characteristics included smiling, laughter, humour, joking, companionship, rapport, compatibility, and regard for each other within a relationship. The participants perceived that when these features were present in a relationship, there was a shared feeling of goodwill and harmony, greater understanding of each other as human beings and a sense of belonging and bonding.

Camaraderie between nurse and patient was directly observed by the researcher. When I was introduced to a patient (kt), he made light of the situation by saying to the nurse performing the introductions(sd), 'You are getting smaller every day!' To her quizzical expression, he replied, 'Wearing your legs out, running up and down all day!' She laughed and he joined in. At the beginning of another interview, the nurse who nominated the patient entered the room. She was holding a bouquet of flowers and said, 'How's this for bribery?' He, recounting that he tends to get along well with nurses, replied, 'I get along *really* well with this nurse! Are they for me?' They both laughed heartily. The nurse said, 'Now listen. The helium balloon had a leak in it - well, don't look at me! I just zipped down the street and got them for you, for bribery. The florist will be back with the balloon shortly because it broke'. He replied, 'I have never had flowers before in my life. I feel honoured.' We all laughed. The interviewee became more relaxed.

One interview was interrupted when a nurse entered to take the patient's blood pressure reading. The patient began to talk about nurses liking "a little bit of a [wise]crack now and again, don't worry about that! It is all in a day's work and fun. I would not be dead for quids." When this nurse left to locate the patient's charts, the patient continued, 'They always know when to come back and laugh'. He spied the nurse returning and said, 'There she is again, sneaking back like a cat!' to which the nurse replied, 'Just to see what you are saying!' They laughed together. Prior to another interview, a patient was recounting the fact that she had asked a nurse for a drinking straw and was yet to receive it, when the nurse entered, carrying a straw. They both laughed while the nurse acknowledged that she had finally remembered and the patient expressed her thanks.

The presence of camaraderie allowed nurse and patient to feel good about their connection in a relationship begun through a need for health and nursing care and a service designed to deliver the same. It made light of a serious situation through sharing of perceptions which recognized the humour and humanness of each other and hospitalization, and by doing so, cemented the relationship between nurse and patient into a more relaxed, friendly union. The nurses and patients described a sense of coming together through the use of humour, a feeling of uniting with a common purpose and a deeper sharing with each other as people, nurses and patients. Camaraderie facilitated a deeper trust in, and meaningful communication with, each other which meant that bipartisan positive goals could be set and mutual decisions made about the process, or processes, by which these goals could be reached.

### Summary

The structure of a therapeutic nursing relationship now embraces fourteen elements. The descriptions of nursepatients, patients and nurses support this format. The participants were united by their commonality of experience. They had all experienced being part of a nursing relationship, either as patients, nurses or both. Their descriptions confirm the presence of these fourteen essential elements of a therapeutic relationship, the focus of which is nursing.

The fourteen elements perceived by nursepatients to be essential to a therapeutic nursing relationship are:

1. **communication** which is open, appropriate, informative, interested, sensitive and reciprocal;
2. **interchange** of feelings, meanings, knowledge and learning, based on honesty at personal and professional levels;
3. **equality** of relational and situational sharing, acceptance and respect;
4. **support** each other as people with credibility, commonsense, adaptability, competence, grace, presence and assuagement;
5. **safety** of physical, psychological, and environmental areas;
6. **knowing** each other as people to lend continuity and security to the care and caring;

7. **liking** each other as people, patients and nurses, showing mutual acceptance and respect which enhances enjoyment and rapport in a working relationship;
8. **closeness** of functional and relational intimacy and advocacy;
9. **consent** to exercise control and enjoy freedom within the relationship;
10. **perceptiveness** wherein nurse and patient show sensitivity, insight, empathy and sympathy to each other's needs;
11. **trust** in each other to be honest, reliable, responsible, confident and committed to the relationship;
12. **contentment** with the relationship and the care;
13. **satisfaction** with self, process, relationship and results;
14. **camaraderie** in harmonizing with each other as people come together through the guise of health care.

This, then, is the essence of a therapeutic nursing relationship.

## THE CONCEPT OF A THERAPEUTIC NURSING RELATIONSHIP

A therapeutic nursing relationship is one in which there is a connection made between nurse and patient which gives perceptual equality and equity to both. The two parties of the relationship, nurse and patient, are not polarized by place or position in its description or labeling. In current nursing literature, the terms "nurse-patient relationship" or "nurse-patient interaction" are used to separate nurse and patient into two distinct concepts. Nurse and patient are whole people with physical, emotional and social needs that can be fulfilled through a beneficial relationship. A therapeutic nursing relationship is a dynamic partnership wherein activity is directed to achieve beneficial outcomes for both patient and nurse. Such a relationship is therapeutic in its content, context and mechanics, and thus may be deemed to have healing qualities.

Given the information available, a therapeutic nursing relationship was difficult to define because of its inherent affective boundaries. It is an intangible, malleable reciprocal entity which develops between a nurse and a patient. The relationship evolves from the fourteen qualities perceived by the participants in this study, and appears to be dependent upon personal attributes present in both nurse and patient. For both, this type of relationship involves a willingness to enter the world of another and the ability to see the relationship progress toward a mutually beneficial outcome. It appears to be important that the nurse is perceived to have a commitment to doing one's best, both personally and professionally, to set things right for the patient. This working essence is looked for by the patient, and is instantly recognisable by those looking for it in a nurse-patient relationship. This may explain the difficulty nursing, as a profession, has in explaining what it is that nursing does that sets it apart from other professions. In this instance, nursing, via a therapeutic nursing relationship, effects an inner feeling of self that is difficult to articulate with, and for, understanding.

An definition of a therapeutic nursing relationship emerged from the composites of data generated by this study. Essentially, a therapeutic nursing relationship is:

"a symbiotic relationship between nurse and patient which gives an assurance of friendship, well-being, self-worth and a positive quality outcome in nursing and health care".

The meaning of a therapeutic nursing relationship for the participants was a validation of self-worth through mutual liking and respect, which lead to improved emotional and physical well-being, a sense of confidence, care and compassion enhanced by effective communication and an increase in personal coping abilities. In this relationship, there was a guarantee of positive outcomes for patient, nurse and institution. Nursing care does not happen alone, or in isolation from patient or nurse. It is the result of interaction between nurse and patient, a combination of possibilities and personalities, a mutual interpretation of needs and events, and an appreciation of each other's strengths and weaknesses as human beings, in a relationship designed with therapeutic outlooks and outcomes. The term "therapeutic nursing relationship" expresses this function of nursing care succinctly, and its construction admits the healing properties of the relationship between nurse and patient.



Experiencing a therapeutic nursing relationship was perceived to be a rewarding experience for both nurse and patient. Understanding each other's perceptions of care and relationships meant that interventions were planned to meet needs, resulting in quality outcomes for both nurse and patient. Experiencing a therapeutic nursing relationship also offsets other less satisfying relationships. It gave nurses and patients hope and anticipation. They looked forward to the next contact and its fruition as a positive experience. The nurses were perceived to have gained a great deal of personal and job satisfaction from participating in such a relationship. A therapeutic nursing relationship left lasting impressions upon patients who expressed having feeling of goodwill toward the nurse or nurses, and the institution in which this type of experience occurred. There were several benefits for the patient, best explained in terms of self - increased self-respect, an uplifting of self-ability to see things through or progress to the next step in health care through the relationship, improved self-confidence through recognition of one's own abilities to effect care and outcomes, and a perceptual difference in self which effected the relationship in a more subtle, positive way. Nurses were able to experience similar effects upon themselves as people, and professionals. This firmly established the mutually beneficial effects of a therapeutic nursing relationship.

Therapeutic nursing relationships require caring, sensitive responses to an other's emotional needs, intertwined with self-awareness of one's own abilities to meet those needs. It is important to the development of such a relationship that the meanings of care and relationships between nurse and patient are clarified through open, honest communication. Patients look for, and respect, truth in a relationship. Health care workers are seen as providers of professional knowledge which enables patients to cope with the experience of being ill and requiring assistance in health care. They expect that this knowledge will be shared in a constructive way for their better good. Patients want to regain their health in any capacity. A therapeutic nursing relationship recognizes and respects these rights, and works to uphold them for, and with, the patient.

### **A MODEL FOR PRACTICE**

The model evolved in stages which mirrored those of the research process. It began with a simple listing of the elements and their enveloping characteristics. To this list was added the benefits of a therapeutic relationship and the perceived outcomes of such a union for both nurse and patient. The model took form through a studied reflection of the specific element or set of elements which lead to a particular benefit, and in conjunction with a re-reading of the data. This involved matching definitions and descriptions of the fourteen elements with the anticipated therapeutic outcomes as qualified through descriptions given by nursepatients, patients and nurses. Thus the structure was exposed by a process of matching and blending of all participants' base perceptions of a therapeutic relationship. Throughout all this scrutiny, the operational definition of a therapeutic nursing relationship developed from data given by nursepatients did not change, but was supported as the absolute description for the term.

The elements of a therapeutic relationship are communication, interchange, equality, support, safety, knowing, liking, closeness, consent, perceptiveness, trust, contentment, satisfaction and camaraderie. These elements have qualifying descriptors of definition and meaning for the relationship between nurse and patient.

Some elements are complex, while others are simplistic in their descriptions. Communication that is reciprocal, open, appropriate to the age, condition and circumstances of the patient, and informative for both nurse and patient is essential to the formation of a therapeutic nursing relationship. Both parties of the relationship need to be interested in each other as people, patients and nurses. Communication at this level requires talking, listening and acting with sensitivity and respect for each other and the time and place of the relationship. Interchange of knowledge, feelings and experiences occurs honestly on both personal and professional levels. Equality refers to relational and situational sharing, acceptance and respect in, and of, each other within the relationship. Support encompasses recognising each other as credible authorities of self, needs and needs-meeting strategies. Safety includes physical, psychological and environmental security.

Knowing embraces personal and professional knowledge of each other as people capable of feeling, thinking, controlling, desiring, anticipating and expecting certain returns for effort. Liking meant mutual acceptance of, and respect for, each other within a working relationship. Closeness was attuned to intimacy with each other, where nurse and patient were perceived as co-conspirators in a relationship directed at health and nursing care.

Consent was mutual control and freedom of decision-making. Perceptiveness was actively demonstrated by interactions based upon sensitivity, insight, empathy, and sympathy according to each others needs within the relationship. Each party had trust in each other to be honest, reliable, responsible, confident and committed to the relationship. Camaraderie was reciprocal feelings of goodwill, harmony, compatibility, understanding, and belonging, laced with, and braced by, humour. Contentment meant pleasure, relaxation and comfort within the relationship and the care. Satisfaction with, and within, the relationship and its outcome, or outcomes, and results removed doubts and validated the self-worth of all parties involved in such a relationship, that is, nurse and patient, patient's significant other/s, and, or, all three members of a therapeutic nursing relationship.

The benefits of being part of a therapeutic nursing relationship were of a personal and professional nature, and were most often wrapped around subjective feelings and judgments. In a therapeutic relationship, experiential subjectivity has equal weighting with objective happenings. For all participants, it was difficult to separate the two facets. Nurses were generally able to separate the professional gains of such a relationship by applying nursing knowledge of expected signs for the patient. It was more difficult to discern the personal gains for nurses who were either not accustomed to complimenting themselves, or thinking positively about their contribution to the relationship. The concept of therapeutic use of self was not easily accepted in the context of patient-

nurse interactions. Most of the nursing participants appeared to think and reflect upon their own personal feelings in juxtaposition to professional knowledge.

The more important gains from the relationship were in health status for the patient. From the descriptions given, it was possible to see the broader implications of a therapeutic relationship for patient satisfaction with nursing and health care. This particularly applied to the image that patients took away with them after hospitalization and its effect upon the likelihood of their returning for more care in the future. As such, there appeared to be implications for nurses, hospitals and health care in general, which stemmed from the type of relationship offered patients by their nurses. A therapeutic nursing relationship assured patients a positive, "take-away" image of nurses, nursing and the institution in which this relationship was experienced.

### ***Model Construction***

The first three models were constructed from the given data of a therapeutic nursing relationship. Each model was subsumed into the next by reducing the format into definitive parts. The third version was used as a discussion catalyst at the first forum held at hospital A. The fourth model was constructed using the feedback from this forum. It was presented to the participants at the next forum held at Hospital B. In turn, the evaluative comments from this forum were utilised to construct the fifth and final model of a therapeutic nursing relationship.

### **MODEL BUILDING SEQUENCES:**

#### **Model 1: A Therapeutic Nursing Relationship**

This model was constructed as a flow-on-effect chart (Diagram A). This allowed the elements of a therapeutic nursing relationship to be placed in the context of results and outcomes, consistent with the research methodology. This initial model was cumbersome with qualifying statements and effects. It was useful in that it dissected dialogue into sections which could be collapsed downward to capture the essence of the structure of a therapeutic nursing relationship.

#### **Model 2: The Basic Model**

Using the first model as a visual cue card, each section, that is, elements, results and outcomes, became a précis of essential components. The basic model (Diagram B) was constructed. This second model of components accompanied by short qualifying statements and outcomes had a more simple step-wise progression than the first construction. It retained the basic message and meaning of the process and effects of being exposed to a therapeutic nursing relationship. As this model, too, was detailed and intricate which denied observers easy comprehension, it was collapsed into its basic constituents, to form a third model.

DIAGRAM A:

**A THERAPEUTIC NURSING RELATIONSHIP**

Elements:

<u>approach</u> friendliness approachability welcoming unhurried pleased to meet & see you concerned about you	<u>environment</u> safe physical psychological homely atmosphere non-confining commitment  competence	<u>attitude</u> positive interaction pleasant company personal interest appropriate humour sense of fun enjoyment in & of contact caring about you as a person
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Results:

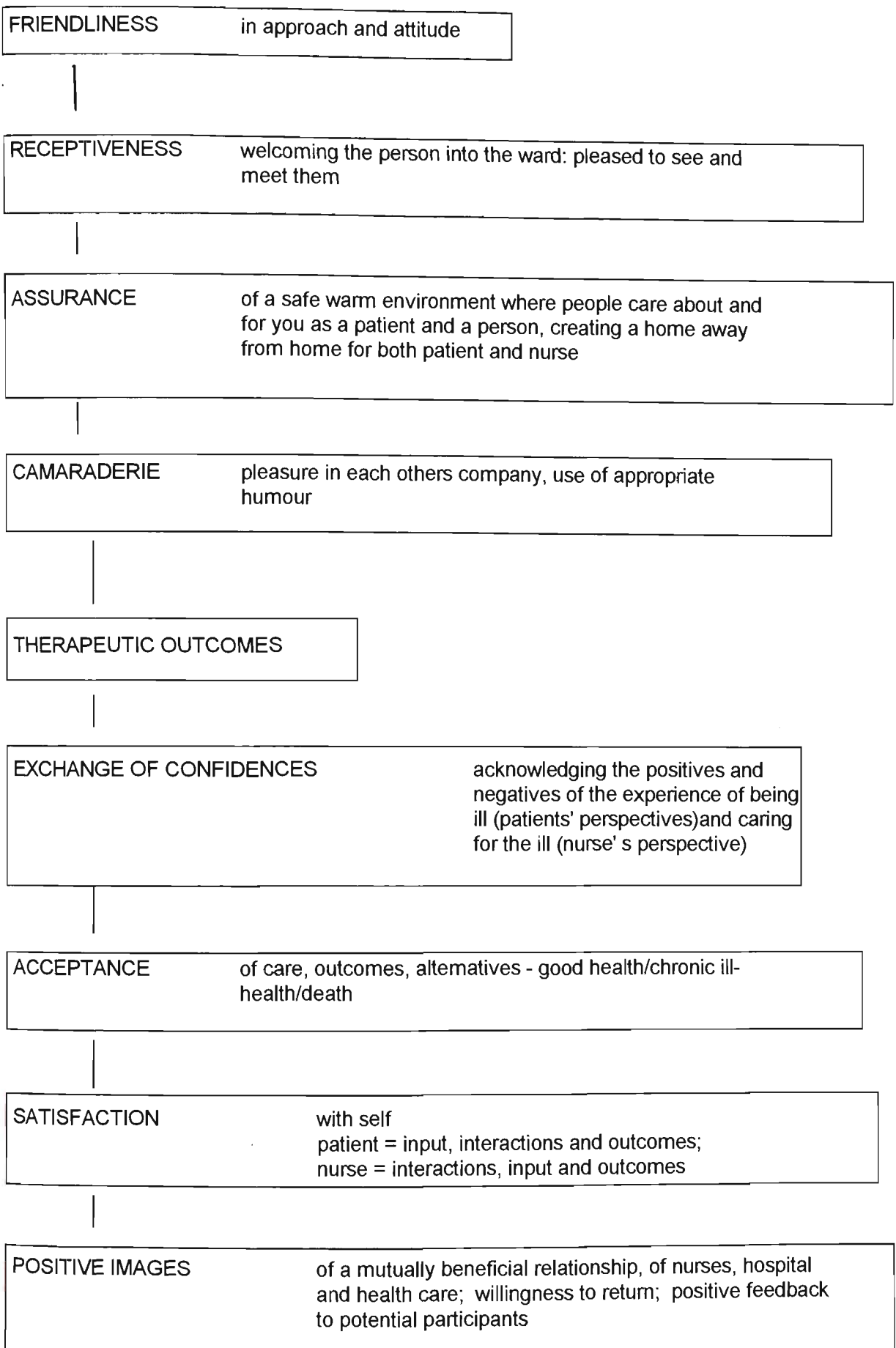
camaraderie	feeling of belonging, familiarity, affinity
assurance	of environment where people care for & about you
relaxation & relaxed	exchange of confidences: positive and negative aspects enjoyment & pleasure in each others company
awareness	of intimacy/safety of environment & exchanges, short term of relationship
confidence	reciprocal: anticipation,
self awareness	of part in relationship and health care, responsibilities & rights
exchange	give & take, positives and negatives of being ill, cared for and a caregiver

Leading to:

acceptance	of situation, nursing care, outcome - be it good health, chronic ill-health, death
self satisfaction	with self, input, outcomes (nurse and patient)
changed perceptions quality planning together	of a mutually beneficial relationship based on accurate information and matched perceptions
positive residual feelings	positive feedback between nurse and patient, willingness to return, positive take- away image of nurses, hospital and health care

DIAGRAM B:

THE BASIC MODEL



### Model 3: The Working Model

After revisiting the data, the basic model was articulated into a flow chart format or "working model" (Diagram C). This third model demonstrated the relationship between components and the probable, or possible, outcomes of such a union between nurse and patient. In basic format, the working model was evaluated by practising nurses who attended the open forum held at Hospital A. This simplistic visual diagram, captured on overhead, was accompanied by an oral presentation of the dynamics of the working model. The focus of this presentation was examination effective working relationships. Discussion was geared to expose the factors which made these relationships therapeutic, in the context of its given operational definition. Participants therefore evaluated the reliability of the working model as a visual representation of their relationships with patients which assured beneficial and healing outcomes for both nurse and patient.

DIAGRAM C:

THE WORKING MODEL

FRIENDLINESS

RECEPTIVENESS

ASSURANCE

CAMARADERIE

THERAPEUTIC RELATIONSHIP

OUTCOMES

EXCHANGE OF CONFIDENCES

ACCEPTANCE

SATISFACTION

POSITIVE IMAGES

BENEFICIAL PERCEPTIONS

## *Forum Evaluations of the Model*

### *Forum One : Hospital A*

The forum began with an oral presentation of the research findings, complemented where necessary by overheads. The Working Model was used to stimulate reflection and invite comment upon its usefulness as a directive for practice, a representation of their relationships with patients, and a model of nursing. The visual diagram was also a means of clarifying the verbal information. Participants were invited to participate and encouraged to ask questions at any time. The forum focus was clearly stated as assessing the usefulness of the model in practice.

The ensuing discussion supported communication as an important aspect of any nurse-patient relationship as this allowed nurse and patient to understand each other as people, patients and nurses. Clear communication between nurse and patient enabled everyone involved in a nursing relationship to look at the topic of discussion in, and from, the same context. In this sense, communication assisted the relationship in its therapeutic endeavours. However, communication was seen as a singular process with little connection to the other elements presented by the model. Therefore only communication was validated by these forum participants as component of a therapeutic nursing relationship.

The agenda of the participating nurses lay in achieving patient satisfaction. They made the connection between a therapeutic nursing relationship and patient satisfaction in two ways. In this relationship, there is room for nurse and patient to exchange confidences and thoughts in a safe environment in which the contents of the conversation will not go outside of the bed area, ward or hospital. This exchange also gives both nurse and patient the scope to problem-solve immediately, at the coalface. The forum participants were able to see the connection between the elements depicted by the model and the ultimate outcomes of such a relationship, if only in terms of their own understanding.

Forum participants agreed that a therapeutic nursing relationship left the patient feeling well looked after, and had the potential to increase the nurses' sense of job satisfaction. They commented on the frequency of such a relationship in practice and concluded the discussion with two hypotheses about occurrence rates. When a patient experiences one therapeutic nursing relationship during hospitalization, then this relationship appears to outshine the other less satisfying relationships encountered. When a nurse experienced a therapeutic relationship, it was seen as a one-off event that could be overshadowed by several less satisfying relationships with patients. This supported the importance of perceptual satisfaction as an essential element in any relationship, and cemented the pathway between this element and contentment with self, both in input and outcomes.

Nurses were less prepared to give themselves credit for developing effective working relationships with patients. They did not place a great deal of emphasis upon nurses gaining satisfaction from their work with patients. They talked of the problems perceived to reduce the effectiveness of a



relationship. These were largely confined to discussions of obvious barriers to effective communication, lack of clarity in the process of forming relationships, and the highly individual needs of each patient and skills of each nurse. Sadly, these negative aspects of the relational contact between nurse and patient appeared to prevail in the thoughts of nurses who attended this first forum, however, participants felt that the usefulness of the model lay in its simplicity.

#### Model 4: A Therapeutic Nursing Relationship: Version 4

The information obtained enabled the researcher to reflect upon the process and revise its format into the fourth model (Diagram D). In comparison to the previous model, this model contained a list of the elements with descriptive statements which gave a clear indication of the content and meaning of each. More information meant that there was less room for interpretative error by future forum participants. These additions assured less participative speculation about each element, kept the discussion focused, reduced researcher input and explanation, and increased discussion of the salient features of a therapeutic nursing relationship.

#### *Forum Two: Hospital B*

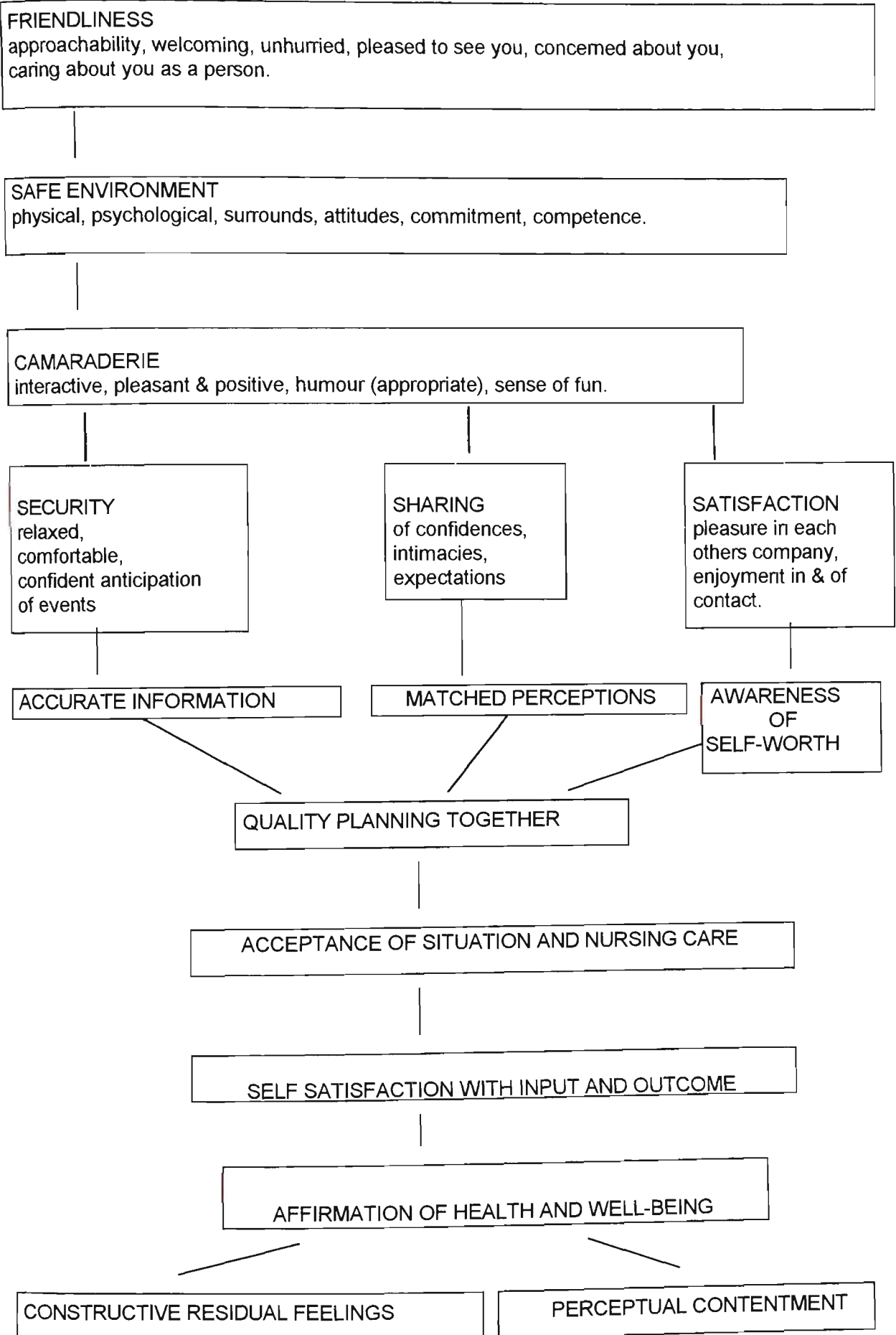
This revised diagrammatic representation of a therapeutic nursing relationship was presented to members of a forum held at the second hospital. A brief introduction to the model was given and comments invited from the audience about its usefulness to everyday practice. Points of discussion arose about the model's components, process, time frame, precursors, benefits, assumptions and the influence of other factors upon its fruition. Through constructive debate and brainstorming, participants were able to see the utility of the concept in practice.

Forum members thought that the model's format and process was clear and easy to follow. There was general agreement that having simple explanatory qualifiers made the model easy to read and understand. The process was considered logical and each step prioritized according to their understanding of a developing relationship. Outcomes were received less favourably and were considered to be somewhat removed from a nurses' sphere of evaluation. Although forum members agreed that these outcomes were possible, many thought that they were idealistic and not always achievable.

This second forum raised some pertinent issues which might constrain the formation of a therapeutic nursing relationship between nurse and patient. These factors were time, attitudes, conflicting beliefs, workload, culture and compromised patient participation. The issue of confidentiality in a hospital environment was also discussed.

DIAGRAM D:

### A THERAPEUTIC NURSING RELATIONSHIP



*Constraints upon the model:*

*Time, Attitudes, Conflicting Beliefs, Workload, Culture and Compromised Patients' Participation*

Concerns were raised about the time frame for the development of a therapeutic relationship given the reduced length of time patients now stay in hospital. One nurse stated that it would be better for the patient if this type of relationship developed as quickly as possible. Others thought that relationship development depended upon the feelings of the patient and the nurse, and this being so subjectively individualised, meant that timeframes were also variable. A therapeutic nursing relationship may develop in minutes, hours or even days. One nurse pointed out that if the model was applied as demonstrated by the diagram, the whole relationship hinged upon the initial contact where a smile or a welcome for the patient allowed the process to occur in sequence, therefore a therapeutic relationship was possible from first meeting.

Nurses discussed the amount of time available for relationship formation using this model, as the general consensus was that in any one shift, a nurse's time is tightly controlled by many external to the relationship factors. Questions arose about whether or not a nurse would have time to do all the things depicted in the model for, and with, any one patient. It was explained that, in therapeutic nursing relationship, interaction can take place anywhere, at any time, and is more often undertaken when performing nursing care, therefore is not something extra to do. Nurses stated that patients can see and hear everything that happens in the ward, and usually do realize that nurses have a limited amount of time to spend with each of them. They agreed that any time spent with a patient could be constructively utilised by a nurse familiar with the model to initiate the necessary steps toward developing a relationship which was mutually beneficial and healing for nurse and patient.

Attitudinal factors were perceived to preclude the formation of a therapeutic relationship. This was a two-way street centred around the attitudes of the patients toward hospitalization, and of nurses to their daily contact with recalcitrant patients. It was conceded that it was difficult to be "nice to someone who does not want to be nice to you or does not want to be in hospital". It equally as difficult to deal with patients who come in time and time again with the same condition which was being exacerbated by continued lack of self-health care. One nurse commented that "it seems as though you fixed them up for the same thing not long ago and they come in again ... It is a bit of a lost cause sometimes." Non-compliance, which apparently increases nurse frustration with patients, then, may have an inhibitory effect upon the development of any working relationship between nurse and patient. However, these "boomerang" patients possessed a familiarity with nurses and the hospital environment which was seen as a positive force in the development of a therapeutic nursing relationship.

The forum members discussed the relevance of complementary therapies in health care. It was felt that these therapies are coming into the fore now as people appear disillusioned with conventional medicine and that perhaps these are more widely used by dying patients when conventional medicine fails them. This could result in disunity if patient and nurse beliefs about the alternative

therapy are in conflict. One nurse related a recent incidence when she had difficulty relating to a patient who was undergoing conventional therapy while concurrently applying the principles of an alternative therapy. The patient was very angry about his combined therapy not being accepted at face value by nurses. The nurse found it very difficult not to point out what she saw as the duplicity of the patient applying conventional with alternative therapy and expecting health care providers to accept it unconditionally. She found that "it was a bit hard to handle, taking one's own beliefs about [the alternative therapy] and the patient having chemo as well and being angry at the nurses".

Forum members conceded that it was difficult to be smiling and welcoming when the arrival of another patient increased their workload and very often their stress levels. Time was perceived to be a crucial element in maintaining quality of care with an increased number of patients. There was lively discussion about timing the patient's arrival to the ward's routine and not to the outside agendas of the admissions office or the admitting area of the hospital. Members of the forum realized, in talking this issue through, that it was not the patient's fault that this occurred, and that their reception of patients was not to be coloured by things that occur outside of the relationship. Some nurses professed difficulty with appearing cheerful when there were outside stressors effecting their feelings. It was acknowledged that patients are often very aware of the fact that nurses attitudes and, or, behaviours are different from previous contact times, and use these observations as a means of conversation or camaraderie about what is causing the change.

It was noted that the model was Anglo-Saxon in origin and intent, having developed from a population of informants which was largely white Australian. They questioned the appropriateness of the model for all cultures and raised the issues of cultural mismatching, misinterpretation and misunderstanding. Nurses were particularly concerned with the inappropriateness, in certain cultures, of the smiling and welcoming approach inherent in the model's initial stages. Following open discussion, forum members came to some firm conclusions. Cultural beliefs effect patients' approaches to nurses, nursing and health care. Nurses who were "culturally aware", were able to break down the barriers which can occur through "cultural mismatching" of nurse and patient. Professional health care providers need to be sensitive to, and respectful of, the cultural needs of each patient and assimilate this knowledge into the care of all patients. Nurses who are "culturally adaptable" can effect good working relationships with patients. A therapeutic nursing relationship was recognised as essentially acultural, and even transcultural, in its composition. It was hypothesised that if a patient and nurses were "in tune" with one another as people, then there would be no clash of cultures, but a mutual respect for each as partners in a joint quest for better healthcare.

Nurses discussed the predominance of females in nursing and the effects this fact may have on the development of a good working relationship with patients from different cultures. Several interesting points resulted from examination of forum members' opinions. There was a general belief that regardless of culture, differing perceptions of the status and roles of women effected the manner in

which some patients received nurses, and that this sometimes caused both nurses and patients undue stress. There was potential for the large numbers of women in nursing to antagonize the situation with patients from patriarchal societies, and nurses' own cultural beliefs to cause an impasse because of lack of mutual understanding. In relation to the model, forum members felt that a smile or a welcome would not easily overcome some prejudices, but the process was still sufficiently credible to achieve satisfactory outcomes for both nurse and patient.

As the focus of the model was upon verbal interaction, questions were raised about its utility in areas where the patient was unconscious, that is, theatre, intensive care units and emergency areas. Under these conditions, it would be difficult to obtain patient involvement, and nurses may be perceived as inappropriate if smiling and welcoming. The forum members considered that, in these instances, the model still offered benefits for the nurse, and was equally applicable to interactions with the patient's significant others. In overall performance and potential, a therapeutic nursing relationship was deemed universally useful in practice.

#### *Benefits for nurse, patient and patients' significant others*

Participants were able to acknowledge the benefits for nurses, patients and patients' significant others. Job satisfaction featured for nurses, while patients and their families received additional support and safety from a therapeutic nursing relationship.

The outcomes for nurses engaged in a therapeutic relationship were discussed. A point was made that nurses' benefits may be less obvious because they are subjective and evolved around a feeling of "a job well done". All members agreed that nurses often told about the things they don't do well, but seldom are congratulated for something done well. It was felt that nurses generally tend to "kick themselves about the head" psychologically after any given shift or event in which they perceived themselves to lack competency or efficiency. This was a feeling often reinforced by other people's casual and causal comments. The perceived benefits for the nurse of being part of a therapeutic nursing relationship were essentially that of the personal satisfaction of knowing that they related to, and with, someone effectively, and that the outcomes for the patient were more than suitable.

The benefits of the relationship for patients were more easily identified. It was seen that in a therapeutic nursing relationship, interaction acted like a cathartic for patients in that they could say what they liked, about any aspect of their care or their lives, without fear of repercussions. Patients felt safe and supported in their actions. This effect was likened to the patient to patient support systems observed by nurses where patients "bonded" and "banded" together to support each other in times of need, and in negotiations with nurses and other hospital personnel. This relationship was so strong that when a patient was discharged, fellow patients would express hopes of seeing one another outside of the hospital and wish each other well. It was generally felt that these patient to patient support systems were stronger than the support given by nurses to each other. This was thought to be rather unusual in the light of the small amount of time patients had spent together, in

comparison to the length of time some nurses had known each other. It was agreed that patients did spend a great deal of time together in an intimate and safe environs of the hospital, which may have precipitated or acted as a catalyst to this comradeship. In a therapeutic nursing relationship, nurses became a patient's comrades in arms, which strengthened the support systems of both.

There was a recurring theme in the discussion. It was felt that relatives often played a greater interactive role with nurses than did patients, and as the model was not patient-nurse specific, relatives were able to be incorporated into the process, joining with nurse and patient to form an efficient ongoing care system.

### *Confidentiality*

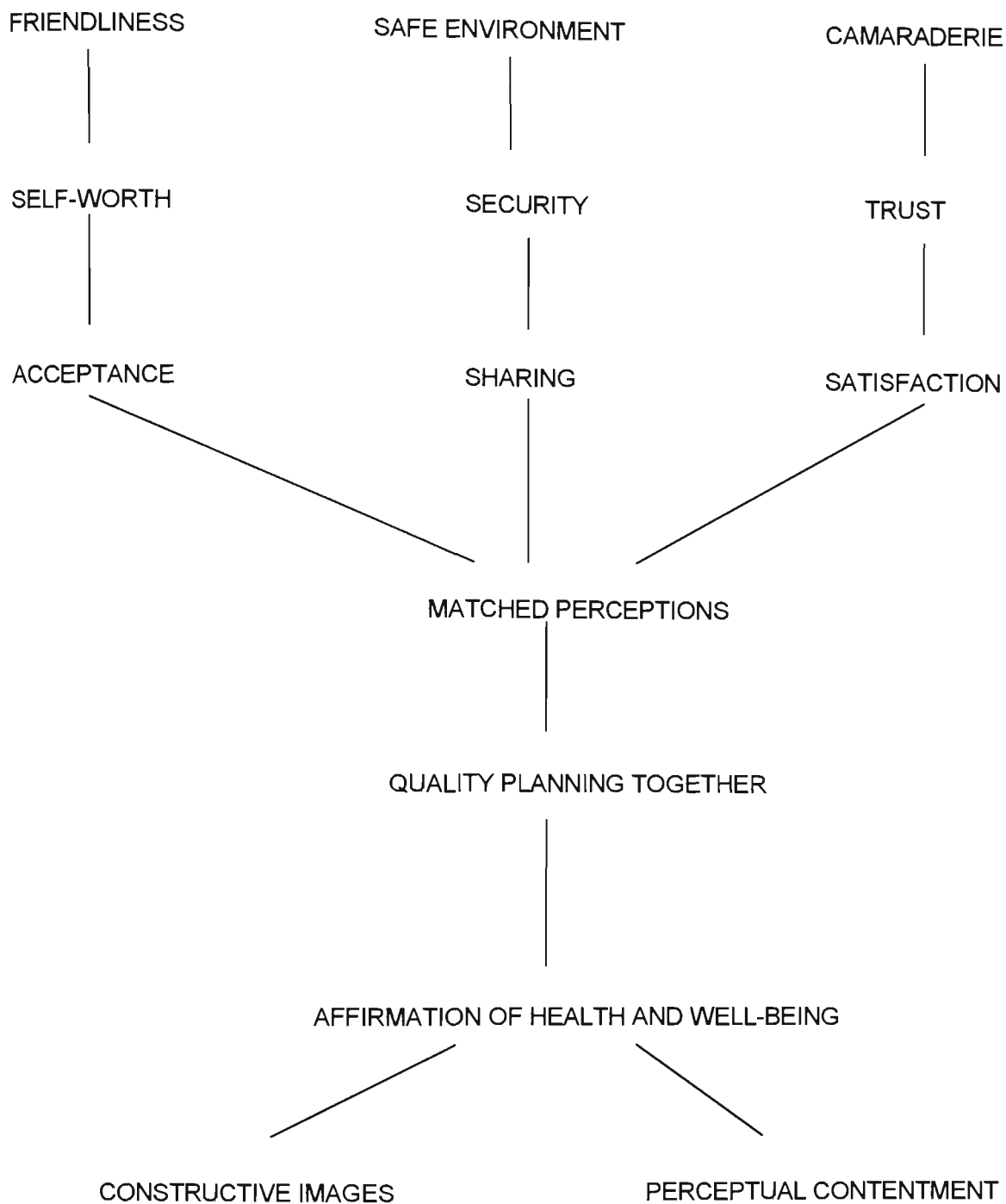
A question was raised about the place of confidentiality in the interactive format of the model. The researcher admitted that it was implied because it was an important facet of nursing care. Another member remarked that it was "pretty difficult to be confidential when the patient was deaf, had two hearing aides that did not work well and was in a four bed ward". Discussion ensued with the general consensus that patients respected the rights of fellow patients and their privacy. Even when curtains were drawn around the bed, and patients knew that these were not soundproof, fellow patients respected the presence of screening, demonstrated by occupying themselves with something else or removing themselves from hearing if this was at all possible. Patients did not, generally, appear to be eavesdroppers. It was perceived that there was no value in this type of activity for them as they were all patients.

### Model 5: A Therapeutic Nursing Relationship

Feedback from this second forum was constructive. Forum members were positively receptive to the model which was seen as simple, adaptable and easy to apply to everyday practice. The points discussed allowed revision of the model into its definitive form as depicted in Diagram E.

DIAGRAM E:

### A THERAPEUTIC NURSING RELATIONSHIP



## **A THERAPEUTIC NURSING RELATIONSHIP**

A therapeutic nursing relationship is a novel way of interpreting the relationship between nurse and patient. It is an holistic vision of a relationship based upon productive verbal interaction by, and through, which both nurse and patient benefit. The importance of this new conceptualization of the nurse-patient relationship lies in its recognition of the value of human to human contact and the connection of effective relationship formation to quality health care. A therapeutic nursing relationship allows nurse and patient to consistently relate to each other as people within a focused relationship bound by the environment of its making. The concept of a therapeutic nursing relationship gives clear directions for nursing practice through its simple and clear conceptual mapping of a relationship which is therapeutic for both nurse and patient.

A therapeutic nursing relationship is the re-conceptualisation of both patient and nurse as human beings who interact to achieve mutually beneficial outcomes. In this relationship, patient and nurse exist symbiotically in an environment created by their appreciation of each other as humans with real, but different, needs. The basis of the relationship is equity and fulfillment for both nurse and patient. In a therapeutic nursing relationship, nurse and patient share all aspects of their health care union, forming an association which is inherently beneficial and healing. The development of this type of relationship requires sensitivity and awareness by both parties. The roles of each are subtly defined by the circumstances, but the most important factor in the development of a therapeutic nursing relationship is the recognition of each other as people who can work together to achieve goals.

A relationship that is therapeutic in its content, context and mechanics ensures a beneficial outcome for both nurse and patient. A therapeutic nursing relationship is dynamic. The activity is directed to achieve satisfaction, mutual goals and beneficial outcomes for both patient and nurse. Nursing care does not happen alone, or in isolation from the patient or the nurse. It is the result of interaction between patient and nurse, a combination of personalities and possibilities, a mutual interpretation of needs and events, and appreciation of each other's strengths and weaknesses, in a relationship designed to be therapeutic in outlook and outcome. A therapeutic nursing relationship is distinct from the impersonal dichotomy of the nurse-patient relationship described in nursing literature. In a therapeutic nursing relationship, the two concepts, nurse and patient, are not polarized by place and position. There is a connection between nurse and patient which gives equality and equity to each party. A therapeutic nursing relationship expresses this function of nursing care succinctly and its construction admits the healing properties of the relationship between nurse and patient.

A therapeutic nursing relationship assures quality nursing care. This relationship recognizes that both nurse and patient are whole persons with physical, emotional and social needs. A therapeutic nursing relationship develops through the interactions which take place between nurse and patient. These interactions shape the relationship and determine the effective and affective outcomes for both nurse and patient. The relationship works toward successful achievement of health-orientated



goals, fulfilling the needs of both nurse and patient. A therapeutic nursing relationship is effectively healing and beneficial by its duality of purpose.

### **Definitions within the nursing paradigm:**

Most nursing theories are defined within the paradigm of nursing. The current paradigm embraces four interrelated concepts of nurse, patient, environment and health. A therapeutic nursing relationship can be defined within this context, but its conception adds a new dimension, that of symbiosis, rather than interdependence. This implies that the paradigm needs to be more malleable in order to fully encompass those human properties inherent in the world of nursing. Within the context of the current nursing paradigm, a therapeutic nursing relationship can be definitively subsumed into the four concepts:

A **nurse** is a human being with professional knowledge and skills to effect and affect a positive outcome for patients and self through a therapeutic nursing relationship.

A **patient** is a human being who can achieve desired outcomes in health and nursing care for self and nurses through a therapeutic nursing relationship.

The **environment** surrounds the human being as a physical and psychological atmosphere which is capable of being altered through a therapeutic nursing relationship. It has two phases, the first is controlled within the hospital and the second, controllable within a therapeutic relationship.

**Health** is physical, psychological and social well-being, effected and affected by relational contacts and activities. Health is impacted upon by the environments of others with whom the person comes in contact, that is, nurse, patient, other carers, and significant others.

A **therapeutic nursing relationship** incorporates these concepts. It is a symbiotic relationship between nurse, patient and their environments which gives an assurance of friendship, well-being, self-worth and positive, quality outcomes in nursing and health care.

A therapeutic nursing relationship recognizes that the relationships are vital factors in shaping human perceptions of the world of nursing. It upholds the relationship between two people as a puissant instrument for effecting and affecting changes in health status through interpersonal interaction. A therapeutic nursing relationship recognises the whole person within the patient and, equally, the whole person within the nurse. A therapeutic nursing relationship is sharply focused by its health-orientated environment. Its purpose is clear. Interactive discourse elicits mutual aims and elucidates their method of achievement. Fruition of the relationship into the sphere of therapy and healing occurs through the effort of both nurse and patient to reach positive mutual outcomes. As such, a therapeutic nursing relationship is a sound conceptual approach to the relationship between nurse and patient.

## CHAPTER SIX: REFLECTIONS ON THE FINDINGS

The findings are discussed in the context of their meaning and relevance to nursing theory and practice (Bums & Grove, 1993). The phenomenon of being a nursepatient is clearly described through themes illustrated with data extracts. This description was extended by examination of the nature and effect of a therapeutic relationship between nurse and patient. The portrait is intertwined with personal and professional health care outcomes which establish the significance and applicability of a therapeutic nursing relationship to current nursing practice. The benefits of such a relationship, for both nurse and patient, are clearly stated. A therapeutic nursing relationship is compatible with nursing's knowledge base of professional-patient relationships. It is logically connected to a philosophy of caring for others and the theory surrounding holistic nursing care. The research findings are energising in that they cry out for extension and suggest areas for future research. To affirm these claims, each particular aspect of the findings is examined and discussed in turn, and the theory of a therapeutic nursing relationship is critically assessed in terms of its value as a theory to nursing and nurses (Meleis, 1985).

### THEMES

Nursepatients' narratives were encapsulated into descriptive themes. The thematic descriptions present a composite overview of the experience of being a nursepatient. They gave a general portrait of what occurred for these nurses who circumstantially became patients. These themes economise the complex and detailed information offered by the nursepatients. For ease of communication to others, the themes summarise the experience of being a nursepatient into a set of graphic statements which tell readers exactly what it was like to be a nursepatient. Through individual data extracts, the reader is reminded that each nursepatient had highly individualised perceptions of her own experience as a patient in relationships with nurses.

The themes provide a frame of reference for practice. They spare nothing in this precise recall which captures the key aspects of the nursing world of the nursepatient. Readers are made fully aware of the type of nursing care to which these nursepatients were exposed. The impact that nurses make upon patients' perceptions of care and caring actions is clearly demonstrated. Exposure to thematic representation of the stories of nursepatients infers that nurses can use this knowledge to make "favourable changes ... in other situations" with patients (O'Toole & Welt, 1989, 246) and pre-determine a more constructive approach to patients who are 'different' from the norm.

#### *The whole picture*

Generally, nursepatients felt that their experiences of being patients were negative, unpleasant and unsatisfactory. Anecdotal evidence from other nurses who have been patients supports the fabric of the stories of nursepatients. Shriver (1995) found that nurses were not really listening to their patients, and consequently, delivering care that was less than optimal. Parish (1994) talked of being

ignored and treated like an object or a disease by both nurses and doctors, until she spoke out against the practice. Bailey's article (1985) called on nurses to observe social etiquette, and not treat the patient as a non-seeing, non-hearing and non-feeling object. Lissenden (1985) recalled her experience of being a patient leaving her with feelings of not being cared for as a person, until one nurse acknowledged her fears. Paxton's (1985) experience echoed these stories. Bores bemoaned the lack of time and friendship offered by nurses to him as a patient (1985). The similarity between these accounts and those of the nursepatients in this study rings warning bells for a profession which claims to care equally and holistically for all its patients.

Nursepatients are not alone in their lasting impressions of less than satisfactory nursing care given them as patients. Other research studies have reported similar patient experiences at the hands of nurses purported to be *caregivers*. Koch (1994) found that patients in a geriatric ward felt depersonalised, segregated, deprived and ignored by the actions and reactions of their nurses who "appeared to have neither the education nor insight nor power to challenge practices". Rieman's 1986 study reported that nurses' actions and attitudes left patients feeling devalued as human beings, vulnerable, helpless, humiliated, frightened and out of control. Rieman stressed that these negative and unpleasant impressions could be vividly recalled and described "even years" after the event. Lazare (1992) believed that, although most of the negative feelings associated with hospitalisation are attributed to the "assault of illness on the self...and self-image", the things health care workers do to, and for, patients can either perpetuate these feelings, or restore patients' dignity and self-worth. For many patients, it would appear that the former is more prevalent than the latter.

Nursepatient stories are anecdotes in action, with their own inherent meanings and significance for current practice. These anecdotes have powerful messages for nurses and nursing care. They compel attention, encourage reflection, foster involvement, evoke a response and transform thinking (van Manen, 1989), in this particular case, about the relationship between nurse and patient, when the patient is a nurse. It would appear the nurses need to be more aware of the impact of their actions and words upon patients, and the differences between caring and non-caring behaviours as perceived by patients. Looking after the whole patient, including his or her emotional baggage, means appreciating that being hospitalised is a dramatic event in the lives of all patients, whether or not they are familiar with the process and care of hospitalisation, and not making a priori assumptions about patients' feelings without consultation.

### *The controversy of caring*

Nursepatients also experienced caring responses from nurses. These caring actions stood apart from the rest, because they were perceived to be real interactions, between patient and nurse, involving mind, body, emotions and spirit of both. This is a definition echoed by Starck and McGovern (1992). In these true interactions, the nurse involved was perceived to genuinely care for the nursepatient, as a person, patient and nurse. Interactions with this nurse were emotionally satisfying and assured quality outcomes. So why do these relationships occur so infrequently? The

answer may lie in the current literary debate concerning the definition and properties of the concepts 'care' and 'caring', as they apply to nursing.

As early as 1984, Noddings, who has informed nursing with her writings, claimed caring an ethical activity, and diversified the debate about caring in nursing. Wolf (1986) maintained that indicators of caring nursing practice are difficult to determine and measure because the concept is a complex, multi-dimensional mixture of actions and attitudes. He challenged nurses to find the quintessence of caring which will inform practice. Benner (1991) claimed that the dominant ethic of nursing practice was care. For Benner, care was synonymous with responsibility for the "preservation and extension of human possibilities in a person, a family, a tradition". Morrison and Bumard (1991) tied caring to communicating. Green-Hernandez (1991) saw caring as an esoteric subjective property of the person's natural caring abilities and learnt professional caring strategies that positively "affect the human spirit". Rawnsley (1990) stated that caring was a human trait, and nursing needed to articulate its own particular type of caring to differentiate professional from personal types of caring. Drew and Dahlberg (1995) claimed that "the essence of nursing is caring, the interpersonal confirmation and support that exists within and qualifies all of the concrete tasks of providing care". May and Purkis (1995) called nursing "work ... [which is] an inherently moral activity". It would appear that the concept of care/caring is complex, with theorists and researchers unable to reach a consensus around the parameters of care offered by, and in, nursing. This lack of agreement challenges nurses to find answers.

The uncertainty surrounding caring centres around the issue of whether or not caring is inherent or learnt, or a combination of both. Chick and Meleis (1986) claimed that to care for patients, nurses use "care strategies, i.e., the nursing therapeutics" to guide their actions and interventions. Rieman (1986) stated that caring is "not only what the nurse does in the way of physical acts of assistance, but what the nurse is". Brown (1986) concurred with Rieman, and believed that caring was demonstrated through nursing actions taken in the best interest of the patient, while adding a cautionary note that "in most situations, the nurse cannot assume that a well-intentioned nursing act will be experienced as care". Morse (1992) argued that "caring" was an inadequate concept for nursing practice because it neither "encompass[ed] the entire domain of nursing actions", that is, what nurses "do", nor does it "provide an explanatory basis for how nurses perform".

This theoretical milieu adds to the dilemma for nurses trying to actuate caring constructs in practice. Lack of a firm working base which explains what care is and how one does it, may explain the inability of some nurses to truly care and be caring toward patients (May & Purkis, 1995). Even in definition, there is a strong suggestion that nursing's epistemology is a little confused about the properties of caring and holism. When nursing knowledge is grounded in perplexity about what nursing is and does, then the practice-theory gap widens. Useful information may be lost in complex language. Nurses cannot put into practice that which they do not understand.

### *Looking at the whole person inside the patient*

In 1983, Gadow insisted that nursing "ought to" be concerned with the whole person of the patient, and called for a nursing philosophy which laid claims to this concept of care. Since then, holism has become an accepted tenet of nursing (Easley, 1989). Nursing lays claim to holism as a construct of nursing which entails "caring for the whole person in body, mind and spirit" (Holden, 1991). Yet, in this decade, a small group of nursepatients rarely experienced nursing actions that were directed at their whole persons, vis-à-vis holistic care.

Bruni's 1991 analysis of discourse demonstrated little support for holism as a construct of nursing. She felt that holism, as a conceptual entity associated with nursing, was doomed when nursing theories persisted in representing the body of nursing knowledge as a set of domains, or prime areas of concern. This, Bruni reasoned, rendered the whole structure of nursing knowledge divisive. The chosen domains of nurse, patient, environment and health did not acknowledge the other dimensions of persona as social, political, thinking, talking human beings, nor did their meanings convey the wealth of subjectivity involved in nursing. She maintained that these domains need to be challenged and changed to encompass the subjectivity of the real world of nursing.

Nursing ontology apparently supports a reductionist way of looking at nursing which spills over into practice. Seed (1994) maintained that the socialisation of nurses into particular practice arenas precludes them from thinking holistically and perceiving patients as people. There is an over-emphasis upon doing things for the patient. This, she claimed, meant that until novice nurses mature into experts (echoing Benner, 1986), they cannot see patients as whole beings, only diseases and objects requiring nursing. She advocated that nurses need to be more reflective in order to understand the whole person within the patient. This is in opposition, but paradoxically, complementary to Taylor's wish to see the nurse re-conceptualised as a person (1992). Taylor believed that current definitions of nurse and patient were inadequate because, while they recognise the person within the patient, they do not assign this quality to the nurse. She felt that conceptualising the nurse as a person and a professional would facilitate better nursing care of the patient, as both had a common bond or "sense of shared humanity". This continual questioning of the very substance of what nurses do, and what they are, adds further dilemma for nurses challenged to uphold these caring ideals in practice.

### *Relationship reality*

The nursepatients in this study experienced a wide gamut of relationships during their hospitalisations. In the words of the nursepatients, some relationships are bad, others good, while some were "really good", in terms of healthy feelings, recollections and outcomes. Their descriptions confirm that nursing relationships are discrete in that they are formed by two individual people, and intricate, because these two people initially (and often, for the nursepatient, continually) have different perceptions of the purpose of their relationship. The descriptions verify that the

circumstantial bond of health care that brings nurse and patient together does not necessarily mean that their relationship will be successful.

The lack of success in relationship formation was attributed by the nursepatients to inadequacies in the nurse, or themselves, and or the environment in which the two met. There was more than a suggestion that nurses (including themselves) need to extend their relationship repertoire to embrace the properties of that "one really good relationship", to ensure that *all* relationships are therapeutic for both nurse and patient. Kagan and Evans (1995) supported these views, while arguing that many relationships are constrained by outside factors, such as rules and regulations, which cannot be controlled by the people trying to form relationships. Duncan (1992) reiterated this, and added that complications can arise during relationship development because the therapist/nurse has to be able to "accommodate a wide variety of client interpersonal styles". These authors chose to ignore the fact that the relationship rests on the willingness of the patient to co-opt the nurse in such a situation, although illness may reduce his/her ability to do so (Cassell, 1992).

Beck, Rawlins and Williams (1988) observations added strength to this position. They acknowledged that there are "barriers" to relationship formation which come from the nurse's previous experiences and personality, the external setting, and the behaviour of the patient to the situation, the nurse and the environment. These authors suggested that nurses can manipulate the environment to make it more conducive for relationship formation, and change work practices to facilitate therapeutic relationships with patients. Those nurses who fail to do so leave the patient feeling excommunicated, labeled, judged, ignored and offered little human support (Bond,1986), which echoes the nursepatient stories depicted by this study.

Nursepatients were labeled by their caregivers. Labeling of patients is a common practice in nursing (Abbott & Wallace, 1990). Nursepatients applied labels to themselves when in relating their stories. They did not want to be seen as "troublemakers", "malingering back patients", "whingeing bitches", and "one of *those* back patients". Many nurses will be able to relate to the skepticism applied to patients with back injuries. One nursepatient expressed the dilemma clearly when she said, "There are backs and there are backs ... and the non-genuine ones spoil it for the ones with real troubles ... you [nurses] never know who is and who isn't genuine"(jb,10). No matter what specific objection each nursepatient had toward some aspect of their care, they all found it particularly difficult to complain because of the risk of being labeled and suffering deleterious changes in caregiver attitudes to their requests and ongoing care. Sadly, all nursepatients believed in the reality of that risk and its consequences.

Nursepatients talked of being judged as patients, nurses and people by their caregivers. They were surprised by this and not expecting to be judged in any capacity. Perhaps somewhat idealistically, nursepatients reasoned that nurses usually do not judge their patients, because they respect and, or, come to like them as people. In doing so, nurses offer patients a type of friendship that obviates

judgment (Gammage, 1988). Nursepatients were prepared to be friends with their caregivers, but were not always perceived as friends by their caregivers. Their experiences led them to believe that judging was a human trait which their caregivers could not allay from their relationships with patients who were different from the norm, and more particularly, their peers. The atmosphere created by their caregivers did not allow the nursepatients to be friends with nurses. Caregiver attitudes prevented nursepatients from speaking freely and openly of their concerns. It was a subtle method of control. Nursepatients were perceived as a threat because they could use their 'insider' knowledge of the principles of nursing care, apply this to their own circumstances of being 'on the other side of the bed', and actively judge the standard of received care for themselves (Johnson & Webb, 1995).

The nursepatients' stories reflect the common barriers to effective formation of professional-patient relationships. Northouse and Northouse (1992) described these barriers as primarily involving role uncertainty, responsibility conflicts, power differences and unshared meanings. Nursepatients were certain about their role. They were patients who were nurses. However, the majority of nurses saw them in mirror image. Nursepatients were willing to participate in their care, and share the responsibility of managing their illnesses. Nurses rarely shared that same opinion, with some abdicating the responsibility, while others maintained rigid control. Power differentials existed because nursepatient caregivers held a common (mis)conception that health professionals possess "expertise" while patients are "novices" in their own healthcare (Hewison, 1995). Nursepatients, like all patients, had an intimate knowledge of their own feelings and perceptions of their illnesses. Their care givers did not attempt to find the meaning of being ill for, and with, these nursepatients, but presumed to know what was best for their care. Reliance upon the interpretations of others did little to increase the nursepatients' feelings of safety and security in their health care and its outcomes. Nursepatients were consequently rendered powerless by the attitudes and actions of the majority of their caregivers (Johnson & Webb, 1995) who had neither respect for the knowledge and experience of the nursepatients, nor thought for their particular needs and concerns.

These stories show the need for effective communication for nurses and patients to develop a shared set of meanings about the experience of being a patient and being ill, for "it cannot be taken for granted ... that nurse perceptions of what makes a difference to the patient is in agreement with patient perceptions" (Astrom, et al, 1993). Nurses and patients "can only understand one another's reality through conversation" and "shared meanings develop from an interactional process that takes time, commitment, and a conscious effort" (Northouse & Northouse, 1993,85). "Sharing" with caregivers was a facet of their care that nursepatients bemoaned as rarely happening for them. The exception was the "really good relationship" because this offered friendship, invited the nursepatients to talk openly, respected what they had to say and fostered an critical examination of the attitudes and views of both nurse and patient. This relationship was sensitive to the needs and concerns of the nursepatients and nurses. It facilitated an exploration of differences of opinion between nurse

and nursepatient, presented opportunities for modification of their views and allowed them both develop informed opinions of each other in the context of health care provision.

Nursepatient stories allow nurses to fully understand what it is like to be patient in relational contact with a nurse. Parker (1990) advocated describing the relationship of nurse and patient so that others may learn. She added that this relationship can only be effective if, and when, it involves "engaged listening, authentic responsiveness, mutual disclosure and negotiation". Parker cautioned that the true meaning of the relationship can only be gauged by looking at both perspectives - that of the nurse and the patient. Chambers (1992) claimed that "knowing and communicating are always partial (no-one knows the whole story) and contextualised (all stories are rooted in a particular time place and set of socio-cultural conditions)". Being a patient did influence the formation of the residual impressions of the nursepatients for they had experienced the paradox of opposites. Conceptually, they know the whole story. The experience allowed them to "take the role of another" and fostered their ability to look back at themselves and learn (Cheritz & Swanson, 1986). It positively coloured their perspectives of themselves, and others, as nurses and patients. In a truly phenomenological sense, nurses reading of these meanings for nurses who had been patients can learn vicariously to change, or perhaps, applaud their own practices of being in relationship with patients.

### *Summary*

The sequencing of the themes flowed through the initial experiences of nursepatients, explored relationships in practice, and finally encapsulated the qualities of an ideal relationship. The themes paint a realistic picture of the relationship between nursepatient and nurse. They are derived from real experiences. Each story is a graphic depiction of life as a nursepatient. The themes are idiosyncratic of the experience of nursepatients. They are self-limiting. Themes are presented through the words of the nursepatients to create, in the reader, an appreciation of what was like to be a nursepatient, and, for nurses in particular, an opportunity to reflect upon personal practices and ways of being in relationships with patients. Ultimately, nurses exposed to the stories of nursepatients can covertly, and more importantly, overtly, change their individual perspectives of the practice of relating to patients who are peers, and, in turn, relate this to all those who are people.

### **MEANINGS**

Nursepatients' residual impressions were coloured by their experiences as patients and their relationships with nurses as caregivers. Recalling the experience of being a patient sent the nursepatients in a cognitive search for the rationale for their experiences, that is, its significance and importance for them (Cassell, 1992). They came to the conclusion that caring for a patient who was a nurse made a difference to the quality of the relationship offered by some nurses, while other levels of relational involvement incorporated and respected, but were not altered by, this fact. Each nursepatient tried to rationalise the experience of being a patient in terms of what should, or could.



have happened. This clearly demonstrated that they were trying to find meaning for it in the context of their own lives as people, patients and professional nurses.

Meanings are highly individualised to each particular experience, however there were common elements fostered by the less than satisfactory aspects of some nursing care, and the failure to form effective relationships with all nurses. Personal meanings were derived from a combination of the overall effects of being a patient and its impact upon their personal lives, the experience itself and the degree of introspection each nurse had undertaken following the experience, and, indeed, during interviews. Many of their conclusions were related to their individual abilities to cope with a stressful situation. Profession-orientated meanings centred upon the usefulness of their experience for their own practice arenas. Nursepatients applied this experiential learning, or first-hand experience of being a patient, to effect a positive change in their practice of forming relationships with patients. This re-focusing upon the importance of the relationship meant that they offered a more emancipatory and participatory relationship to the patients in their care. In this sense, for the nursepatients, a therapeutic nursing relationship became a practice reality.

The complexity of being a nursepatient added dimensions that no other patient had experienced to the phenomenon of being a patient. Patients are leading informants of the subjective components of their illnesses, and often possess knowledge of the objective nature of their conditions. They are consumers in the health care system. Nursepatients also held more subjective than objective knowledge of their illnesses, whilst, as providers, had intimate knowledge of the health care system. After the experience of being a patient, nursepatients were able to collate all forms of knowledge to draw some firm conclusions about their role in future hospitalisations. The duality of their position as nursepatients meant that, in future, they had the potential to be more effective consumers in, and quality providers of, health care.

Nursepatients examined their experiences as patients to try and discover the elements which would have altered their impressions of being cared to (self as object), as opposed to "being cared for" (self as person), (Noddings,1984). These elements centred around control, redressing the power differentials, participation, communication, fully involved interaction, respect for individuality, and thoughtfulness in their own care. These features were a reflection of the experience, conglomerated with their own practice beliefs as nurses, and mixed with personal observations of "really good" relationships in practice. Isolating the key factor, or factors, of successful relationships meant that the nursepatients had found the 'holy grail' of relationships which explained, for them, their apparent failure to have an ideal experience as a patient who was a nurse. Nursepatients' overall perceptions of their experiences as patients led them to believe that they had been cared for as objects, or diseases, rather than people with health care problems.

Nursepatients were not alone in their experiences of being an object of care. A 1996 search of the information available on CINAHL data base revealed seventy-seven anecdotal accounts of nurses

who had been patients, most of which echoed the stories of the nursepatients. Many of these nurses had also searched for meaning in their experiences (Allen,1995; Cristo,1995; Goodwin,1995; Davidhizar,1995; Dumas,1996; Saarinen,1995; Evans,1995; Laborde,1996). And, like the nursepatients, they were also able to identify certain qualities that, if present, would have made a difference to their care. Allen (1993) emphasised having control of decisions and being "in charge of your own body". Shriver (1995) advocated that nurses listen to their patients. McKenna (1995) talked of the "little things that mean so much", expressed primarily through talking and listening to the patient. Jaffray (1995) stressed the importance of empathising with patients. Edwards (1994) felt that the relationship between nurse and patient was vital to quality care. Parish found humour an ideal antidote for distress (1994). Kendrick (1993) emphasised advocacy and now found herself standing up for her patients. Haybach (1993) rejoiced when nurses saw her as a person and not just as a patient. Mitchell found "deeper understanding" after being a patient (1994). These nurse who had been patients had learnt from their experiences. They were willing to share their experiences and conclusions in the hope that other nurses would be able to develop insight into the world of the patient and effect better patient care.

The nursepatients in this study were able to grow personally and professionally from the experience of being a patient. Gillies, Child & Biordi (1993) found that many nurses who had been hospitalised put their knowledge "to good use" by "responding, teaching and supporting future patients". This learning in hindsight was a valuable tool for the nursepatients' own professional development and nursing practice, especially in the formation of effective relationships with patients. Each nursepatient redirected this experiential learning back into their own practice to effect quality care for their patients. Ganong (1993) asserted "quality patient care requires that nurses be fully aware of, and respond to individual differences among patients, evaluate information about them in an objective manner, and develop relationships that promote communication". Nursepatients felt that they were more able to meet these needs *after* they had been patients.

In the context of nursing relationships, the experience of being a patient meant ultimately that the nursepatients were more sympathetic to the patient's whole needs. They adopted the word "sympathy", in preference to nursing's current alignment to empathy, as it meant more to, and for, them. Empathy was seen as an aspect of care that was most applicable for nurses who had never been patients, for they would need to use imagination to 'put themselves in the patient's shoes'. Nursepatients had been patients. They felt that sympathy was a more apt expression for their changed position, as they had *worn* the shoes of the patient. Sympathy clearly expressed the depth and breadth of the emotions they now felt about the place of the patient in the relationship between nurse and patient and consequently, its effect upon quality care.

Essentially, the experience of being a patient meant a personal and professional crisis for each nursepatient. They thought that their interactions with nurses would allow them to cope with the situation as capable human beings. However, in the majority of relationships and contacts with

nurses, this was not the case. They had to rely on their own resources and that "one really good relationship" to get by. This therapeutic relationship had a special, permanent position in the memories of the nursepatients, which supports its recognition as the "medium of care" (Moccia,1986) in nursing, and its importance as a bi-partisan link to quality care for both nurse and patient.

Nursepatients' experiences, in this and other studies, and in anecdotes, reinforces the notion that the social context of the patient plays an important role in how patients are perceived by nurses. They add support to Ganong's hypothesis that nurses do judge people on socio-cultural bases and that this reflects on the care given, for "if a nurse holds strong beliefs about a group in which the patient is a member, the nurse's ability to provide quality care may be negatively affected" (Ganong,1993). For the nursepatients in this study, this meant being ignored, judged, labeled and denied the care they needed as patients. Nurses need to question this narrow vision of their peers who become patients, and consider its implications in the wider context of the social and cultural diversity of Australian health care users, and providers. Fortunately for themselves and nursing, nursepatients were able to constructively redirect this knowledge of being a patient into a vow to, in future, develop "really good" relationships with patients, thereby assuring quality health and nursing care for them both.

## **ELEMENTS**

The participants in this study identified what they perceived to be the essential elements of a therapeutic relationship. These fourteen elements are communication, interchange, equality, support, safety, knowing, liking, closeness, consent, perceptiveness, trust, contentment, satisfaction and camaraderie. The multi-faceted nature of the relationship between nurse and patient is supported by research studies conducted by nursing scholars and those from other disciplines. Some studies have isolated similar elements which are conducive to the formation of an effective relationship, while others have been concerned with establishing the importance of a single element to this relationship. Elements in a relationship between nurse and patient have been linked to certain patient outcomes and nurse related benefits. The format of a relationship between nurse and patient appears to remain an enigma to nurse practitioners and scholars. Some of the mystery may be removed by the findings of this study.

### *Multi-faceted nature of the relationship*

Theoretical frameworks of nursing confirm that the relationship between nurse and patient can legitimately be composed of multiple, functional elements which are interdependent. Paterson and Zderad (1976) described the caring nurse-patient relationship in elements of "openness, presence, going into the rhythm of the patient, being with the patient, and genuine dialogue" (Astrom, et al,1993). Sundeen and others (1994) listed trust, empathy, caring, hope, autonomy and mutuality as essential components of successful nurse-patient relationships. Bond (1986) talked of support and trust. Carr (1988) emphasised the importance of trust, openness, self-disclosure and inner honesty in professional relationships. Madden (1990) linked equality, trust and respect as important facets of relationships. Northouse and Northouse (1992) saw trust as a central variable in relationships where

communication involved accepting others without "evaluating or judging them". Timmerman hypothesised that trust was consistent with intimacy, closeness and communication in a relationship of quality between professional and client. A professional relationship is therefore perceived to be a complex phenomenon, the success of which rests upon the presence of several interconnected elements.

In other disciplines, studies have revealed the importance of particular, connected elements to the relationship between two people formed by specific circumstances. Martin (1982) concluded that knowing and trusting each other were essential to an effective student-teacher relationship. Field (1983) found that communities function effectively when relationships within them are based upon intimacy, two-way communication, respect, trust, confidence, flexibility, stability, innovation and support. Patterson (1985) saw the relationship between psychotherapist and client resting upon their acceptance, respect, empathy, openness, genuineness and honesty with each other. Some of these ideas of relationships are compatible, while others are disparate. This illustrates the complex structure of any professional-client relationship and the diverse qualities that make such a relationship successful in terms of outcomes and effects.

#### *Similar elements*

Several studies support the place of certain elements within a satisfactory relationship between nurse and patient which are analogous with those described by the participants in this study. Little (1993) wrote of a "communicating friendship" between professional and patient which led to "self-discovery and self-responsibility". Kadner (1994) credited intimacy as one of those properties which humanised the relationship between nurse and patient. Timmerman (1991) also believed that intimacy was important. Both defined this element as 'a sense of closeness or connectedness between two persons'. The nurse's presence or sense of "being there" for the patient figured in many studies of the relationship between nurse and patient (Bergum,1994; Cameron,1994; Brown,1990; Pettigrew,1988; Brown,1986; Rieman,1986), while humour was an adjunct (Wooton,1996; Hamies, 1995; Astedt-Kurki & Liukkonen, 1994; Pasquali,1990; Simon,1988) and trust, a necessity (Browne,1993; Carr,1988; Chenitz & Swanson,1986; Wolf,1986). These elements are closely aligned with the concept of a therapeutic relationship (Flickinger,1994; MacLeod,1994; Altschaul,1983; Littlefield,1982). All of these studies recognise that nurses and patients are connected through their relationship with each other in a health care context, and that certain elements make that connection fruitful for both parties. They add support for the place of a multi-dimensional, explanatory theory in the literary milieu surrounding the relationship between nurse and patient

#### *Singular elements*

Nursing research has investigated the value of select elements to the relationship between nurse and patient. Travelbee (1966,1971) advocated rapport as the essence of nursing relationships. Peplau (O'Toole & Welt,1989) regarded professional closeness, expressed in intra-elements of

affective involvement and detachment, as an essential factor in nursing situations. Benner and Wrubel (1989) stressed the importance of finding the right level and kind of involvement. Fielding and Llewellyn (1987) saw communication as an important feature of relationship formation, and Garvin and Kennedy asserted that nurse-patient interaction was "made possible through communication"(1990). Others (Morrison & Bumard,1991; Wilson-Barnett,1984) advocated talking and listening as valuable tools for exposing, and thus comparing, the expectations of both nurse and patient in, and of, their relationship with each other. Swanson (1991) felt that knowing and "striving to understand the meaning of that an event has in the life of another" was an essential dimension of caring for an other. Astedt-Kurki and Liukkonen (1994) found humour to be a meaningful factor of the relationship between nurse and patient. Several studies considered friendship between nurse and patient essential for the fruition of the relationship (Astrom,1993; Rawnsley,1990; Toumishey,1989), while others regarded manipulating the environment to make the patient feel at home as an important tool available to each and every nurse (MacLeod,1994; Smith,1992; Sherrard,1988; Donnelly,1980). Capturing the quintessence of a quality relationship between nurse and patient appears to be a never-ending quest for nurse scholars.

#### *Links to outcomes*

Single and multiple elements have been linked to the success of the relationship between nurse and patient and the attainment of specific outcomes for and from that relationship. Literary descriptions support that an effective relationship between two people, particularly that with a professional to person focus, rests upon the presence of certain elements, which lead to certain, often predictable, outcomes. As early as 1982, Martin saw effective teaching and learning occurring through teacher-student relationships which focused upon: "knowing and trusting each other, accurately understanding each other, influencing and helping each other and constructively solving problems and conflicts". In 1983, Field found that, in order to change dietary patterns of communities, experts working in the field needed to develop a relationship with community members which embodied the elements of intimacy, two-way communication, respect, trust, confidence, flexibility, stability, innovation and support. Patterson (1985) believed that, in psychotherapy, a good interpersonal relationship hinged upon the psychotherapist displaying acceptance, respect, empathy, openness, genuineness and honesty in their dealings with clients. This gave the person a sense of security and a measure of control in the care. These authors were able to connect specific elements of effective relationships to positive subjective and, or, objective outcomes for the client peculiar to the profession from which these relationships developed. For the nursepatients, nurses and patients involved in this study, a successful relationship was also tied to health care outcomes, some of which were affective in orientation, and others objective assessments of the results of hospitalisation.

Specific elements have been attributed to particular outcomes of a relationship between nurse and patient. Much detail and discussion has been given to the importance of communication, knowing, humour, presence and trust in the relational contact between nurse and patient, and the ultimate

outcome or outcomes of that union. Such outcomes are primarily described in terms of effect and affect for the client.

Communication between nurse and patient was a positive asset for the relationship and gave firm rewards for both in terms of psychological safety (Minardi & Riley, 1988). As early as 1963, Brown asserted that paucity of conversation between providers and consumers of health care led to misunderstandings because nurses and patients did not, and indeed could not, share their perceptions. This led to unsatisfactory relationships. On the other hand, when conversation worked toward finding the "common ground" between nurse and patient, it unified the two within the relationship (Kristjanson & Chalmers, 1990). Sharing in this manner encouraged the development of a mutual support system in a situation where, without it, one could feel alone and vulnerable (Bergum, 1994). Communication, then, is associated with human well-being and comfort (Fosbinder, 1992; Drew, 1986).

Knowing each other as people allows assimilation of differences so that both parties may realise potentials within the relationship (Emdon, 1985). It assists the nurse in making clinical judgments, learning about people and being a patient advocate, because "knowing the patient means knowing the patient's typical pattern of responses [which assures] safe and astute nursing care" (Tanner et al, 1993). Knowing each other is essential to feeling cared for and about.

Astedt-Kurki and Liukkonen (1994) found that humour facilitated interaction, while fostering a patient's well being and coping, and increasing a nurse's job satisfaction and motivation. Morgan (1997) regarded humour as a valuable asset in nursing and attributed its appropriate use with breaking down barriers, promoting patient relaxation and encouraging mutual exchange between nurse and patient. In older adults, humour appears to positively influence patients' perceptions of health, life satisfaction, and morale (Simon, 1988). Humour reduces stress (Wooten, 1996; Hamies, 1995; Pasquali, 1990) and improves the function of the body, the mind and the spirit. Laughing with the patient allows them to see their situation in a different perspective, and builds confidence in the relationship.

Presence is mentioned by many studies as an element of a successful nurse-patient relationship. Presence or "being there" for each other increased coping, self-esteem and a sense of connectedness between two people in a relationship (Bergum, 1994; Brown, 1990; Pettigrew, 1988). Rieman (1986) believed that nurse actions and presence made a difference to patient care outcomes. She described the benefits of this close relationship as resulting from the nurse being "*truly present* in thought, word and deed", wherein feelings were evoked which supported healing and well-being in the patient, and promoted a sense of value for both patient and nurse. Cameron (1994) calls these simple actions as the "grace of being totally present" which nourishes the relationship and establishes a special friendship. Quality care, comfort and support came with true presence (Brown, 1986).

The ability to trust each other within a relationship was essential to its development and fruition as a health care activity (Wolf,1986). In its value to humanising care, trust is akin to respect (Browne,1993). People trust nurses to maintain confidentiality, and will talk to nurses and reveal content that they do not share with other people (Chenitz & Swanson, 1986). Nurses who respect the knowledge that patients bring with them evoke trust and effect quality care and caring. Trust relationships [are] an important theme in the professional status of nursing" (Carr,1988). In this type of relationship, patient and nurse accepted (Weissman & Appleton, 1995), liked each other (Smith,1992) and were more like friends (Astrom,1993; Rawnsley,1990; Toumishey,1989).

The importance of these five elements to the outcomes of the relational contact between nurse and patient has been demonstrated by various studies. The participants of this study have reiterated these elements in their stories of a therapeutic nursing relationship, and added a further nine in their efforts to describe the elusive qualities of such a relationship, however, controversy continues to cloud the issue of the impact of particular elements upon health care outcomes.

#### *Enigma in action*

The ties of certain elements to each other and health care outcomes would appear to remain a puzzle to nursing scholars and practitioners. Discussion continues about the credibility of certain elements to the relationship's success in terms of feelings, well-being and improved health. The lack of firm outcome measures, other than in terms of participant affect, may deter consensus on their value to health care as a whole.

Humour is beginning to feature as an essential component of nurse-patient relationships. Its value as a therapy is still being assessed (Mallett, 1995). Summers (1990) found that although humour was regarded as an adjunct to personal problem-solving, although few nurses in her study, utilised this approach in their professional roles. There appeared to be uncertainty among practising nurses about its appropriateness as a nursing tool and the reception of its use by patients. The nursepatients, nurses and patients of this study applauded humour as a valuable asset in nursing and health care.

Krouse and Roberts (1989) evaluated nurse-patient interactive styles in terms of outcomes based on feelings of control, power and satisfaction. They advocated active negotiation between nurse and patient to facilitate self-care, vis-à-vis successful discharge from nursing care. A study by Fallavollita (1991) found that there was a "meaningful, although limited, relation between feelings of personal control and patient well-being". Earlier, Kovner (1989) claimed that nurse-patient agreement on goals and strategies positively effects patient satisfaction with care and reduces the length of time patients stay in hospital. Peplar and Lynch (1991) also found that offering patients control validated them as people, and afforded them choice in health care interventions. This enabled patients to effectively problem solve for themselves, with nurses acting as consultants. In

order to make those choices and exercise control, Dennis (1990) says, patients rely on access to appropriate information supplied by nurses. When this does not occur, patients are unable to successfully fulfill the patient role, relinquish control to nurses and feel deprived as people and patients. This supports the stories of nursepatients who were rendered powerless and ignored, and indirectly, upholds their demands for the reverse elements in a therapeutic nursing relationship.

Drew asserts that nurses still have a lot to learn about the nurse-patient relationship for "the essence of health care is still 'something that happens between people' ". To facilitate a therapeutic nursing relationship, nurses have to be willing to open to the patient's experience and do all they can to make a patient feel acknowledged as a human being in need of nursing and health care. Nurses need to be aware that most patients are strangers to hospitals and this may inhibit their ability to interact with nurses (Toumishey,1989) whose intentions are revealed "immediately and unmistakably in a look, a smile, an intonation, or a handshake" (Marcel cited in Rieman,1986).

Embracing the patient's clinical reality (Jacobs, 1980) effectively removes the power differentials inherent in a professional-patient relationship (Hewison,1993) by acknowledging that the "real teachers are the persons who happen to be patients" (Stein-Parbury,1993). Nurses are called upon to alter the patient's environment so that it is conducive to making the patient feel at home (MacLeod,1994; Smith,1992; Sherrard,1988; Donnelly,1980), engage their relatives (Knight,1985), and facilitate patient choice (Tmobranski,1994). The complexity of human nature and the unique context of each relationship of nurse to patient adds a cautionary note to all these demands. A factor which is deemed appropriate for one set of circumstances may not transpose so easily to the next, and not all nurses possess the talents necessary to be able to respond appropriately toward each individual patient.

### *Summary*

Exploring their experiences for "that one really good relationship", and examining its effects on their feelings as patients, had positive benefits for the nursepatients. It allowed them to see the full spectrum of their experiences as patients, and move on, conceptually, by personal selection and identification of the essential properties of this ideal relationship which they owned under the label of therapeutic, that is, "mutually beneficial and healing". The place of these elements in relationships in practice was confirmed by nurses and patients whose descriptions added credibility to those given by the nursepatients.

Dissecting the relationship into its components parts is essential to understanding what it is that makes a connection between nurse and patient convert into a deeper set of interactions, that is, a true relationship. Nursing theory and research, like that of other disciplines, has taken this approach in the effort to explain the dynamics of an ideal nursing relationship. Descriptions and findings present various processes and elements as essential factors in the development of a successful relationship between nurse and patient. The outcomes of such a relationship are also the subject of



much investigation, but almost unequivocally focus on the benefits for the patient. A notion of benefits for the nurse begs consideration by practising nurses, and nursing as a profession faced with rising attrition rates not solely contributed to by natural events.

Literature supports the proposition that quality relationships depend upon the presence of elemental properties, which influence outcomes for, and residual perceptions of, those involved. The success of the relationship between nurse and patient does not rest on any specific element, but a collection of features and factors that define and establish its identity. This study builds on previous research by identifying several elements which are perceived to be essential for the development of a therapeutic relationship between nurse and patient. These elements are sequentially tied together and linked to specific outcomes, particularly concerning personal satisfaction and health care goals, for both nurse and patient. Its development and infrastructure as a mutually beneficial and healing way of relating to each other removes some of the mystery created by previous examinations of the relational connection between nurse and patient. A therapeutic nursing relationship is a means of assuring a quality relationship between nurse and patient.

## **CONCEPT**

A therapeutic nursing relationship was conceptualised from the descriptions given by nursepatients, nurses and their patients. Their agreed definition of a relationship which was mutually beneficial and healing for nurse and patient, took on the dimensions of therapy. In this relationship, a nurse was perceived to act as a therapist whose interactions with patients were mutually therapeutic. Therapy of this nature resulted in obvious good for the person to whom it was directed, and more subtly, for the person directing the care. Healing occurred because of, and through, the involvement of two people, nurse and patient, concordant with quality health care.

### *A Therapeutic Relationship*

The idea of a therapeutic nursing relationship developed from, and through, the words of the nursepatients. Their definition of a this relationship as "mutually beneficial and healing" was accepted by the nurses asked to describe their therapeutic relationships with patients. Patients were able to relate to the description of "a really good relationship" when describing their relational contact with nurses. The concept was accepted by this study's participants as a practical application and approach to nurse-patient relations. It was a simple explanation of the ideal relationship between nurse and patient based upon communication and participation.

The importance of communication to the development of a therapeutic relationship was stressed by the participants in this study. Talking and listening to each other was vital in achieving the mutually satisfying and healing properties that such a relationship could offer both nurse and patient. There is support for communication as the cornerstone of the relationship between nurse and patient. Hasselkus (1991) considered a therapeutic relationship to be a personal connection between nurse and patient built mutual understanding and partnership which developed through talking and listening

to each other. Dybvick and O'Neill (1993), and Arnold and Boggs (1989) emphasised that a therapeutic relationship develops through active communication between nurse and patient. Huttlinger et al (1992) concurred that communication was the foundation of a therapeutic relationship. Sundeen et al (1994) advocated the use of therapeutic communication by nurses in order to build a relationship which respected and validated the patient as a person. Holsti (1969) also favoured communication as "the most basic form of human interaction ... necessary for any enduring human relationship".

Participation in their own health care was a favoured option for the patients in this study. They wanted to be involved in all stages of their health care planning, delivery and organisation. Nurse-participants were willing to consult with their patients, and involve them in their care. A participatory relationship had a two-fold effect. When a patient's views are solicited and perceived as worthy contributions in nursing care, this simple action reinforces the humanity, power and security of the patient. The nurse gained in knowledge of, and was attuned to, the patient's real needs. Porter (1994) reported that, over the years, "nurses efforts have reaffirmed the full humanity of people requiring health care" by changing the orientation of nurse-patient relationship from nurse to patient through improved communication "which has lead ... to the empowerment of patients". Such a relationship is integral to caring and holism (Ashworth et al, 1992).

Biley (1992) maintains that participation is always conditional. She found patient choice and participation was restricted by the severity of illness, depth of information and the patient's perceptions of his/her abilities. Severity of illness was the most influential component, for "when patients are acutely ill, they do not want to be involved in choosing and decision-making". Waterworth and Luker (1990) found that not all patients wish to participate at all in decisions regarding their care, preferring to be passive recipients. This echoes the findings of Strull, Lo and Charles (1984). They warn nurses to carefully consider imposing such rights upon *all* patients.

A therapeutic nursing relationship recognises the need for either partner to assume control when, and where, necessary. Each person in the relationship relies upon the other to be responsive, responsible and committed to achieving quality care and beneficial outcomes for each other. Many of the patients in this study had been acutely ill, which, at times, had restricted their abilities to actively choose and participate in their health care schema. They perceived that, as a therapeutic nursing relationship was based upon mutual understanding and trust, they could confidently relinquish this power to the nurse and know that any decisions made would be appropriate to their own desires. A therapeutic nursing relationship automatically gave permission to the nurse to make those 'hard' decisions when the patient was unable to participate and choose. The equity of a therapeutic nursing relationship is not indeterminate, but rather based on sharing its control by both nurse and patient.

A therapeutic relationship also explicated the purpose, aims and outcomes of this particular relationship for both nurse and patient. Why then, was it such a rare occurrence in practice? Nursepatients rarely experienced a therapeutic relationship. The therapeutic nursing relationship described by nursepatients was demonstrable in practice. However, nurses reported that they often were only able to establish this type of relationship with a few patients. And complementary to these reports, while exposed to numerous nurse practitioners, each patient named only one nurse with whom they experienced a therapeutic relationship. A therapeutic relationship, then, was not a common option offered by nurses, to patients. This paucity was attributed to a variety of on-job and personal constraints, including time, tasks, environment, personal hesitance and reluctance. Reluctance to add therapeutic qualifiers to descriptions of the nurse-patient relationship may be explained by the fact that therapeutic relationships between nurse and patient are apparently rare in practice. Constraints imposed upon nurses by their job may inhibit the development of a therapeutic relationship. But perhaps of greater impact upon the process are nurses themselves, their own perceptions of what constitutes an effective relationship, and seeming inability to effect such relationships with patients.

Morrison and Bumard (1991) found that while relationships were hindered by nurses who felt obliged to perform tasks and take control of patients to effect quality care, nurses felt constrained by their work ethic (where circumstances called for instant decisions), work environment (large patient numbers, little time for contact) and their personal defense mechanisms (implemented to reduce stress). This constraint situation is further complicated by the multitude of health care practitioners with whom a nurse must interact on a day to day basis, and the inevitable juggling of each other's "professional practice boundaries" (Pilette et al, 1995) within the patient care machinery.

Koshy (1989) dismisses these claims, by pointing out that "nurses spend more time with the patient than any other professional worker" and have an "important responsibility to create an essential environment which allows patients to establish relationships by developing a warm, home-like, accepting atmosphere". For Koshy, "the nurse-client relationship is a valuable therapeutic tool", made effective by understanding attitudes and behaviour which includes active listening. He calls on nurses to build therapeutic relationships which show that they care and are interested in patients as people *and* patients.

A therapeutic relationship appears to be complicated by demands, intentions and the inherent differences of the people involved (Brammer, et al, 1989). Spencer (1989) says that this is due to the fact that when a professional meets a client, these two persons "have varying developmental backgrounds, value perspectives, social and physical environmental experiences, cultural ties and lifestyle patterns". A therapeutic relationship is complex in format and function (Patterson, 1985), for it calls on the therapist to relate to the client as a "whole and total person, including thoughts, intentions, and actions, as well as feelings and emotions". The therapist does this through a "stance that is involved yet neutral, connected yet separate" and central to the process (Brown,1991). This

calls on nurses to practice "a wide repertoire of interpersonal skills and competencies" in order to "interpret and understand the viewpoint of another ... [which] ... is not an ability possessed by all" (Kasch,1984) A therapeutic relationship, then, is a paradox (Bumard,1992). And sadly, perhaps, this makes it too complicated for nurses, and nursing, to articulate in practice.

While the nurses in this study were able to describe a therapeutic relationship, they did not see themselves as therapists, or acquaint nursing with therapy. Therapy was associated with observable change wherein what the therapist does for, and with, the patient made a difference to the progress and prognosis of that patient's illness. For them, it was difficult to extract from the health care milieu that surrounds each patient, exactly what it was that nursing effectively changes. The effect of nursing upon the patient was often described in less tangible and observable changes than those offered by allied health professions who can identify improvements in movement, abilities and behaviour. In these professions, a professional-patient relationship was, and is, commonly described as "therapeutic" and the term "therapist" to articulates their practice arenas, for example, physiotherapy, occupational therapy and psychotherapy. This terminology appears less frequently in nursing literature. The nurse-patient relationship is multi-faceted because it concerns the whole person within the patient undergoing a wide range of therapies. Nursing is, in itself, a therapeutic composite which incorporates other modalities of therapy, including helping, guiding, supervising, counseling and behavioural change (Stein-Parbury,1993).

While Travelbee (1966 & 1971) and Peplau (1957 & 1989) have advocated the formation of therapeutic relationships between nurses and patients, the use of this descriptor has come under scrutiny in the pursuing years. Kasch (1983) criticised the therapeutic perspective of relationships as being "incompatible with the instrumental and interpersonal demands of many clinical situations", and negating "shared understanding". Morse (1991) argued that while "most nurse-patient relationships are in the therapeutic category ... not all these relationships truly respect the patient as a person, facilitate trust and result in care that makes a difference to the patient". May (1993) claimed that a therapeutic relationship is possible in nursing, but fraught with difficulty because nurses have to actively demonstrate caring attitudes and aptitudes derived from their own perceptions, education and socialisation processes, which may be far removed from that of the patient. This "confirms the dominance of [the nurse's] reality" over that of the patient (Barker,1989) and may lead to outcomes that are less than therapeutic in the eyes of the patient. Articulation of the therapeutic nature of the nurse-patient relationship to practice may be compounded by the lack of a firm contemporary theoretical support for the use of such a concept in nursing practice.

Some contemporary views of the nurse-patient relationship embrace some of the concepts of a therapeutic nursing relationship, but, in description appear impersonal, tightly structured, and orientated to what the nurse does for the patient. Drew and Dahlberg (1995) talked of an "intersubjective relationship between caregiver and patient" which generated holistic caring. In this relationship, the nurse recognised the personhood of the patient, and was able to "understand what

ought to be done [before] prescribing and doing". Savage (1993) talked of a "contracted clinician" model of a relationship in which patients were self-determining and nurses were responsible for the extent of care. Limits of freedom and involvement were contracted with the patient who was seen firstly as a person, and secondly as a patient. Patients say "I want" while nurses perform skills. Taylor (1993) also invested the nurse with meeting the patient's needs, but chose to ignore the nurse's needs within the relationship. Astedt-Kurki and Haggmann-Laitila (1993) found that clients' perceptions of care are markedly effected by the type of relationship they enter into with nurses. They maintained that a good relationship is one in which the patient will "feel that he [sic] is at the centre of all activity and that 'adding' to his personal well-being is the goal of health care".

In a therapeutic nursing relationship, nurse and patient agreement is reached by more informal methods of sharing personal and professional information which encourages feelings of well-being for both. There is no clear division between 'doing' and wanting'. It is an amalgam of wishes, at times unspoken, but powerfully evident. Minardi and Riley (1988) maintain that a relationship between nurse and patient must go "beyond merely the 'social' level [so that] both participants feel safe enough to openly discuss their feelings". The association between nurse and patient is more to do with "how people feel about and perceive each other than ... a particular set of skills" (Morrison & Bumard, 1991). A therapeutic nursing relationship recognises the dual nature of the relationship where the nurse's sense of well-being is of equal importance to the fruition of the relationship, for "every patient encounter is meaningful ... it always has impact ... it always effects both the patient and the nurse" (Jurchak, 1990). Pegram (1992) argues that nurses who do not take the opportunity to combine physical tasks with psychological care, are denying the patients, and themselves, valuable opportunities to interact, learn and grow together.

The therapeutic intent of the relationship between nurse and patient is an underlying principle of quality nursing care. The relationship between nurse and patient is an important focus in health care evaluation. The relationship is clearly connected to standards of care and care outcomes. Minardi and Riley (1988) claim that "the standard of care delivered depends on the quality of the relationships that individual nurses build with their clients". Hoff (1989) acknowledges that the outcomes of the work nurses do with patients is more dependent on the quality of the relationship that nurses establish with patients, than it is upon theoretical and technical knowledge (Hoff, 1989). The expression of "human interest [in the patient] by the health care professional was ... viewed as a pre-requisite to high quality care" (Thorne & Robinson, 1988). Ludwig-Beymer et al (1993) found that patients described quality nursing care in terms of a nurse's abilities to function as a professional and a person in the context of delivering well thought out, and thoughtful, nursing care in a healing environment. The best care was perceived to be given by a nurse who "had a heart" and was able to combine technical skill with caring, respect, encouragement and a willingness to do more for, and with, the patient. Nurses who are perceived to be flexible and adaptable to situations, and toward the people involved in them, increased the likelihood of "meeting patients' needs and achieving desired outcomes" (Bortoff & Morse, 1994). Perceptions of quality care evolve from, and revolve around,

the relationship between nurse and patient, because this is more often the closest human to human contact a patient experiences whilst undergoing health care.

A therapeutic nursing relationship acknowledges the value of the patient's contributions to his or her own health care. It upholds the patient's dignity as a basic human right (The National Association for Retarded Citizens, 1979). A therapeutic nursing relationship respects that "patients want nurses to be compassionate as well as technical" (Betta, 1993), and that both nurse and patient have a certain expertise. A therapeutic nursing relationship is a combination of technical competence and personal attitudes that are conducive to communication, interaction and participation. This relationship is a "special case of loving" (Jourard, 1971) - loving who you are, what you do and how you do it in the context of relationships with other people.

Each person in a therapeutic nursing relationship recognises and moreover, *knows*, that both will benefit from their association in this health care context. In a therapeutic connection, both nurse and patient create conditions conducive to the effective functioning and personal growth of each other (Kasch, 1983). Its certain reliance on nurses and patients to be adaptable to the demands of the relationship reaps benefits for both. Some of these benefits will be concrete, while others will be more obscure, being feted in emotions and feelings shared between nurse and patient. Nonetheless, the effects will be evident, if only in the perceptions of those thus involved. Indirectly, a therapeutic nursing relationship impacts upon the institutions in which nurses work, by building a positive 'take-away' image for patients exposed to this type of connection with nurses, and increasing nurses' satisfaction with their work and workplace.

A therapeutic nursing relationship respects the contributions of both nurse and patient. It embraces the whole nurse and the whole patient in a relationship designed to identify concerns, define meanings, determine goals and achieve outcomes. A therapeutic nursing relationship embraces the principles of holism, and applies them to professional and patient, and both as people. Its applicability in current nursing philosophy is timely, and apt, considering nursing's adoption of holism as part of its philosophy of caring for others. A therapeutic nursing relationship expresses what nursing is and does for patients and nurses. Adopting a therapeutic relationship ethos of patient care means making a commitment to change by offering patients a relationship which makes a visible difference to their care, and being willing to articulate this concept to the world as a nursing entity.

A therapeutic nursing relationship demands a paradigm shift. This relationship supports the realm of therapy and therapeutics in nursing practice through its potential to achieve mutually beneficial outcomes for both nurse and patient, and by fostering healing on physical and emotional levels. It does not polarise the concepts of nurse and patient, but combines them in an harmonious conglomerate of two people who will work together to achieve mutual aims. There is a connection between nurse and patient which gives equality and equity to each person. It is a type of partnership which "builds on a world view of interconnectedness and wholeness" (Young & Flower, 1996). As

such, a therapeutic nursing relationship is distinctly different from the nurse-patient dichotomy espoused by current nursing paradigms. It is time to change and capture the essence that is nursing - the relationship between two people, one of whom happens to be a nurse, and the other, a patient.

### *Therapy*

A therapeutic nursing relationship is akin to therapy. Upholding nursing as therapy is an innovative way of acknowledging the impact that the nurse as professional, and the nurse as person, has upon health care, and relationships developed with patients. It also gives equal importance to the skills, knowledge and personal attributes of the patient. Therapy is a unique label which conceptually combines through a relationship, what nurses do and who they are, with the complementary characteristics of patients, that is, who they are and their specific nursing care needs. The nurse not only takes care of, and cares for, the patient, but cares about the outcomes of their relationship. Similarly, patients care about themselves, for the nurse and the outcomes of their relational connection. Patients do not passively accept the care given, but are active participants in their care (Duffy,1992). This collaboration between nurse and patient assures that, while each has a firm measure of control within the relationship, their combined efforts as a unit will empower them to effect satisfactory outcomes and quality health care.

Seeing nursing as therapy means adopting a new philosophy which places emphasis on the importance of developing effective relationships with patients. Patterson (1985) stated that "therapy, by almost any definition, involves a personal contact between the therapist and the client". The nurse-patient relationship is a personal connection between nurse and patient. Lloyd and Maas (1991) believed that the relationship between nurse and patient *is* the key element in facilitating therapy. Muetzel (1988) also felt that therapeutic power lay in the quality of the relationship developed between nurse and patient, and more particularly, through a relationship wherein each were seen as "whole" people. She asserted that nursing was a therapy, but acknowledged that "nursing is most often perceived as a activity that supports the therapy of others, rather than being a therapy itself". Muetzel called for nursing to redefine the word 'therapy' to accurately describe its features for nursing and nurses. McMahon (1986 & 1991) concurred with Muetzel. He believed that, until this redefinition of nursing occurs theoretically and is articulated into practice, nurses cannot "deliver care which is consistently therapeutic" (McMahon,1991).

Defining nursing as a therapy means identifying and describing its inherent properties so that nurse practitioners may know what is, and what is not, therapeutic nursing. Contemporary thought surrounding nursing's therapeutic intent is diverse, which, while adding to the debate, does little toward informing nurses or empowering them to change their practices (McMahon & Pearson,1991). While there appears to be a general consensus that the personal and professional qualities of the nurse mediate the delivery of nursing as therapy, and the relationship between nurse and patient is the medium of nursing therapy, continued argument about the exact elements and activities which are therapeutic, and the effect of these factors upon nursing practice and patient outcomes, impedes

general acceptance of nursing as a therapy. McMahon (1991) called for research which articulates these essential features of nursing therapy and enables nurses to know, and practice, therapeutic nursing.

This research provides some answers about nursing's therapeutic modalities. The participants have provided a list of the elements which they believed were essential to a therapeutic nursing relationship. This list, by definition and description, gives nursing the means to proclaim itself a therapy. The information provides direction for nurses wishing to deliver therapeutic nursing to their patients. The relationship provides benefits for both patient and nurse, in effect and affect, and is healing to, and for, them as health care consumers and providers. This type of nursing, then, can truly be called "therapy".

### *Mutuality/Reciprocity*

A therapeutic nursing relationship was mutually satisfying for nurses and patients as people, patients and nurses. Each participant was adamant that this effect was reciprocated for their partner in care. The patients in this study reported that a really good relationship with a nurse made them feel "good" as people and patients. They held positive images of nursing, nurses and the health care facility because of this relationship, and believed that the relationship had a reciprocal effect upon their nurse caregivers. This interactive effect was perceived to hasten patient recovery and be physically and emotionally healing for both patient and nurse. The nurse participants echoed these reports and recognised that, although nursing can be emotionally and physically draining for its practitioners, a "really good relationship" between nurse and patient allowed them to feel revived and refreshed as both nurses and people. For these nurses, a "really good", or therapeutic, relationship made up the shortfall in the emotional and physical cost that nursing exacts upon its nurses (Smith,1992) and had obvious potentials for the patients exposed to its principles of mutuality and reciprocity.

A therapeutic nursing relationship regards the relationship between nurse and patient as the most important component of quality health care (Murphy and Hunter,1979). Each participant shares in the relationship and contributes to defining and meeting health care goals (Sundeen et al, 1994). However, the mutuality of a therapeutic nursing relationship means more than being together in a relationship. In a therapeutic nursing relationship, mutuality involves sharing each other, each other's contributions to the relationship, and the situation through a "posture of personal attachment" (Parker,1990). This relationship is based upon mutual respect and honesty in sharing information and feelings, together with collaborative, interdependent, equal and active patient participation (Chiltem,1982). Nurse and patient are responsive to each other through their relational connections which bring them in touch with each other and wherein both accept the other's invitation to be "a close traveling companion on an uncertain journey" (Parker,1990). A therapeutic nursing relationship embraces these ideas and ideals of relational contact between nurse and patient which best describes the depth of the relationship between nurse and patient in this context.



Reciprocity is synonymous to mutuality, but for this study meant that each participant, both nurse and patient, benefited from relational contact with another in a health care context, and specifically through their relationship. It recognises that, while the relationship between nurse and patient is designed to help the patient, professionals also need to gain satisfaction and grow from the relationship (Brammer,1988). A therapeutic nursing relationship emphasises the positive effects of sharing between nurse and patient, in terms of building trust, confidence and mutual understanding through a "healthy balance" of giving and receiving.

The "best possible nursing care" is given to the patient involved in a relationship with a nurse that is "characterised by mutuality and reciprocity" (Ramos,1992). This "mutual giving and receiving is a very powerful form of therapy" (Moyers,1994) for both nurse and patient. Trust and respect between nurse and patient were recipes for success in terms of nurses' satisfaction with nursing, and patients' adopting a more positive approach to illness and health care (Phillips,1986; Bond,1986). Reciprocal benefits for both nurse and patient arise from their helping each other as people and contribute to them both achieving quality in health care (Betta,1993; Gilbert, 1993; Chalmers,1992; Morse,1992; Morrison,1992; Chinn,1991 & Marck,1990).

### *Healing*

A therapeutic nursing relationship was perceived to be healing in its nature and intent. There were subjective and objective components to this perception of healing. Subjectively, both patients and nurses believed that they had gained from their interactions within a therapeutic nursing relationship. Patients felt that they had improved in health and well-being, were relaxed, and had made friends with the nurses. Nurses felt that they had matured as nurses and people by contact with patients in a therapeutic nursing relationship, and were pleased with their methods of delivering comprehensive caring care. More concrete, measurable outcomes for the patient were enhanced self worth, satisfaction, improved health status, progression toward independence in eventual discharge or death, and achievement of mutually derived health goals. Nurses talked of being able to meet all of the patient's needs throughout the relationship's process, growth, fruition and termination. This gave nurses an enhanced sense of satisfaction with themselves as nurses, and their relationship prowess. Both nurse and patient believed that a therapeutic nursing relationship meant optimal, quality care and engendered a feeling of confidence and optimism about future hospitalisations.

McMahon (1991) believed that nurses were slowly "recognising that they too are the healers and facilitators who allow the patients to heal themselves". For McMahon, healing was synonymous with, and complementary to, therapy and therapeutics. Muetzel (1988) promoted a therapeutic relationship as the medium for healing. It is through this type of relationship where hurting is balanced with human warmth, gentleness and compassion, that healing occurs (Hodgkinson,1993). Jourard (1971) maintained that the quality of the relationship, and "sincere attempts to know and understand a patient and help him to be comfortable increase his sense of identity and integrity, and

this experience seems to be a factor in healing". A therapeutic nursing relationship respects these ideas and integrates them into its fabric.

Because "healing is a mutual act" (Pellegrino, 1982), and healing occurs through the mutual connectedness of nurse and patient (Moyers,1994), a therapeutic nursing relationship is the means to healing. Healing is assisted when the meanings of events, such as illness, are identified by, and shared among, its participants (Duffy,1992), as "an interest in, and an acknowledgment of the full gamut of inner experience in oneself and in others is contagious" (Jourard,1971). Moyers' studies of healing (1994) identified certain essential "healing" tools in a health care relationship. These were listening and giving attention to another, sharing meanings, and looking beyond the events of today. This, he felt, led to a lightening of the burden of illness. A therapeutic nursing relationship promotes healing because it is based in, and on, communicating, sharing, and instilling hope.

### *Summary*

The nursepatient participants in this study defined a therapeutic nursing relationship as one that was beneficial and healing in process and outcomes for both nurse and patient. Nurse and patient relational contact became, or was, a therapy. Nurse and patient participants readily accepted this definition as an adequate description of their experiences. The notion of a relationship with positive outcomes for nurses and patients is not commonly referred to in nursing literature where the usual emphasis is upon relational benefits for patients. It would appear that, for maximum impact upon practice, outcomes of nursing theory and research have to be spelt out in terms of effect and affect for the patients as the pan-ultimate beneficiaries of nursing care. A therapeutic nursing relationship does not deny this singular effect of the relationship between nurse and patient, but gives equal credibility to its impact upon *both* participants. Healing and therapy are also terms that appear to be less frequently associated with professional and practical nursing. A therapeutic nursing relationship is a healing therapy for both nurse and patient. The concept of a relationship between nurse and patient that is therapeutic in nature and intent is not new to nursing, however, appears to be experienced infrequently in practice. As a relational concept that sprang from nursing practice, a therapeutic nursing relationship has relevance for practising nurses and their patients by acknowledging the total reciprocity of their relationship, including its healing abilities and therapeutic effects upon health care outcomes.

At this conceptual stage, a therapeutic nursing relationship offered a broad definition and a set of constituent elements purported to improve the quality of care and relational contacts between patient and nurse. It represented a nursing perspective of what 'goes on' in a relationship between nurse and patient. The phenomenological baseline from which the concept developed assured that it "was faithful to the real world of lived nursing experience...[through] the effective communication of insights into that human experience" (Moccia,1986). As a burgeoning concept, a therapeutic nursing relationship held up a mirror of nursing practice antithetical to that experienced by nurses who have been patients. It challenged nurses to look at the meaning of this type of nursing care for

patients, and, ultimately, themselves. This type of reflective examination entailed taking a serious look at oneself and being aware of the significance of one's actions (Oliver,1990) and words on another (Wilson,1966). The idea of a therapeutic nursing relationship was proffered as an inspiration for practice change, but was in its infancy as a nursing concept. Further exploration exposed its utility as a means of achieving quality outcomes for both patient and nurse.

## **MODEL**

### *Development*

The model developed from the concept described by nurses who had been patients, and grew out of the opinions expressed by practising nurses and their patients who had experienced a therapeutic nursing relationship. In order to encapsulate the wealth of information supplied by all the participants in this study, and coagulate the fragments of description into a logical format of antecedents and consequences, a model of a therapeutic nursing relationship was constructed. It is a graphic representation of the concept's constituent parts and their effects for the parties involved, with the attributes of a therapeutic nursing relationship listed sequentially to its outcomes. The model typifies an everyday example of a relationship in which nurse and patient are active members of a union designed to achieve satisfactory outcomes for both.

### *Function*

A therapeutic nursing relationship retained its holistic, intersubjective and contextual focus when subsumed into the model. The model is a means of representing the concept in a simple, 'easy to understand and follow' format for articulation to practising nurses (Patterson,1985). The model takes the salient points of the relationship between nurse and patient and places them into a simple diagram which demonstrates their relationships to each other and the whole, and, more essentially, the outcomes of such a relationship for both nurse and patient. It defines the involvement of the nurse and the patient in a therapeutic caring process which enhances the likelihood of both reaching specific health care goals (Betta, 1993). The model identifies a therapeutic nursing relationship as a particular *nursing* concept involving nurse and patient, and excludes what "is not-the-concept" (Rodgers,1989). In this way, its references are set to enable practising nurses to differentiate between a therapeutic nursing relationship and other types of relationships which they may form with patients. As such, the therapeutic nursing relationship model is designed as an exemplar of best nursing practice.

### *Purpose*

Theoretical descriptions of models of the "nurse-patient relationship" abound in nursing literature. Many are used to differentiate the types of relationships patients and nurses have experienced. Others describe the differing effects of these relationships in terms of patient care. Most models make recommendations and give directions for nursing practice (Christensen, 1993; May, 1991; Wolf,1986; Murphy & Hunter, 1983). Fawcett's 1992 analysis of nursing theories highlighted the reciprocity of nursing practice and model development. She concluded that conceptual models

influenced the ways in which nursing practice was experienced and understood, while nursing practice "informed and transformed the content of the conceptual model". A model is a framework for practice (Morrison & Bumard,1991). Modeling the concept into a simple diagram offers structural clarity through identification of the stages in the relationship which, in the absence of any theoretical bias, can be used as a guide and a checklist for nurse practitioners (Bumard,1992).

### *Representativeness*

The model of a therapeutic nursing relationship is firmly fixed within the scope of the relationship between nurse and patient. It represents a way of relating to patients that nurses may utilise in practice. It does not represent a world view of nursing, but offers the world of nursing a simple view of the mechanisms of relationship building with patients. The model does not align with any particular known theory of nursing. It offers its own explanation for relational connections between nurse and patient, in terms of mutual benefits for both, and quality outcomes for patients, nurses and, consequently, health care facilities in which it is practised. The model is not context-specific or culture bound. It is adaptable to any context or culture in which a nurse and a patient come together under the guise of health care.

### *An Evaluation*

Evaluating a model involves scrutinising its development and the rationales behind its conception (Thibodeau,1985). The background for this study began with the researcher's own practice and observations that nurse practitioners offered patients many different types of relationships. Diversity was most evident when the patient was also a nurse. This focused the search for explanation upon descriptions of relationships experienced by nurses who had been patients. Their stories confirmed the variety of relational connections nurses make with patients, and set in motion the idea that relationships could be mutually beneficial and healing if a certain set of qualities were present. The concept of a therapeutic nursing relationship was born, and along with this, a search for support for its utility in practice. The processes of inductive and deductive reasoning saw the journey culminate with a new approach to nurse-patient relations expressed as a therapeutic nursing relationship.

As a model, a therapeutic nursing relationship was accepted and evaluated by a group of practising nurses as an accurate representation of their practice realities. The forum participants shared a belief in the model's values, knowledge and methods of practice. They supported the surrounding philosophy of a mutually beneficial and healing relational involvement of nurse and patient. For these nurses, the model appeared to be a coherent whole which gave them, and their patients, a united sense of purpose, common goals and a shared understanding of the benefits of such a relationship in a health care context (Wright,1990). They could see that the model was firmly rooted in practice, and had been developed using the talent and expertise of their workplace peers. Its practical application could yield results quickly and effectively. The language in which it was couched was uncomplicated and realistic in, and to, daily practice. The model primarily focused upon the patient and nurse, and was interwoven with their social and cultural backgrounds. It also

embraced the vistas of the facility in which the relationship was occurring. The model was perceived to be adaptable and transferable to other settings because it was neither enmeshed by social and cultural factors nor tied into time-consuming activities. Patients were welcomed into the relationship and perceived to be capable, thinking human beings interested in their health care world and that of their caregivers. Nurses were not required to learn new skills to effect a therapeutic nursing relationship, but to bring forward and refine those human abilities of taking an active interest in another human being whose present situation required health care, and more particularly, *nurse* care. The model also called on nurses to extend this interest to each other as practitioners and people involved in health care.

The symbiotic nature of the relationship between nurse and patient, where each part ensured the success of the other, was evident in the model's structure and design. The model recognised the value of nursing and nurses to health care (Wright,1990), while inherently upholding the place of the patient in the relationship, and the overall provision of quality health care. It also validated the rights of nurses and patients to derive satisfaction from their relationships with each other. The model emphasised successful achievement of goals common to both nurse and patient, and illustrated the cyclic consequences of these benefits, in terms of personal growth, change and satisfaction. It also demonstrated a formula for pro-active public relations. The model acknowledged that this joint relational effort of nurse and patient had intrinsic value for the facility in which this type of relationship was practised. The quality of caring achieved positive outcomes which were reflected simply by patients' willingness to return for further and or future care, and nurses' satisfaction within the organisation.

### *Summary*

It is legitimate to express the concept of a therapeutic nursing relationship in the form of a model. A model defines the boundaries of a therapeutic nursing relationship and nursing's place within them. It is a clear base from which to work toward nursing care which makes a difference for the patient, and, the nurse. The model of a therapeutic nursing relationship presents a framework of ideas for relationship building in nursing. It clearly articulates what nursing is, does, and can be, in this context. The model is relevant to nursing practice, nurses and patients. It is not static, but amenable to, and encourages, change in both nurse and patient, and, ultimately, the health care facility in which this type of relational contact between nurse and patient is practised.

As a diagrammatic summary, the model identifies and organises knowledge by simplifying and ordering factors in relationship to each other, and links theory to practice (Chinn,1986). As a model, it is open to scrutiny of its suggestions for nursing practice which make a difference to patient care (Fawcett,1992; Wright,1990). Stember (1986) says that:

"Models in both everyday and scientific usage provide a means of exhibiting, examining, observing, and teaching the structural relationships of many realities that cannot otherwise be observed ... Model building is a logical theoretical and

methodological process with the intent of clarifying and testing relationships and communicating them more effectively". (1986,103).

A therapeutic nursing relationship sprang from practice. It exposes those properties of a mutually beneficial and healing relationship between nurse and patient that are not always articulated by nurses and patients, but obvious in observation and outcomes transference. Expressing the properties of a therapeutic nursing relationship in the form of a model communicates the concept to nurses and, ultimately, patients. It is, then, an effective strategy for further development of the concept of a therapeutic nursing relationship into a theory of nursing which expresses nurse and patient relational involvement as an area for best practice (Thibodeau, 1985).

## **THE THEORY**

The theory of a therapeutic nursing relationship is a situation-producing theory the purpose of which is prescription (Thibodeau, 1985). It builds on the reality described by the model and explains the relational connection of nurse and patient in a therapeutic healthcare context. It addresses the function of that connection for both nurse and patient. As a practice guide, the theory offers specific guidelines for nursing action by describing how a nurse must act in order to bring about desirable therapeutic situations and reach mutual goals with a patient. The theory expands existing nursing knowledge of the relationship between nurse and patient and challenges the views held by practising nurses about the nature of that relationship. The theory will affirm some practitioners' assumptions about the relationship between patient and nurse, while refuting others. This theory was developed by, and through, research into the practical realities of everyday nursing interactions with their patients. It validates and expands existing nursing knowledge. The nurses who accept and use this theory will find their interactions with patients therapeutic, discover the satisfaction involved in achieving mutual goals, and experience the physical and psychological healing factors of such a relationship for themselves and their patients.

### *Terms of Reference:*

The theory of a therapeutic nursing relationship rests upon the relational contact between nurse and patient. It does not assume that the current adoption of certain concepts into a nursing paradigm is the pan-ultimate accolade of what nursing is and does in relation to patient care. However, for convention and appreciation of the current theoretical paradigm of nursing, which embraces the concepts of nurse, patient, health and environment, the theory can be reduced to a set of base definitions which sit inside this paradigm. This theory is bold enough to add a fifth concept which recognises the import of the relationship of nurse and patient to nursing.

### *Conceptual Explanations*

As a consequence of amalgamating all the perspectives offered by the participants in this study, the basic definitions of the original concept changed. As the theory developed, the terms of reference shifted to include richer explanations and more detail. The four domains of nursing practice, as

defined through examination of the data given by the nursepatients, broadened to include those sequential perspectives offered by nurses and patients, and the concept of a therapeutic nursing relationship. This relationship is defined and extended to describe its dynamics and therapeutic effects for both nurse and patient.

### *1. Base Definitions - Patient, Nurse, Environment, Health and A Therapeutic Nursing Relationship.*

The *Patient* is a person who requires, and is willing to enter into, a therapeutic nursing relationship with a health care provider/nurse to achieve desired outcomes in health and nursing care.

The *Nurse* is a person with personal abilities and professional knowledge and skills to effect and affect a positive outcome for patients and self through a therapeutic nursing relationship.

The *Environment* is the physical and psychological atmosphere surrounding patient (and significant others) and nurse which is capable of being altered through a therapeutic nursing relationship. It consists of three parts. The first enveloping environment is controlled by the physical surrounds in which the relationship occurs, that is, the institution or facility which provides health care. The second environment is produced and controlled by the intimate surroundings of a therapeutic nursing relationship which takes place between nurse and patient. Both of these phases are impacted upon by the third exterior environment in which nurse and patient live outside of the health care arena.

*Health* is the physical, psychological and social well-being of the person which is effected and affected by relational contacts and activities.

*A Therapeutic Nursing Relationship* is a symbiotic connection between patient and nurse which gives both an assurance of friendship, well-being, self-worth and positive quality outcomes in health and nursing care.

### *2. The Relationship between Nurse and Patient*

A therapeutic nursing relationship places the emphasis of nursing care into the realm of the relationship built between nurse and patient. It recognises that this relationship is the strategic centre of, and a powerful tool for, achieving quality health care. This relationship rests on the premise that being in touch with another person in a therapeutic, that is, mutually beneficial and healing, way assures personal and professional satisfaction for both nurse and patient. Personally, both are enriched by the experience. Professionally, both are more than satisfied with the relationship, its progress and eventual outcomes. Nurse and patient also realise that the relationship is self-limiting, and contained within the health care context. Neither look for more from the relationship, nor extension of it into their own social arenas, but are able to envisage future re-connection in the same environment.

A therapeutic nursing relationship promotes a sense of well-being and contentment which reflects upon the person, the profession and the health care facility involved. Put more simply, nurses who are satisfied and happy in their relational contacts with patients, and the quality of the care they can provide, present positive images for nurses, nursing and their place of employment. They are ambassadors and "A-grade" public relations officers. Patients who are satisfied and happy in their relational contacts with nurses, and the quality of their nursing care, are vocal supporters of the nurses from whom they received this care, and more often, the institutions in which this experience occurred. They are also most willing to share these positive experiences with other potential consumers of this service.

A therapeutic nursing relationship is symbiosis in action (Nissan, 1996). Nurse and patient live together in an harmonious existence within the context of health and nursing care. It is an on-going and mutually beneficial relationship of nurse and patient. A therapeutic nursing relationship invites and survives upon the contributions of both nurse and patient. Nurse and patient work and function together, as a team. They are interdependent. In this type of relationship, patient and nurse share experiences "in an effort to co-construct the meaning of seemingly meaningless experiences" (Parker, 1990). Both are bettered by the experience of being in touch with each other as people, patients and nurses. In true symbiosis, the relationship brings about beneficial changes for, and in, both nurse and patient. In true therapy, nurse and patient health and well-being are enhanced through a dual meeting of mind, body and spirit which is inherently healing and satisfying.

### *3. Building a Therapeutic Nursing Relationship - that first contact between patients and nurses.*

This stage of the relationship is vital to its success as a therapy. First impressions are lasting reflections of the standards of health care about to be encountered. Views are quickly formulated and lead to acute speculations about other facets of a health care facility, the people it employs, and the environment in which health care is provided and enacted. These first impressions impact upon a patient's sense of security, well-being and safety, and his or her beliefs in the ultimate outcomes of this experience.

A patient's first impressions of health facilities, nursing and its human elements, nurses and other health care providers, are vital. These visual perceptions are also long-lasting. From this first meeting with their physical surrounds and carers, patients form views about successive health care provision and the environment in which these interactions will take place. Crucial to patient well-being and perceptions of nursing and all facets of health care, is a sense of being made welcome and feeling welcome in this new, and often strangely chaotic environment into which they have been thrust. A therapeutic nursing relationship calls upon the nurse to be friendly toward all patients, welcome them to the ward and exude a demeanor which informs patients that they are appreciated and will be looked after both as patients and people. This receptiveness invites active patient participation in a therapeutic nursing relationship. It begins on first meeting. Primarily, nurse and patient meet as people with different, but interconnected, parts to play and fulfill in a health care



setting. Nurses recognise that they, themselves, are important in terms of what will happen to patients from admission to discharge. Patients are made to feel that they are the most important part of what a nurse is, and does. Understanding of this reciprocity in each other as people, patients and nurses occurs with this initial relational contact.

On admission, patients are usually anxious and have a heightened awareness of other people's attitudes and manner of approach toward them. Patients know that they are vulnerable and interdependent on a wide variety of health care providers. Of particular concern are the characteristics of their primary caregivers, nurses, as they will provide their most intimate care. Patients look for certain qualities in, or mannerisms of, a nurse which tells them that things are not as bad as they seem. They closely observe each nurse's reactions to them as people and patients. They assess and sometimes measure, each nurse's responses to their various states of health. Patients want a friend and an ally during their hospitalisations. They do not want to be alone in this strange environment. Patients see the nurse in two guises, firstly as a person who can offer them friendship and secondly, as a professional who can offer them care and caring. Patients expect that each nurse will see that they too are both people and patients. Patients are ready to give toward a relationship with another person whilst in hospital, and hope that a nurse will reciprocate by offering them a branch for their support networks.

A therapeutic nursing relationship recognises and is built upon the premise that first impressions are crucial to quality patient care and caring. Because the environment in which patients find themselves is often strange to them, a therapeutic nursing relationship emphasizes the need to make the patient feel welcome and be made welcome by nurses. Nurses who practise from this ethos are friendly toward and with patients. They are welcoming of the patient and his or her significant others. They invite participation by the patient, respect the patient's part in quality health care and actively involve the patient in his or her own care. These nurses have a personal commitment to engaging with patients and the professional competence of knowing what to do to make things better for all patients. They recognise the patient inside the person, and the person inside the patient, then reciprocate by exposing themselves as people who are nurses. By giving and taking with a patient, nurses can initiate a therapeutic nursing relationship at that first contact by displaying an acute self-awareness of the importance of the nurse to the patient, the patient to the nurse and of them both to quality health care.

The environment in which a therapeutic nursing relationship is formed is important. This is co-created by people (nurses and other staff) and place. The physical surroundings are secondary to the aura created by the people who work there. Patients like, and want, to be made welcome by staff who are pleased to meet and see them. They want to be seen as a person and a patient. They are quick to sense a nurse's beliefs in the place of the patient in health care. Patients like to feel that they and their care are part and parcel of the health care environment, rather than an imposition or an obligation. Patients are constantly evaluating the nurse's ability to meet their needs as people

and patients. Patients want to reach certain goals - better health or a peaceful death - and know that they cannot do this by themselves. They look for a nurse who will join them in their journey toward better health or a peaceful death, and is not afraid to do so as a professional, and a person.

These assurances are precipitated by the attitudes and actions of nurses committed to a therapeutic nursing relationship with patients. These nurses provide a warm, safe environment, because they care about, and for, patients as people *and* patients. They are relaxed and happy with their work and project an image that this place is a home away from home for all persons involved, but most particularly, patients and their nurses. This hint of cohabit intimacy between nurse and patient assures physical and psychological comfort. Nurses who use humour appropriately to acknowledge their mutual situation with patients admit joint personhood into the relationship. These nurses gain the patient's confidence. Their actions and words enhance the patient's own confidence to operate competently in this new environment. This relaxes the patient, opens the relationship to camaraderie and enhances sharing of secrets.

#### *4. Therapeutic Therapy*

The relationship becomes a therapeutic activity through the actions of patients and nurses. By activating four simple concepts - friendliness, receptiveness, assurance and camaraderie - nurses are able to evoke similar feelings in patients. They feel the togetherness of their situation. There is a certainty that what is discussed and enacted within the relationship belongs to that relationship and is confined by its circumstance and physical surroundings. The safe atmosphere fosters exchanges of confidences. Patients and nurses can share their views, beliefs and wishes about specifics in nursing care, the broader arena of health care, and the wider context of life. This open discussion exposes patients' perspectives of experience of being ill and nurses' perspectives of caring for the ill. Positive and negative images of the situation can be traded and used to build the relationship toward a therapeutic climax.

Creating an atmosphere conducive to open, honest and frank discussion of the circumstances which brought them together allows both nurse and patient to understand each other as people. This understanding extends into nursing and health care, aids progression toward a level of care which is optimally suitable for both, and facilitates goal attainment. The patient is free to express desires and concerns, and to discuss options, alternatives and consequences. The nurse is able to add knowledge of the process and system which impact upon and influence choices. Supplying information about each other as people *and* patients *and* nurses adds surety to the decisions taken, and choices made. Both nurse and patient have faith in the decisions and choices and look forward to their fruition. There is a certain acceptance of the care, the outcomes and the alternatives available for each individual patient and nurse.

When the relationship of nurse and patient is pivotal to quality care, each derives a great deal of satisfaction from the encounter. There is respect for each other and full knowledge that each successive interaction will be enjoyable. This sense of pleasure satisfies the patient's need to contribute and interact with the nurse and feel worthwhile. The nurse's need to care for the patient through their relationship is met. The nurse derives personal and professional satisfaction from interacting with the patient in a productive way and also feels worthwhile. Confidence in the potential of the relationship and its goals means that nurse and patient are able to communicate effectively to discuss and facilitate any changes while being assured of satisfaction with all outcomes of their relationship. These results are both tangible and measurable, such as changes in health status, together with less concrete but noticeable, alterations in attitudes and responses to each other as people, nursing and health care.

Nurse and patients who engage each other in a therapeutic nursing relationship are satisfied with themselves, each other, their health and nursing care. They carry a positive image of these factors and enjoy its recall. They are articulate about its structure and function within the health care context. Patients are confident in their abilities to enter into this type of relationship with each other as patients, and their various health care personnel. Nurses who practice from this perspective in their relationships with patients extend and promote a therapeutic relationship in similar situations with their peers, colleagues and fellow health care providers.

The benefits of a therapeutic nursing relationship for patients, nurses, hospitals and health care in general, are firmly rooted in the positive public image presented by and through such a relationship. A therapeutic nursing relationship promotes nurses and nursing with a positive public image *because* patients are satisfied with their care. Patients who have experienced a therapeutic nursing relationship, its inherent accuracy of direction in their care and mutual benefits are willing 'return for service' consumers. Having been an active participant in the relationship and experienced its reciprocal nature, means that patients do not feel as though they are indebted to nurses and the health care facility, but see themselves as part of its existence. They are positive in their evaluation and feedback to the health care facility. Patients exposed to a therapeutic nursing relationship act, within their social sphere, as public relations officers for the facility by providing 'hands on', 'inside' information to potential consumers. Nurses who take part in therapeutic nursing relationships are satisfied in their work with patients and with themselves as nurses. They are able to give and receive in a relationship which respects their interdependence with patients while upholding their autonomy within the relationship. These nurses practice with a sound working knowledge of the patients' needs and wants as people and patients. Their practice is informed and informative. Nurses who are satisfied in their relationships with patients also act as positive, promotional formal and informal sources of referral for the health care facility.

Personifying the professional relationship between nurse and patient has benefits for both. By relaxing their professional guard and becoming people, nurses can develop relationships with

patients that are therapeutic in nature and outcomes. Patients will feel assured that they are valued as people and patients and relate to nurses in a positive manner. Patients believe in nurses as people and professionals and, most importantly, they believe in themselves as people and patients. They are less afraid of treatment, progression and outcomes in nursing and health care. The possession of 'inside' knowledge about the patients means that nurses can confidently supply the patient with the means to achieve a change in health care status. Both parties are assured of determining mutual goals and establishing agreed pathways to reach them. The benefits are satisfaction with the reciprocal nature of the relationship, the resultant nursing *care*, the level of that care, and the caring for each other as people brought together in a relationship formed by unusual circumstances.

## **AN EVALUATION**

Using the criteria of Meleis (1985), the concept of a therapeutic nursing relationship can be examined in terms of its structure and function as a nursing theory. Meleis says that, structurally, a sound theory has clear connections between its assumptions, concepts and propositions. Functionally, the purpose and consequences of the application of this theory in practice are clearly and simply stated. Both structure and function are logically and coherently connected to each other. Both are consistent with the current paradigm upheld by the profession to whom the theory is directed. Conversely, a calibre theory is versatile its application across disciplines and is cross-cultural and transcultural in outlook. A well-organised theory is thus reducible to a set of statements supported with rationales that render its structure and function easy to follow. In nursing, a theory which meets all of these criteria will be a realistic, meaningful and useful theory for its profession and practitioners. It will be consistent with the profession's values and goals. This theory will give clear outcomes for nurses and their patients, which comprehensively and positively impact upon the health care facility in which the theory is applied. Theoretically, as presented, the concept of a therapeutic nursing relationship is able to meet each of Meleis's criteria, and possesses the potential to actualise all criterion when applied in nursing practice.

### *Assumptions*

The concept of a therapeutic nursing relationship rests upon a set of assumptions which revolve around the relationship between nurse and patient, its reciprocal nature, connection to self-determination and importance to quality caring. These are:

1. The relationship between nurse and patient is *the* focus of nursing care.
2. The relationship between nurse and patient is a two-way liaison.
3. Therapeutic nursing relationships arouse emotions in nurses and patients.
4. The relationship between nurse and patient is mutually beneficial and healing.
5. In this relationship, there is a meeting of skills and personalities which are equalised to establish mutual goals and pathways for satisfactory outcomes.
6. In the quest for quality nursing and health care, the relationship drives the care toward these satisfactory outcomes for both nurse and patient.

7. All parties involved - nurse, patient and health care facility - *want* quality care.
8. A therapeutic nursing relationship assures and ensures optimal care for each patient, and each nurse.

### *Concepts*

Therapy and healing are the conceptual underpinnings of the theory of a therapeutic nursing relationship. The theory accepts nursing as a therapy, nurses as therapists, and nursing activities as therapeutic. It supports nurses as healers and nursing as a healing modality. The relationship between nurse and patient is the medium for nursing therapy and therapeutic activities which lead to healing. These activities are rewarding for both nurse and patient.

### *Propositions*

A therapeutic nursing relationship occurs when its essential elements are cultivated by both nurse and patient. This relationship results in a high level of benefits for both nurse and patient. Both are satisfied with the relationship, the care and the outcomes which, in turn, may be indirectly reflected back toward the health care facility in which this relationship is found. A therapeutic nursing relationship is reciprocal, mutually beneficial and rewarding for both nurse and patient. It assures positive outcomes through optimal care *and* caring. When a nurse and patient are engaged in a therapeutic nursing relationship, both are satisfied with the care given and received by each other. This relationship is a no-obligation gift that a nurse offers a patient, who returns the gift by becoming part of that relationship. Both parties are aware that a therapeutic nursing relationship has its own boundaries within health care, and exists within the boundaries of nursing practice.

### *Purpose*

A therapeutic nursing relationship exists for the benefit of patient and nurse. The spin-off benefits for the health care facility are inherent in its structure and function. A therapeutic nursing relationship is a means of delivering optimal care and caring for each other as people, patients and nurses. It has been defined within the paradigm of nursing, and is an extension of nursing knowledge about the relationship between nurse and patient.

### *Consequences*

A therapeutic nursing relationship potentiates healing, both physically and psychologically. It assures mutual satisfaction for nurse and patient from the contact and the connection. It leads to positive outcomes which result in personal growth for both. Satisfaction with the interaction and its outcomes adds to a nurse's sense of self as a competent practitioner and maturation as a professional. Exposure to the benefits of this relationship ensures that patients will, in future, return for service and continue to expect to be engaged in health care relationships which are therapeutic in nature and intent. The theory supports the existence of firm links between what happens in a relationship with its explicit outcomes, and the wider environment within which this therapeutic nursing relationship occurs. By association, it also exposes the reverse scenario. A therapeutic nursing relationship

does not require extra time, effort or learning, but evolves and revolves around a sense of self and purpose in delivering and receiving quality nursing care.

### *Summary*

The concept of a therapeutic nursing relationship arose from examination of relationships in practice. Its essential structure was described by those who had experienced, or, in the case of nursepatients, wished to experience, this type of relationship in practice. It is operationally defined using the terms of the nursing paradigm to expose its nature and impact upon nursing care. It states what it is, how it acts and why it is important for both nurse and patient. There are obvious implications in the application of this theory which reflect upon patient satisfaction, and quality care indicators, plus nurse satisfaction and job retention rates. These factors were not examined in detail, as they lay outside the focus of the research, but were gathered along the way as inherent outliers which could not be ignored in the process of objectively examining the theory and its overall connection to quality nursing care.

The theory of a therapeutic nursing relationship offers a feasible and relevant description of a relationship derived from practice. It is a method of being in relationship with patients which gives nurses and nursing direction for practice. It is a simple concept which is easily learnt. It requires a change in thinking about the relationship's importance to, and for, nurses and patients. The theory has versatility and adaptability. A therapeutic nursing relationship is acultural in nature and intent. It is not complex in scope and sequence, so can easily be applied to clinical situations which require nurse and patient to work together to achieve desired outcomes. It respects the nurse and the patient as functional partners in care which derives benefits for both. It is directed toward achieving outcomes which are both patient *and* nurse focused. It does not require the patient, as a person, to adapt, adjust, or change. It does not leave patients to negotiate their health care alone. It accepts the patient as a knowledgeable person whose health status can be effected positively by relationship formation with a nurse. It respects the nurse as a knowledgeable person who can assist movement of the relationship with a patient toward desired health care outcomes. A therapeutic nursing relationship is a symbiotic relationship of person to person, human to human, need to need proportions which lead to satisfactory outcomes for both nurse and patient. The theory proposes a relationship between nurse and patient which is therapeutic in origin, actions and outcomes.

### **A CONCLUSION**

A therapeutic nursing relationship exists as a concept and theory which can be demonstrated less verbosely in a clearly and simply mapped practice model. It is a new way of looking at an old nursing instrument - the relationship between nurse and patient (Wilson, 1966). As a construct of nursing, its greatest strength lies in the fact that its very conception arose from anecdotal and narrative accounts of actual therapeutic nursing relationships. A therapeutic nursing relationship focuses health care upon the relationship between nurse and patient in an holistic vision of human connectedness and relatedness which links quality care with therapy and healing. As such, this

theory is synonymous with current nursing theory which espouses the concepts of caring, holism, participation and therapy.

In keeping with being faithful to the real world of lived nursing experience, and utilising a phenomenological baseline (Moccia, 1986), the concept of a therapeutic nursing relationship was explored in its entirety. This incorporated looking at both recipient and provider perspectives of that relationship and accounting for contributing and restricting factors in its development. The concept was exposed by isolation of certain elements which made the relationship between nurse and patient more meaningful in terms of health care outcomes and affective, or emotional, satisfaction. It also acknowledged the factors which impinged upon the development of such a relationship - time, organisation, stress, power and control. Surprisingly, within the intimate confines of a therapeutic nursing relationship, nurse and patient can overcome all of these constraints by their actions toward each other, through open, honest communication and sharing of ideas and suggestions. A therapeutic nursing relationship is enhanced by any contact which occurs within the timeframe allowed its development and fruition. Nurses and patients have the power to effect changes in health care through a therapeutic nursing relationship. Nurses are empowered through this relationship to make things different for their patients. Patients are empowered by their participation in the relationship and the care. Putting their power together in a therapeutic nursing relationship establishes control by nurse and patient and deflects constraints upon its dynamics. This togetherness doubles the impact and effect of the partnership upon concrete health care outcomes, and less tangible emotional gains of nurse and patient as people.

The overall goal of this study was to achieve an accurate portrayal of a therapeutic nursing relationship that enables understanding and valid representation of the meaning of being human in this relationship (Munhall, 1994). In this portrait, a therapeutic nursing relationship is represented through the subjective statements of the people involved which clearly demonstrate how and what these nurses and patients felt about their experiences of this relationship in practice (Morison & Burnard, 1991). The study was objective, in that the steps toward discovery were carried out according to known processes. It was also systematic in looking at all aspects and phases of the relationship between nurses and patient in the context of everyday practice realities. The theory can be linked to existing theory and data on the subject of the relationship between nurse and patient (Holsti, 1969). The study combines the subjective and objective components of available evidence (Mitchell, 1993) on the relationship between nurse and patient to arrive at its final conclusion - a theory of a therapeutic nursing relationship.

# CHAPTER SEVEN: DIRECTIONS AND DIMENSIONS

## - aka Where to from here?

A therapeutic nursing relationship gives fresh directions and dimensions to nursing theory, practice, education, management and research. It is a new way of looking at the relationship between nurse and patient supported by narratives from the real world of nursing which lend it empirical reality (Long, 1984). From its phenomenological basis, a therapeutic nursing relationship exposes insights into nursing practice from which nurses, and other health care professionals, can learn about the world of being a patient and a nurse in relationship with each other. It relates theory to practice by concise labeling and description of practical situations in which the relationship between nurse and patient is predominantly mutually beneficial (Wilson, 1966). The theory challenges nurses to lay aside old meanings connected with the relationship between nurse and patient and open themselves to new meanings "or, at the very least, to bring new life to the meanings [they] already hold" (Crotty, 1996) about this relationship.

A therapeutic nursing relationship presents a new philosophy and set of objectives that are useful in educating nurses about the relationship between nurse and patient and its role in health care outcomes for both nurse and patient. As a theory of nursing, a therapeutic nursing relationship contains guidelines for optimal patient care and has relevance for structuring and organising care so that patients, nurses and the health care facility can reap the maximum benefits from their interactions. A therapeutic nursing relationship begs for extension through research which will determine its ability to predict with accuracy patient and nurse outcomes from their interactions in this context. As a burgeoning theory of nursing, a therapeutic nursing relationship has potentials which are yet to be realised, but in application can be actualised for the benefit of patients, nurses and health care provision.

### *Usefulness as a Theory*

A therapeutic nursing relationship developed theoretically from the stories of nurses who had been patients and was extended and supported by the stories of nurses and their patients who had been involved in a therapeutic nursing relationship. The theory explains the world of the relationship between nurse (Wilson, 1992) and patient in all its intimacy (Langeveld, 1983). It identifies a "human phenomenon which is central to nurses' practice interests and concerns and ... provokes consideration of practice problems about which knowledge is needed" (Schlotfeldt, 1992). It promotes nursing scholarship in the four stage process advocated by Boyer (1990). In order to advance nursing knowledge of the relationship, this theory generated from practice needs to be applied to back into practice, integrated with the perspectives of people who are influenced by nursing, collaborated by other researchers, and incorporated into teaching of nursing students. The theory is the springboard for all facets of nursing activity.



The theory of a therapeutic nursing relationship adds to nursing knowledge of the relationship between nurse and patient as enacted in practice and remembered by patients and nurses (George, 1985). It upholds the view that "nursing's contribution to society is our special involvement with clients" (Munhall & Oiler, 1986). The theory is built upon knowledge that is dynamic and reflective of the social changes in health care wherein consumers and providers are purported to be partners in the quest for quality caring and care. As such, a therapeutic nursing relationship meets the demands of professional nursing bodies (Royal College of Nursing, Australia, 1996) and consumers for quality in nursing practice.

A therapeutic nursing relationship introduces a fresh perspective to relationships between nurses and patients by presenting knowledge derived from observations of practice and giving nurses another perspective of reality (Wilson, 1992). It consists of knowledge that is relevant to the profession (Hayne, 1992) and characterises the phenomenon (Bamum, 1990) of the relationship between nurse and patient in the context of therapeutics and the interconnectedness of the two persons involved. The theory builds upon the personal knowing of nursepatients, nurses and patients to reach a shared understanding of what it was, and could be, to be in a therapeutic nursing relationship. The theory exposes the meanings of a therapeutic nursing relationship for individuals in terms of self-worth, acceptance and positive health care outcomes, and is, in itself, a means of sharing these meanings with others (Moch, 1990).

The theory of a therapeutic nursing relationship extends nursing knowledge of the relationship into the realms of therapy and healing. There is an emphasis upon the bi-partisan, symbiotic nature of the relational contact between nurse and patient. The theory is bold enough to suggest that *both* nurse and patient derive benefits from their relationship. It connects the relationship to outcomes reflective of quality care which has implications for nurse *and* patient *and* the health care system (MacFarlane, 1977). It is a simple process which relies on awareness and thoughtfulness toward others, initially by the nurse and consequentially, by the patient. This is the epitome of caring, in particular human caring for, and about, others to which nursing, as a discipline and a practice, subscribes.

A therapeutic nursing relationship presents and represents an Australian perspective of working relationships between nurse and patient. It admits and commends the colloquialism in its representation of nursing practice as it currently stands in Australian hospitals today. It is a true entity of, and from, Australian nursing practice. A therapeutic nursing relationship is an Australian theory of nursing, proud of its origin and development. Australian nurses will be able to deal with the phenomenon of a therapeutic nursing relationship more expediently and more knowledgeably because of its uniquely Australian context. They can assume responsibility for this particular relationship between nurse and patient and its therapeutic intent and nature. This sense of ownership "will be directly and indirectly communicated to society at large, and professional autonomy and coherence of purpose will progressively emerge" (Chinn & Kramer, 1986).

### *Usefulness in Practice*

The theory of a therapeutic nursing relationship arose from everyday practice and has the potential to become nursing praxis, that is, an accepted practice for nurses. It is a credible representation of reality (Avis, 1995). The theory recognises that a nurse's commitment to another person within the relationship is the "starting point of all nursing" (Sarvimaki, 1988), and that nursing has a purpose. Consequently, the theory has clear goals. The consequences of nurse and patient interaction are plainly stated. The results of this relationship are observable and achievable. It offers guidelines for practice, in terms of application of a set of principles which lead to specific outcomes. The relevance of these steps is established for both patient and nurse, and each is assured of positive effects from their relational contact (Hinds, 1992). The process of achieving a therapeutic nursing relationship with its inherent benefits outweighs the risks of making that human to human, nurse to patient, person to person contact demanded by the theory.

A therapeutic nursing relationship offers a fresh approach to relationship formation between nurses and patients. It encourages nurses to think positively in terms of what can be achieved by their interactions with patients (Moccia, 1986). A therapeutic nursing relationship places these nursing interactions into the realms of therapy. It acknowledges that nurses are therapists who possess the necessary knowledge, skills and understanding which make a difference to the lives of patients. The relationship demands a combination of technical competence and attitudes that are conducive to communication, participation and interaction. The relationship allows nurses to go beyond the technical expertise of the discipline to grow as a person among persons, and be rehumanised (Jourard, 1971).

Fruition of the relationship into the sphere of healing occurs through the efforts of both nurse and patient to transcend the roles given them by the relationship's health care focus. Both must care for each other as people. The conviction that someone cares for them helps people to get well and feel worthwhile (Jourard, 1971). A quality relationship which is meaningful for the patient inspires hope, faith and personal healing properties. Participation in a therapeutic nursing relationship is healing because it gives both nurse and patient a means of expression and a sense of purpose while empowering them to give each other support, emotional relief, and respect (Hutchinson, 1994). Conceptualisation of the relationship between nurse and patient as "therapeutic" encompasses healing and assures that care and compassion for each other as people remains intrinsic to quality nursing care.

A therapeutic nursing relationship is designed to dig much deeper into the imaginations and ponderings of nurse practitioners who want to achieve the best possible care for their patients and a sense of a job well done for themselves. The latter is an emotional need which assures that nurses survive emotionally in a world in which giving succour in all its forms through "a special kind of loving" (Jourard, 1971) is a more frequent occurrence than receiving the same. A therapeutic nursing relationship states that it is legitimate for nurses to have needs which can be met through

their relationships with patients, and for nurses to receive benefits from their association with the health care of patients. The theory is distinct in its recognition of relational mutual benefits inherent in a therapeutic nursing relationship and basing its roots in the symbiosis of nurse and patient in relationship with each other. Its very nomenclature upholds these rights. A therapeutic nursing relationship is a simple way of delivering quality care to the patient from the nurse and, circumstantially, for each other as people and partners in health care.

A therapeutic nursing relationship paradoxically applauds separation and closeness within the relationship of patient and nurse. It encourages nurses and patients to see the "whole picture" of their relationship *and* to see the "big picture" of that relationship in health care (Gleeson, 1996). The theory offers nurses a simple way of ensuring that relational contact with patients is mutually beneficial, while the process leads nurses toward practical evaluation of their relational contact with patients. Its nursing focus encourages nurses in self-examination of their own relationships with patients and asks them to question their own practice in terms of outcomes and consequences. Covertly, a therapeutic nursing relationship challenges nurses to change their behaviour when in relationship with patients and "become partners in developing a symbiotic relationship which means that one will ensure the success of the other" (Wright, 1990).

#### *Usefulness in Research*

A therapeutic nursing relationship describes a nursing method of being in relationship with patients which assures mutual benefits and leads to healing in both body and mind for its participants. The theory explains the nature, actions and intent of the relationship between nurse and patient (Morse, 1991). It is concerned with process and outcomes (Bogdan & Biklen, 1992). The model of a therapeutic nursing relationship maps the pathways for achieving certain outcomes and the consequences of these end results (Oermann, 1991). It predicts the outcomes and extends them into a circular process which assures fruition of the relationship in all spheres of nursing and health care. A therapeutic nursing relationship assumes that quality nursing care and quality of patient life (Wilson, 1992) are the pan-ultimate goals of nursing and nurses, and it works toward this end.

A therapeutic nursing relationship gives new directions for relationships in, and beyond, the dyad of the nurse-patient relationship (Parker, 1990). In this day of open recognition of horizontal violence within nursing, a therapeutic nursing relationship could be used to shape nurse to nurse relationships, and, at last, align nurse to nurse contact with the profession's focus on care and caring. Nurses may learn to truly care for each other and reflect that care back to patients who are ever observant of their nurses' overt and covert behaviours toward each other. A therapeutic nursing relationship is also consistent with the notion of partnership in health care. It has the potential to be extended into other relationships with a health care focus.

Through exposure to this theory, researchers can be stimulated to conduct further research into relationships between nurses and patients. The narrative framework of this research allowed special

access to human experience (Sandelowski, 1991) which bears repetition, if only for the depth of learning and understanding that occurs from listening to an other's experience. This researcher encourages and challenges nurses and other health care professionals to do just this and evaluate their own practice in the light of their findings (Drew, 1989).

In today's society, nurses can choose how to become more involved in the lives of the people who receive nursing care (Moccia, 1988). A therapeutic nursing relationship offers nurses a means of relating to patients in a manner which enhances the depth of that involvement. The theory has meaning (Edwards-Beckett, 1990) for both nurse and patient in terms of achieving unique potentials as people, health care consumers and health care providers. The theory is consistent with current nursing theory which calls for greater understanding of the consumer's point of view, contemporary thought on closeness in professional relationships and the present drive for consumer input into health care provision. The outcomes of a therapeutic relationship are purported to be mutual benefits for nurse and patient and spin-off benefits for the institution in which this method of relating to patients is practised. Further research is needed to support, refute or extend these claims (Robertson, 1989).

The theory of a therapeutic nursing relationship needs to be tested for its usefulness in practice, and as, praxis. Ideally, putting the principles of this theory into practice in a clinical trial will test its effectiveness as a means of achieving quality nursing care and caring. Evaluating the results of this actualisation will determine whether or not a therapeutic nursing relationship makes a real difference, in terms of outcomes, for patients and nurses, as research is "judged by the clinical difference it makes" (Denzin & Lincoln, 1994).

Particular areas also beg extension and confirmation. It would be interesting to determine if the positive results of a therapeutic nursing relationship claimed by the nurses and patients of this study are continually achieved and assured, and to differentiate between the effect, in terms of health care outcomes, and affect, or emotional satisfaction, of a relationship between nurse and patient. Other studies may investigate the factors which prevent this type of relationship from occurring, examine the rates of occurrence of a therapeutic nursing relationship in actual practice, or look at the effects of a therapeutic nursing relationship upon patient return for service and positive public relations. The impact upon health care of patient to patient relationships and support systems is, as yet, undiscovered territory. Future research using the theory as the basis for investigation will be the ultimate test of the theory's usefulness as a research topic.

#### *Usefulness in Education*

Nursing curricula and programs are dynamic and have demonstrably adapted to encompass contemporary changes in the major tenets which underlie nursing theory. A therapeutic nursing relationship adopts and extends these beliefs to include new vistas for nursing practice and broader horizons for nursing education. It presents a philosophy of nursing with clear objectives and simple

concepts. Its principles are simple to learn and easy to apply theoretically and practically. It offers guidelines for curriculum and educational programs by its emphasis on relational connections, process and outcomes. A therapeutic nursing relationship links practice to theory in a clear and concise manner. The relationship between two people described by this theory is a puissant process for quelling factions within a discipline which proclaims to effect and affect change through interpersonal interaction.

Theoretically, a therapeutic nursing relationship rests upon a philosophical belief that the relationship between nurse and patient is *the* most important aspect of nursing practice. Underpinning this philosophy is the notion of symbiosis or dual dependency between nurse and patient. It applauds the things that nurses do which make a difference for patients *and* vice versa. The relationship exists because of the innate dual needs of nurse and patient. They co-exist within, and because of, their relationship to each other as patient and nurse. Nursing care and caring stems from this relationship, and flows through its development in certain phases toward identified goals which assure positive outcomes for both patient and nurse.

The nurses in this study articulated their abilities to relate to patients in a manner that was therapeutic, and ultimately, healing. Nursing theory currently *suggests* that nurses are therapists while it is recognising the healing created by nursing (McCabe et al, 1995). A therapeutic nursing relationship states that nursing is therapy, portrays nurses as therapists and depicts nursing activities as therapeutic. Nursing is recognised as a healing art which encompasses the needs of both nurse and patient. The theory's conceptual basis supports the relationship between nurse and patient as the most important focus of therapeutic, healing nursing care. This sets the boundaries of ownership for nursing. It confirms that the profession's assumptions about therapeutic nursing activities are a reality. Teaching from this perspective recognises the credibility of a therapeutic nursing relationship based upon the concepts of everyday nursing practice which nurses can identify with, own and easily assimilate to effect quality caring for patients and themselves.

A therapeutic nursing relationship links practice to theory because it developed from practice. The formal summary of this practice, the theory, needs to be incorporated into the educational and teaching practice of nursing to enable new nurses to perpetuate the practice and help make nursing better (Wright, 1990). More importantly, this will give credence to those therapeutic, healing actions that nurses are already practising, and allow nurses to believe in their own abilities as therapists and healers. Nursing education that keeps abreast of practice can begin to build into its programs, and curricula, research and theories that recognise therapy and healing as falling within the realms of nursing practice. In this way, nursing education can also theoretically and pedagogically support nurses to act as therapists and healers (van Manen, 1991).

Conceptually, the theory revolves around the whole patient and the whole nurse within a unit. This monad is the relationship and the reason for nurse and patient being together. The principles of a

therapeutic nursing relationship are modeled upon the philosophy of togetherness and thoughtfulness, as expounded by van Manen (1991), which are specifically placed in a relationship energised by its health care focus. Reflective thinking about the relationship is an important tool for objectively evaluating its progress (van Manen, 1995). The structure of health care assures that both patient and nurse have time out to consider the effect of their actions upon the relationship. Within the relationship, the emphasis is upon dualism and symbiosis of action. A therapeutic nursing relationship sees nurse and patient as equals, or partners, in care and caring. Both work together to affect and effect individualised health care. This focus meets societal demands for consumer input into, and equity in, health care, thus addressing some of the health care issues facing nurses and nursing today.

A therapeutic nursing relationship meets the nursing profession's demand for holistic care by calling for thought and action within, and outside of, the intimacy of the relationship and its concern for the whole persons thus involved. Theoretically, it recognises the whole person within the patient and, most importantly for the tenet of holism, the whole person within the nurse. In a therapeutic nursing relationship, this "whole person" focus does not have to be reserved exclusively for patients and nurses, but has the potential to include the patient's significant others, all nurses and other health care professionals within its sphere of influence (Meleis, 1986 & 1992). These principles of interaction are not designed to be confined to nursing practice and the relationship between nurse and patient, but to give direction to other relational activities within nursing practice. Relational parties can be perceived as human equals in other relationships where two individuals work together to achieve goals. The values of a therapeutic nursing relationship can easily be transposed into the educational relationships of teacher to student, teacher to teacher, and teacher to nurse practitioner.

A therapeutic nursing relationship leads to certain benefits for both nurse and patient. The initial intent in developing such a relationship is to assure that nursing care is patient orientated and driven, that is, the patient is able to negotiate a level of care which is individualised, appropriate and considerate of his or her needs. By placing the patient's knowledge of self alongside the nurse's knowledge of nursing and self, as nurse and person, allows both to work together to develop a clear set of goals and establish the means of achieving those goals. Consultation and learning (Maclean, 1987) between nurse and patient occurs continuously because both are willing to engage each other through, and in, the relationship. Each step toward the end results is evaluated before, during and after it happens, and changes made as, when and where, necessary. The process is designed around the relationship's capacity for quality interaction, action and outcome. It ensures optimal caring and quality care. This perception of quality care can be developed and perpetuated by educational programs which recognise the therapeutic contributions nurses make to patient care (Kitson, 1986), enhance caring for others (Noddings, 1994) and place student welfare as the highest priority in education (van Manen, 1991).

A therapeutic nursing relationship is a nursing reality which needs to be incorporated into nursing programs and curricula. From actual practice came a way of viewing nursing which is thoughtfully edited as belonging to nurse practitioners *and* their patients. This mirrors the relationship of theory and practice, and in education, student and teacher. As a method of relational contact between nurse and patient, a therapeutic nursing relationship can be extended into the sphere of educational relationships. In simple description, the names of the involved parties can be transposed by others applicable to other areas of nursing. The rights of both nurse and patient (student and teacher) in health care (education) are upheld in a therapeutic nursing relationship. The theory embraces the principles of caring and holism toward patients (students), and extends them to include nurses (teachers). A therapeutic nursing relationship introduces the concept of symbiosis (Tones, 1986) in the relational contact between nurse and patient (student and teacher). The relationship advocates a change in attitude and approach toward patient and nurse (student and teacher) care and caring which assures quality outcomes. The application of the principles of this relationship to other areas of nursing contains unknown potentials and promises for improvement.

#### *Usefulness in Management*

The principles of a therapeutic nursing relationship can be adapted for use as guidelines for the structure and organisation of care in nursing management. It is a method of problem solution which relies on collaboration and co-operation. Its consultative processes are designed to ensure that all parties involved have an equal voice in decision making, goal setting and determining pathways of attainment. The process has a clear beginning in the initial contact between interested parties, a means of achieving engagement or concerted effort by application of certain elements, and definite outcomes. The theory is logically stated in terms of method, means and ends. It is consistent with applying a formula for change in which the benefits of its use outweigh the risks of application. A therapeutic nursing relationship empowers nurse and patient. It has the potential to be extended into other arenas of nursing with the same beneficial effects.

A therapeutic nursing relationship presents a clear message to nursing and nurses. Because first impressions countenance patient perceptions of the service (Holland, 1995), it is important that nurses are aware of the impact of self upon patients (Hosking, 1993). Every nurse presents an image of nursing to the public which people remember and associate with the profession, or the health care facility, and not the particular person. The theory is designed to be effective *before* a nurse meets a patient. Nurses need to develop a mindset toward the principles of a therapeutic nursing relationship so that upon that initial contact with a patient, relational and health care success is assured. A therapeutic nursing relationship calls for nurses to be more considerate of others and thoughtful of the effects of themselves and their care planning upon others. The theory's focus on approach is interwoven with the desire to change and improve life for people (Bogdan & Biklen, 1992).

A therapeutic nursing relationship is also aimed at nurse managers who are responsible for structuring and organising the day to day care of patients and rostering, and those involved in quality assurance, compilation and evaluation of guidelines and practice, and staff appraisals. Nursing is a complex activity centred around relationships between people who have the right to participate equally in the process (Chenevert, 1983). A therapeutic nursing relationship takes the salient points of a relationship and applies them to the connection between nurse and patient with the assumption that this expose allows nurses, in all facets of nursing, to see the potential for its adaptation to their particular circumstances.

A therapeutic nursing relationship states how nurses relating to patients in a particular manner allows them both to realise that their efforts have made a difference to the outcomes of this connection. Despite the constraints and restraints placed upon nurses in their everyday practice, the relationship with patients (each other and other health care professionals) is important to quality outcomes and satisfied consumers *and* providers. The self-image held by nurses has to change (Keighley, 1988). This means that despite time, staffing, paperwork, personalities and differences, *all* nurses must make an effort to ensure that nursing care is truly patient-orientated so that patients are satisfied with the quality of their nursing care and its outcomes. When the goals of nurses and patients are congruent and successful, both achieve greater happiness and satisfaction from their interactions (Wright, 1990).

The theory stresses the importance of creating an environment where caring is not just confined to the patient, but extended to envelop all health care workers (MacKay, 1990). It is the perceptions of patients, and the solicited views of nurses who work in health care facilities and live in the community, which can make or mar the service. Staff who are happy with their part in the process of giving care are good ambassadors for the facility. A therapeutic nursing relationship emphasises mutual caring and consideration within any relationship. These principles portend for nursing management. As a method of nurses relating to nurses, a therapeutic nursing relationship assures satisfaction for all nurses in their quest for the best possible health care for patients, and some essential rewards for themselves in their efforts to achieve this end.

### *Summary*

A therapeutic nursing relationship is a clear and simple means of relating to patients that makes a difference to their care and the way nurses feel about giving that care. A therapeutic nursing relationship is a virgin theory which portends further research and indicates potential areas for investigation. It recognises its limitations, but can be extended through other methodologies to encompass theory testing and aspects of prediction. As a philosophy, a therapeutic nursing relationship depends on active engagement, togetherness, thoughtfulness and reflection by nurse and patient to achieve a degree of relational contact which leads to positive outcomes. As a management strategy, a therapeutic nursing relationship points out that first impressions are vital to people's perceptions of care and that caring for the staff is as important as caring for the patient.



Staff contentment is reflected into their interactions with all people concerned with health care and, in particular, those around whom health care is focused, that is, the patients.

The relationship between nurse and patient is an important facet of nursing. Its impact upon the wider arena of nursing cannot be ignored. What begins with nurse and patient has the potential to be extended into all areas of nursing practice with the same beneficial effects. In practice, a therapeutic nursing relationship legitimises nurses deriving great satisfaction from their interactions with patients, and supports the principle of reciprocity and balance, achieved by receiving as well as giving, in that relationship. Paradigms of nursing need to change to include therapy and healing as part of a nurse's practice repertoire. Nurses *do* make a difference to patient care and that difference *is* therapeutic for both nurse and patient. The relationship that nurses build with patients does have an effect upon patients' satisfaction with health care and their return for service rates (Westbrook, 1993). In the quest for quality care, placing the emphasis of caring back into that relationship, and extending it to include all health care personnel and patients, may well redress the balance indicated by return for service and nursing attrition data. A therapeutic nursing relationship is the means of achieving quality care for both nurse and patient and making a *real* difference in health care provision.

## CHAPTER EIGHT: EPILOGUE - an end with a beginning.

A therapeutic nursing relationship now exists as a theory of nursing. Through an emphasis upon the relationship between nurse and patient as a major aspect of nursing care, a therapeutic nursing relationship adds new dimensions to an old concept. By directing this emphasis upon nursing deeds, actions and outcomes occurring within the relationship between nurse and patient, a therapeutic nursing relationship consolidates this relationship as the fabric of nursing. The theory sets out ways in which nursing and nurses can begin a new journey toward fruitful relationships with patients. The focus of the journey lies in mutually beneficial and healing encounters between nurse and patient, and a formula which applauds nurses as therapists and healers. A therapeutic nursing relationship acknowledges the importance of both nurse and patient in a relational context which contributes to mutually positive health care outcomes for all. In the context of this study, the theory of a therapeutic nursing relationship is complete, yet paradoxically open. The theory is now exposed to the nursing world as a means of effecting quality nursing care for both patients and nurses. The theory is versatile and adaptable to other disciplines in which relational communication and interaction works toward desired outcomes. Critique of the theory will ensue with further evaluation and scrutiny of its utility as a mode of relationship formation.

### *Conceptual Orientations*

This study supports a therapeutic nursing relationship as an entity of nursing practice. Nurses do interact with patients in a beneficial and healing manner. Nursing is therapy and therapeutic for both nurse and patient. This type of relational contact between nurse and patient can easily be identified by its selective components and the culminative effects of their application within that relationship. A therapeutic nursing relationship is welcomed by both nurse and patient for its actual and potential effects upon well-being. A therapeutic nursing relationship is progressive as both nurse and patient move through defined stages toward completion of the relationship. The process leads to successful and satisfying outcomes for both patient and nurse. The benefits of establishing a therapeutic nursing relationship are not just confined to patient and nurse. A therapeutic nursing relationship has proactive and reactive benefits for quality of care indicators, public relations and public awareness of health care and nursing. A therapeutic nursing relationship is a practical reality and a possibility of everyday nursing practice.

A therapeutic nursing relationship builds upon nursing philosophy of care and caring. The elements of a therapeutic nursing relationship mirror those of care and caring described as fitting within the scope of nursing practice. A therapeutic nursing relationship demonstrates care and caring for patient *and* nurse, and illustrates that, as human beings, both can gain much from their relational contact. A therapeutic nursing relationship is based upon caring thoughtfulness for each other and thoughtful care of each other's needs within that relationship. A therapeutic nursing relationship recognises that effective health care depends upon nurse and patient being in unison with each other as participants and people engaged in health care. A therapeutic nursing relationship utilises certain

subjective qualities to attain a caring relationship between nurse and patient. This caring occurs on a deeper level than most professional relationships without losing sight of the purpose of the relationship or the context in which this relationship occurs. The caring and contact between nurse and patient in a therapeutic nursing relationship is paradoxically constant, but transient, because of its self-limiting health care context.

A therapeutic nursing relationship embraces the concept of “wholism”, rather than holism. The theory's inherent philosophy revolves around the *whole* nurse and the *whole* patient. The patient is seen as a patient and a person. The nurse is portrayed as a nurse and a person. A therapeutic nursing relationship encompasses the *whole* needs of both in terms of their relational contact. This focus also consolidates the relationship. The relationship affords the patient emotional stability and safety through competent health care which leads to satisfactory care, health and personal outcomes. A therapeutic nursing relationship provides the nurse with the means to engage in emotional sympathy with the patient and mesh professional and personal needs to achieve satisfactory nursing care, personal caring modalities and health care outcomes. This whole person orientation means that a therapeutic nursing relationship recognises each nurse and each patient as a person with mind, body, heart and soul. Each person has both subjective and objective opinions, and a life outside of the health care relationship, none of which can be ignored when building a therapeutic nursing relationship.

#### *Philosophical Beliefs*

A therapeutic nursing relationship challenges the assumption that nursing can be reduced to a set of well-defined tasks that nurses perform with patients. Nursing is much more than what nurses do for, and with, patients. Nursing is what nurses know about their patients as people and patients. It is an ability to reach a degree of intimacy with a patient that allows that patient to openly share his or her life with a nurse who is invited to do the same. This sharing gives nurse and patient a sense of coming together and uniting for a common purpose of achieving quality patient-orientated nursing care. In the deeper sense of things, this sharing transcends the mere association of two people circumstantially brought together in health care, and becomes a union for quality health care through better nursing care.

A health care relationship can be ruled by the circumstances of its beginnings to be shallow, impotent, marginally functional, vulnerable and limited. A therapeutic nursing relationship is deep, dynamic, fully functional, empowering and not at all limited by its beginnings in the patient's search for health care. In a therapeutic nursing relationship, the very ordinary things that occur between nurse and patient have a pivotal effect upon the relationship, and each person's perceptions of care and caring. A therapeutic nursing relationship is not just a process, but a way of nurses being in relationships with patients that recognises, supports and upholds the rights of both to a rewarding and satisfying connection for themselves as people, nurses and patients.

### *Practice Strengths*

The greatest strength of a therapeutic nursing relationship is its origins in practice. It rests on the power of the anecdote to relay a content which describes what people think and feel about relationships which take place in the world of nursing practice. The everyday practice of a sample of nursepatients, patients and nurses produced an informed theory about relationships which can now be used to inform practice. The theory bridges the gap between practice and theory in a way that mirrors the union of nurse and patient in their relationship. It connects the reality of nursing practice to an explanatory theory. This theory presents a simplistic means of nurses and patients relating to each other which does not require additional skills, but rather an awareness of the impact of self upon others with whom one comes in contact through the sphere of nursing and health care. At this stage, a therapeutic nursing relationship is focused firmly upon nursing and now takes the ideas of nurses and patients back to nursing where it asks acceptance, and welcomes critique.

A therapeutic nursing relationship offers nurses concrete, tangible properties with which to work. The relationship rests upon the fourteen essential qualities of communication, interchange, equality, support, safety, knowing, liking, closeness, consent perceptiveness, trust, contentment, satisfaction and camaraderie to reach its therapeutic zenith. These deemed components are present in every person, but often need awaking and bringing to the surface for mutually beneficial and healing, aka therapeutic, relationships to develop between nurse and patient. Nurses will be the informed party in a therapeutic nursing relationship because they can be exposed to the theory. They will know of its properties, mechanics, pathway and function. Nurses have the professional knowledge and skills to effect and affect a positive outcome for patients and self through a therapeutic nursing relationship. A therapeutic nursing relationship recognises the importance of this prior knowing by nurses. As a form of relational etiquette, a therapeutic nursing relationship calls upon nurses to invite patients into nursing relationships and upholds the reciprocity of this union by allowing patients the right to invite nurses into their lives.

A therapeutic nursing relationship directs nurses to re-think their ways of being in relationships with patients. Patients appear to be able to sense intuitively if, and when, a nurse is able to offer them a relationship which will assist them in their quest for well-being. Patient health, in terms of physical, psychological and social well-being, is effected and affected by relational contacts and activities with others. The patient requires a therapeutic nursing relationship to achieve desired outcomes in nursing and health care. In a therapeutic nursing relationship, nurses and patients create and control a safe environment which encourages both to participate. The physical and psychological atmosphere surrounding a patient is capable of being altered through a therapeutic nursing relationship. Patients are able to openly vocalise their concerns within the broad context of health care *and* the specifics of nursing care. A frank exchange of perceptions and sharing of fears, worries and needs is cathartic for both nurse and patient. Freeing these emotional burdens enhances closeness and facilitates accuracy in problem identification and solution. Respecting confidences and sharing details of each other's lives authenticates the nature of the relationship. In

a therapeutic nursing relationship, nurse and patient become confident confidants which assures satisfactory results for them both.

Adopting a therapeutic nursing relationship as an ethos of patient care involves nurses making a commitment to change and offering patients a relationship which makes a difference to their care. This also means not being afraid to articulate this ability to, and cultivate it in, others. Sharing these experiences with others increases awareness, encourages reflection, develops insight, finds meaning and facilitates learning which leads to personal and professional growth, and better relationships with patients. In this way, other paradigms of practice may emerge which will swell nursing's knowledge bank and encourage further beneficial changes in nursing practice.

#### *Questions of credibility and validity*

The validity of this research lies its procedural accuracy and consistency between the two stages of the study. Phenomenology and Concept Synthesis are complementary processes wherein one builds upon the other. Phenomenological inquiry exposed a picture of a relationship between nurses and patients. To obtain clarity, and enrich understanding of this relationship, an identified aspect of this picture was expanded by Concept Synthesis into an explanatory theory. The theoretical framework of Travelbee (1966 & 1971) lends a perspective which recognises the value of the relationship between nurse and patient to quality nursing care. The directions for gathering data to reach fruition of the study were clear. Within each method there are inbuilt safeguards to assure the accuracy of the researcher's interpretations. Using this combination of techniques enhanced the validity and credibility of the findings.

Phenomenological research inquiry relies for its validity upon each stage of the research method being able to do what it set out to do. The phenomenological research interview question elicited the full story of the participant's experience. In this case, each person, or nursepatient, was interviewed by the same method and questions to provide consistency. For accuracy, interpretations and meanings were clarified by feedback to, and from, the participants. Phenomenological research inquiry calls for validation of the findings by the participants to assure faithfulness in collating and reporting the given descriptions. Validation occurred when the findings were presented to the participants and they were each able to identify their own personal experiences within the collated form. Face and content validity occurred because the participants had experienced the phenomenon, and were intelligent, articulate human beings capable of recalling and reflecting upon the experience of being a patient. The ultimate evaluation will occur when other nurses can identify the reality of these stories within their own practice arenas, and recognise the utility of the concept of a therapeutic nursing relationship for their relational connections with patients.

Concept synthesis allowed exploration and development of a concept which had been observed in practice and was based in a descriptive study. Collection and examination of data from all sources was essential so that the concept could be empirically verified and modified where necessary. For a

theory which describes and defines a concept to be considered complete, all aspects of the concept have to be disclosed and evaluated, and its conceptual fit into existing knowledge established. The concept of a therapeutic nursing relationship in its definitive form is exposed through this research for consideration of its utility by, to and for, practising nurses.

### *Theoretical Shifts*

Theoretically, a therapeutic nursing relationship picks up and builds upon the salient points of the theories offered by Travelbee(1966,1971) and Peplau (1988). The theory acknowledges and incorporates Pearson's (1985,1988) practical applications of nursing therapy and the everyday activities of nursing practice as advocated by Taylor (1991 & 1994), and marries them to observations of therapeutics in action. By retrospectively examining these aspects of the relationship between nurse and patient in the context of the present study, some conclusions can be drawn. Rapport is beneficial to nurse and patient. The effect of self is profound. Nursing is therapeutic. The ordinary things that nurses *and* patients do are effective. But a therapeutic nursing relationship demonstrates that the relationship between nurse and patient is more than each of these facets.

A therapeutic nursing relationship explains the association between nurse and patient in terms of nurse and patient input, resultant affects and lasting effects. Nursing is directed by the theory to achieve quality outcomes for both nurse and patient. It assists in making the relationship between nurse and patient more meaningful. Exposure to the vocabulary inherent in a therapeutic nursing relationship adds a richness to nursing theory of the relationship between nurse and patient and adds to nursing's practice repertoire. By claiming healing and therapy as properties of nursing, a therapeutic nursing relationship changes the organising principle that underlies the way nurses think about themselves and their world. This relationship improves patient and nursing care. Consequently, a therapeutic nursing relationship makes nursing recognisable as a healing art and science and affirms its membership of the health care fraternity.

### *Conclusion*

A therapeutic nursing relationship is a symbiotic relationship between nurse and patient which gives an assurance of friendship, well-being, self-worth and a positive, quality outcome in nursing and health care. The concept has been explained in terms of a working definition, functional model and theoretical description. The working definition simply and clearly states the meaning of a therapeutic nursing relationship for, and to, nurses, patients and nursing. The model visually maps the framework of the concept, displays its structural components and demonstrates the relational dynamics of a therapeutic nursing relationship. The theoretical description establishes the therapeutic nature and construction of the relationship. The theory adds a new perspective to existing nursing knowledge of the relationship between nurse and patient. However, as the relationship between nurse and patient is a human endeavour, subject to much change and

conjecture, the theory is not static, but encourages new and challenging research in the area, which, in turn, will enhance nursing knowledge, practice, education and research.

# APPENDICES



## **APPENDIX 1**

### **COLAIZZI'S STEPS**

## COLAIZZI'S STEPS (1978):

1. Read each entire transcript for complete understanding.
2. Extract significant entries or phrases.
3. Contextually frame meanings from the statements.
4. Organise the meanings into clusters or themes.
5. Re-read transcripts to ascertain missed, complementary or contradictory data.
6. Integrate into a thorough description.
7. Identify and organise the phenomenon's fundamental composition.
8. Validate the analysis by returning to each participant, asking if the analysis describes their experience, allowing them to delete or add any data and incorporate this into the final research report.

**APPENDIX II**

**CONCEPT SYNTHESIS**

## CONCEPT SYNTHESIS - WALKER & AVANT 1988

Process:

1. Identify concept or primary idea.
2. Determine its components.
3. Verify the concept.
4. Return to data.
5. Verification through interviews, literature.
6. Establish a clear relationship between data sets.
7. Form a definition which demonstrates the meaning of the concept and defines its attributes.
8. "Fit" the concept into existing theory to complete validation.

Translated into the research project, the process assumes the following dimensions:

1. Relationships between nurses and patients differ in quality, content, involvement and satisfaction.
2. Use data from nursepatients about therapeutic relationships to extend into further interviews.
3. Identification of components of a therapeutic relationship.
4. Development of the concept of a therapeutic nursing relationship.
5. Interview nurses and their patients.
6. From their descriptions identify components.
7. Conduct literature reviews.
8. Establish clear relationships between components, process and outcomes.
9. Develop a definition that conveys meaning and structure.
10. Validate this through further interviews and comprehensive review of all data.
11. Fit findings into what is already known in theory.
12. Examine the implications for nursing and nurses.

**APPENDIX III**

**INFORMED CONSENT**

# INFORMED CONSENT FORM FOR RESEARCH PARTICIPANTS

## CERTIFICATION BY PARTICIPANT

I.....

of.....

certify that I have the legal ability to give valid consent and that I am voluntarily giving my consent to participate in the research project entitled "The Essence of a Nurse-Patient Relationship as Perceived by Nurses Who Have Been Patients" / "The Concept of A Therapeutic Nursing Relationship", being conducted by Suzanne Mountford. This project is the component of a Masters/Doctor of Philosophy program conducted by Victoria University of Technology, Faculty of Human Development, Department of Nursing, Footscray Campus. Further information may be gained from the project supervisors Barbara Brice, Head of Department of Nursing, and Dr. Maureen Ryan, Department of Education.

I certify that

1. The objectives of the research and any associated risks have been fully explained to me by the researcher,
2. I freely consent to participate in a series of interviews,
3. I have had the opportunity to ask and have my questions answered to my satisfaction,
4. I understand that I can withdraw at any time without prejudice,
5. I have been informed that the confidentiality of the information that I provide will be safeguarded,
6. I agree that the research data collected may be published, provided that my name is not used,
7. I have received a copy of this form for my own reference.

Signed.....(participant)

Signed..... (witness)

Date.....

**APPENDIX IV**

**INTERVIEW PROMPTS**



## INTERVIEW PROMPTS

### NURSEPATIENTS:

1. What do you see as the purpose of nursing.
2. What concepts are important to you as a nurse.
3. How do you see yourself practising within the universal paradigm of nursing.
4. Are there any concepts that you feel should be included that are not articulated by the experts.
5. What role does the nurse play in this.
6. How do relationships develop between nurse and patient,
7. What influences the development of relationships between nurse and patient.
8. What particular attributes does a nurse need to develop a relationship with any patient.
9. What do you see as essential to the development of a good relationship between nurse and patient.
10. How do you feel about being a patient.
11. Did you experience relationships that differed from your ideal in Q8.
12. What contributed to this.
13. What is the difference between being a nurse and being a patient.
14. Influences/differences/similarities.
15. What would you change about the experience of being a patient if you could.
16. Did the experience effect you as a person, patient, nurse.
17. Did the experience effect your thinking about nursing, and practising nursing.
18. Why/how.
19. What do you see as the crux of a nurse-patient relationship.
20. Did you tell your caregivers that you were a nurse.
21. Why/why not.

## **NURSES:**

Can you describe an instance in which you had a mutually beneficial and healing (therapeutic) relationship with a patient?

Is this patient in hospital at the moment and would you mind if I also spoke to him/her?

Were there any particular qualities present in this relationship?

How do you think that these things fit together?

What did it mean for you to have this type of relationship with a patient? ...as a person, as a nurse.

What do you think it meant for the patient?

How is the relationship between nurse and patient therapeutic?

## **PATIENTS:**

What is it like to be patient?

What sorts of things do nurses do with and for you as a patient?

How do you feel about being a patient when a nurse does these things?

Are there any particular things about your relationship with a nurse/nurses that makes you feel this way?

What does it mean for you to have this type of relationship with a nurse/nurses?

What did you expect nurses to be like before you came into hospital?

## **APPENDIX V**

### **RESEARCH AIMS: INITIAL PROJECT**

RESEARCH AIMS FOR INITIAL PROJECT "The Essence of a Nurse-Patient Relationship as Perceived by Nurses who have been Patients".

1. Obtain descriptions of the world of the nursepatients.
2. Examine nursepatients' relational involvement with caregivers.
3. Expose the individual practice paradigms of nursepatients and their perceptions of those held by their caregivers.
4. Obtain descriptions of the nature and intent of nursing as perceived by nursepatients.
5. Examine the perceptual differences between being a nurse and being nursed.
6. Identify the factors which influence relationship development in this context.
7. Determine the elements essential to developing rapport between nurse and patient.
8. Examine the consequential practice and conceptual changes that have occurred for the nursepatient because of the experience.

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