

What Makes a Quality Therapeutic Relationship in Psychiatric/Mental Health Nursing: A Review of the Research Literature

F Dziopa, K Ahern

Citation

F Dziopa, K Ahern. *What Makes a Quality Therapeutic Relationship in Psychiatric/Mental Health Nursing: A Review of the Research Literature*. The Internet Journal of Advanced Nursing Practice. 2008 Volume 10 Number 1.

Abstract

Although a therapeutic relationship is essential to psychiatric/mental health nursing practice, its use is problematic because the nursing attributes contributing to a therapeutic relationship are elusive. A review of the literature in the field of psychiatric/mental health nursing was conducted to conceptualize constructs contributing to the development of a therapeutic relationship in advanced practice psychiatric/mental health nursing. A typology of nine general attributes were identified which have practical implications for psychiatric/mental health nursing education and practice. Recommendations include the application of a typology of constructs upon which psychiatric/mental health nurse curricula, in-service education, and reflective practice can be based.

INTRODUCTION/ BACKGROUND

The establishment of a quality nurse-patient relationship is considered important in most nursing situations ([1]). However, in psychiatric/mental health nursing, the interpersonal interaction is the core of practice ([23]) making the therapeutic relationship a fundamental element of mental health care ([4]). Indeed, the therapeutic relationship employed in mental health care has been associated with therapeutic outcomes across a range of clinical settings and patient populations ([5]).

Ironically, despite the therapeutic relationship being vital to treatment outcomes, the formation of a quality therapeutic relationship between the psychiatric/mental health nurse and patient is not an instinctive occurrence and requires great skill to be established ([6]). Berg and Hallberg ([7]) found that caring for people with mental illness ‘demands an intensified presence, not allowing one to glide away, close the door or just disappear’ (p. 329). The daily work demand requires psychiatric/mental health nurses have the capacity to handle continually new and unpredictable experiences ([7]). This endeavour is made more difficult because in some situations psychiatric/mental health nurses are faced with the paradox of providing therapeutic care in conjunction with involuntary treatment ([8]) and detainment ([9]). In short, psychiatric/mental health nurses require specialized skills in order to develop and maintain therapeutic relationships with

patients.

The specialized skills required by psychiatric/mental health nurses to develop therapeutic relationships are elusive ([10]). Weissmark and Giacomo ([11]) concluded in their discussion of measuring therapeutic relationships, that although global rating methods can use items such as “warmth” and “judgementalness” to distinguish good from poor relationships, these terms do not specify what the therapist does to establish a therapeutic relationship. As long as these interpersonal attributes remain vague, opportunities for high level practice and research will be lost.

The purpose of this paper is to review the research literature in psychiatric/mental health nursing to develop a typology of the components that constitute one of the main tools of psychiatric/mental health nursing; that of the therapeutic relationship with a patient. This typology will constitute the beginning of the operationalization of specialist behaviors and skills required in building an effective nurse-patient relationship, which will enable the development of behavioural criteria to enhance advanced psychiatric/mental health nursing practice, research and education.

LITERATURE REVIEW

A search was conducted through the electronic search engines MEDLINE, CINAHL, PSYC INFO and WEB OF

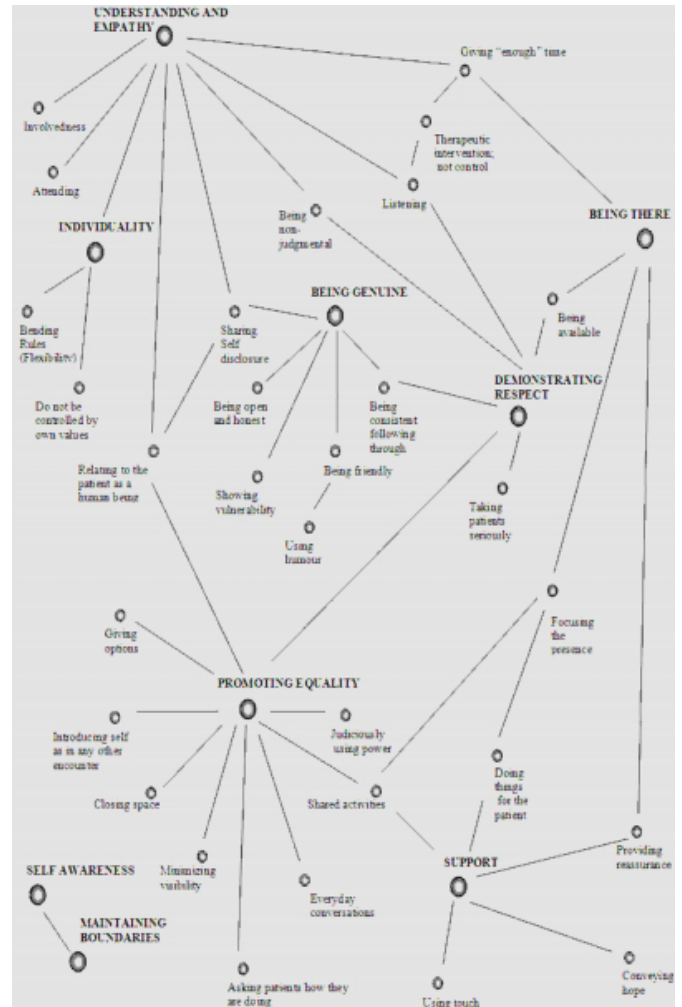
What Makes a Quality Therapeutic Relationship in Psychiatric/Mental Health Nursing: A Review of the Research Literature

SCIENCE. The keywords used were therapeutic relationship, therapeutic alliance, working alliance, nurse patient relationship, nurse patient interaction, mental health, mental illness and psychiatry. Research literature between the years 1996 to 2008 was accessed because this period marks the publication of almost all articles on evidence-based practice ([12]). Peer reviewed studies which referred to and described nurse attributes in their findings were included. The literature review yielded 31 research studies. These studies were heterogeneous in that the sampling, data collection, analysis and research focus of the studies all differed.

The investigators found that a therapeutic relationship in advanced psychiatric/mental health nursing could be deconstructed into nine main constructs: conveying understanding and empathy, accepting individuality, providing support, being there/ being available, being genuine, promoting equality, demonstrating respect, maintaining clear boundaries and having self awareness. Figure 1 provides the attributes contributing to these constructs.

Figure 1

Figure 1: Attributes and Constructs Contributing to a Therapeutic Relationship in Psychiatric/Mental Health Nursing



UNDERSTANDING AND EMPATHY

Understanding is a vital element in the development of a therapeutic relationship in mental health nursing. Both patients ([213]) and nurses ([3]) value the ability of mental health nurses to convey understanding. Conveying understanding is important as it instils patients with a sense of importance ([14]). Feeling important is significant to the lives of people who live in a society, which often stigmatizes them because of their mental illness ([15]). Notably when the nurse knows and understands the patient, the nurse assists patients to understand themselves ([16]), empowering them to influence their treatment ([13]). Consequently knowing the patient promotes individualized care ([6]).

Active listening is considered to be one of the core elements of understanding ([1517]). To fully apply listening to convey

understand the psychiatric/mental health nurse must not only hear the patient but also be attending and attentive.

Accordingly, Johansson and Eklund ([13]) determined when psychiatric/mental health nurses gave proper attention and appeared interested, patients felt understood. Needless to say interpersonal and communication techniques such as summarizing, clarifying, reflecting, and providing eye contact are considered essential to understand and relate to the patient ([15]).

In addition to the skill of listening to understand the patient accurately, the psychiatric/mental health nurse must appreciate the unique communication, problems and situation of the patient ([13,16]). To truly understand the uniqueness of each situation psychiatric/mental health nurse must go beyond what is expected of most other health professionals to attain an in-depth personal knowledge of the patient ([15]). As noted by Geanellos ([18]) rather than simply containing “testing” and “acting out” behaviour, the psychiatric/mental health nurse must look beyond the obvious and strive to understand and ascribe meaning to the behaviour. The in-depth knowledge required to develop this level of understanding requires time and skill to understand ([15]).

Importantly, the patient’s unique personal experience is worthy of the deepest respect. The psychiatric/mental health nurse is required to treat the patient’s personal experiences as a gift brought to the relationship ([10]). The expression of thoughts and feelings should be encouraged without blaming, judging or belittling ([18]). As found by Shattell et al. ([15]), the way the psychiatric/mental health nurse responds when the patient divulges “terrible” information can either promote or impede the relationship. When psychiatric/mental health nurses in their study had developed skills to be able to respond without shock or revulsion, the patient felt a sense of understanding in addition to feeling normalized as a human being ([15]). Non-judgemental attitudes are critical to this process ([2]).

Essentially by relating to the patient as a person, the psychiatric/mental health nurse enables the patient to feel understood ([15]). To encourage this type of understanding the psychiatric/mental health nurse must interact foremost as a human being ([17]), talking to the patient as a neighbour or friend rather than a counsellor or expert ([15]). In addition the sharing of common experiences, such as similar backgrounds and mutual adversities has also been found to

help the patient to connect with the psychiatric/mental health nurse and feel understood ([14]).

In psychiatric/mental health nursing, certain situational expectations and communication barriers make understanding an involved process. For instance Hem and Heggen ([19]) were astonished by the way the psychiatric/mental health nurse in their study maintained empathy for the patient. When subjected to fierce personal attacks, the psychiatric/mental health nurse retained the desire and ability to understand the patient. Involvedness is also required when patients expect nursing staff to understand the patient even when they are unable to express their needs verbally ([7,20]). Furthermore Johansson and Eklund ([13]) found that understanding was an involved process for “younger” psychiatric/mental health nurses who had to defeat barriers to communicate with patients who were uncomfortable disclosing their problems with “younger staff”. Seemingly, in different situations, individuals will require different levels of involvedness and skill to practice understanding.

INDIVIDUALITY

Individualized care is mediated through knowing the patient ([6]). To obtain this knowledge the psychiatric/mental health nurse must see patients as individual people with lives beyond their mental illness. Seeing people as individuals with lives beyond their mental illness is imperative to make patients feel valued ([21]) and respected ([22]). Muller and Poggenpoel ([23]) investigated patient experiences when interacting with psychiatric/mental health nurses and these researchers concluded that accepting individuality is important as discrimination can occur when patients are stereotyped. Accordingly, O’Brien ([16]) found psychiatric/mental health nurses in a study viewed their role not as a manager of illness but as supporting the patient to manage their own life in the face of illness. Appropriately, in order to accept the patient as an individual, the psychiatric/mental health nurse-therapist must not be controlled by his or her own values, ideas and pre-understanding of mental health patients ([13]).

Illustrations of how psychiatric/mental health nurses respond to the patient’s individual needs were identified in the research literature as what these investigators have called “bending of rules”. To meet individuals’ needs psychiatric/mental health nurses spoke of the potential to ‘bend the rules’, which required an interpretation of the unit

rules and the ability to evaluate the risks associated with bending them ([24]). Similarly, Thomas et al. ([25]) spoke of the perceived importance of flexibility of unit rules. Notable rule bending was an intervention used by experienced practitioners rather than inexperienced staff ([24]).

PROVIDING SUPPORT

For the therapeutic relationship between the psychiatric/mental health nurse and the patient to evolve, patients must feel safe and comfortable ([26]). Feeling safe and comfortable occurs through the supportive environment created by the psychiatric/mental health nurse. Methods found to provide patients with support include active responses, such as giving suggestions and feedback ([14]), conveying hope ([22]), reflecting concern in one's voice ([2]) and providing patients with reassurance ([627]). Doing things for and with the patient; such as fetching a blanket ([7]), sharing a cup of tea ([20]), or taking a patient shopping ([27]) were also suggested to demonstrate support. Interestingly, Jackson and Stevenson ([20]) also spoke of supporting through "mothering" vulnerable patients. Mothering vulnerable patients involved a protective nurturing role and while not readily described in research literature review was believed to be extremely therapeutic in the applicable context. Importantly, not all patients desire to be "mothered" ([20]).

Support in the research literature also encompasses physical support. Physical support is manifested through the use of touch ([28]). For example Shattell et al. ([15]) found patients described feelings of connection when the psychiatric/mental health nurse hugged them or put a hand on their shoulder. Similarly a psychiatric/mental health nurse in Berg and Hallberg's ([7]) study described an element of a working relationship as comforting through holding a patient's hand. Moyle ([6]) also identified that patients with depression described relief when the psychiatric/mental health nurse embraced them. Importantly, the literature suggested that therapeutic touch is a skill dependent on different clinical situations and practitioners. For instance, physical touch to provide support was often elicited in studies for depressed and vulnerable patients. Further, McAllister et al. ([29]) noted that on initial psychiatric/mental health nurse patient encounters nurses tend to avoid touch, even the "touchiest" of nurses. This finding suggests that the use of physical touch to provide support is related to the individuals involved; and that touch is not a generic therapeutic relationship skill but one that requires individualized

application.

BEING THERE/ BEING AVAILABLE

Being there for the patient is a complex attribute, which is also referred to as 'nurse presence' and 'accessibility' in the literature. In order to be there for the patient, the psychiatric/mental health nurse is willing to invest time in the patient ([30]). Ultimately giving the patient "enough" time was considered fundamental to both psychiatric/mental health nurses ([21324]) and patients ([2225]).

How the time spent with the patient was utilized was seen as important. For instance, patients stated they liked the way psychiatric/mental health nurses used time with them employing therapeutic techniques rather than using control techniques. As stated by one of the patients 'They sit down with me and talk to me, they give me medication only if I need it...' ([2]) p. 473. Further patients noted they appreciated the time spent listening to them ([6]). Enough time enabled the client to open up and disclose their story and for the psychiatric/mental health nurse or therapist to truly understand the meaning behind the story ([13]). Likewise, another sample of patients noted that they would not trust a therapist who intervened too quickly and made faulty interpretations ([13]). Interestingly, different psychiatric/mental health nurses held different views on how much time is "enough" to form a therapeutic relationship ([8]).

The presence of a psychiatric/mental health nurse, even without speaking, has been demonstrated to encourage therapeutic relationship development, although some contradictory evidence on this issue exists. Patients with depression felt psychiatric/mental health nurse presence, in particular bedside presence, was beneficial to the relationship as the presence of the psychiatric/mental health nurse helped to alleviate their fears ([6]). On the other hand, some researchers concluded that "being there" constituted more than mere presence. Berg and Hallberg's ([7]) study suggested that "being there" meant focusing the presence, which involves being there for the patient psychologically and physically. Similarly, patients considered assistance important to strengthen the therapeutic relationship ([2]). Giving proper attention demonstrated to patients that psychiatric/mental health nurses believed in them ([24]) in addition to facilitating understanding ([13]).

Arguably, if psychiatric/mental health nurse presence supports relationship development, the lack of

psychiatric/mental health nurse presence will presumably inhibit the relationship. Thus, when psychiatric/mental health nurses are unavailable to patients, the quality of the therapeutic relationship is questionable ([31]). Experiences of psychiatric/mental health nurse unavailability were evident in the research literature. Patients complained that psychiatric/mental health nurses distanced themselves ([22]) and at times appeared abrupt resulting in a failure to express understanding and show compassion ([23]). Other patients described negative responses when attempting to seek psychiatric/mental health nurse attention. For instance, some patients noted some psychiatric/mental health nurses spent a majority of the shift in the nursing office. Patients described knocking on the nursing station door only to be dismissed by staff ([20]). Not unexpectedly, psychiatric/mental health nurse unavailability or “not being there” evoked feelings of disinterest ([21]), which evidently impeded the development of the therapeutic relationship.

Accordingly, the research literature promotes ways for psychiatric/mental health nurses to be available and accessible to patients. In the community, Adams et al. ([32]) referred to availability in terms of regular patient contact and physical and emotional accessibility. In the inpatient setting to negate avoiding the patient due to insufficient time, Scanlon ([8]) suggested the psychiatric/mental health nurse must clearly communicate to the patient the time allocated for them. Significantly managing time to spend an extra five or ten minutes with the patient has been reported to make all the difference to the patient ([15]).

Importantly in contemporary nursing, time is constrained ([8]) and psychiatric/mental health nurses are required to form therapeutic relationships in a demanding and unpredictable environment ([7]). Not surprisingly, O’Brien ([16]) found that being there for the patient can leave the psychiatric/mental health nurse feeling emotionally drained. O’Brien ([16]) interviewed community psychiatric mental health nurses who felt they underestimated the energy required to be there for patients in a consistent and supportive way. Consequently “being there” for the patient may not be as simple as it sounds; and appears to be a skill perfected with advanced practice.

BEING ‘GENUINE’

Being ‘genuine’ or ‘authentic’ is essential to therapeutic relationship development enabling the psychiatric/mental health nurse to be as close as he/she can to using the entire

self to a therapeutic end ([10]). Genuineness requires the psychiatric/mental health nurse to be natural or authentic in their interactions with the patient ([19]). Psychiatric/mental health nurses should be congruent with their values and beliefs ([10]), in addition to being consistent and reliable in both time and person ([16]). Skills identified in the literature to convey ‘genuineness’ include consistency and following through. For instance, Schafer and Peternelj-Taylor ([21]) found that a psychiatric/mental health nurse’s ‘genuineness’ is determined through the level of consistency displayed between their verbal and non-verbal behaviour. Similarly, Scanlon ([8]) found that genuineness was expressed by fulfilling stated tasks.

Through the practice of genuine relationships, psychiatric/mental health nurses are often viewed as friendly people. To promote a friendly relationship, psychiatric/mental health nurses spoke of the importance of using humour ([8]) and being open and honest ([33]). In the pursuit of being open and honest, Shattell et al. ([15]) found genuine emotion, such as tearfulness, blunt feedback, and straight talk facilitated the therapeutic relationship. Importantly, Forchuk et al. ([31]) noted that the friendship of a therapeutic relationship is different to a sociable friendship in that the therapeutic relationship friendship is asymmetrical in nature.

An important element of being open and honest is self-disclosure. Self-disclosure involves the psychiatric/mental health nurse sharing life experiences. Sharing experiences permits psychiatric/mental health nurses to relate to patients as human beings ([29]), to allow patients to see them as a real person ([16]) in addition to normalizing experiences to convey understanding ([24]). Self-disclosure is also essential to therapeutic relationship development because as the relationship grows patients are reluctant to give any more information if they feel the relationship is too one sided ([20]). Importantly, Scanlon ([8]) found psychiatric/mental health nurses in a study were confused over the degree of personal experiences they should be sharing with patients.

Despite the apparent support for a friendly relationship in psychiatric/mental health nursing, conflict exists with regards to the exact level of closeness required to be friendly. Jackson and Stevenson ([20]) suggested that psychiatric/mental health nurses must be able to develop friendships with patients, which are closer than those usually offered in mental health. In contrast, Forchuk et al. ([31])

stated that the friendliness referred to in their study was not comparable to the level of intimacy that occurs in a friendship. This confusion is further demonstrated by Hem and Heggen's ([19]) study. For instance, when the psychiatric/mental health nurse participant in their study was open and vulnerable with the patient, the nurse was able to better understand the patient's situation; but devalued this vulnerability considering it unprofessional. Likewise, the colleagues of this psychiatric/mental health nurse frowned upon the vulnerability demonstrated in the interaction with the patient. Clearly reflected here is the conflict which exists between 'being a genuine human' and 'being professional' which suggests different levels of self-disclosure may exist that individuals feel comfortable with.

Notably, while the research has identified the importance of psychiatric/mental health nurses maintaining a non-judgemental attitude towards patients ([2318]) other researchers ([8]) recognize a conflict between being non-judgemental and being 'genuine'. Scanlon ([8]) observed that if psychiatric/mental health nurses are to follow the requirement of being non-judgemental towards patients they are '...bracketing their own personality traits or learned prejudice, the psychiatric/mental health nurses are betraying their own personalities and presenting an artificial front to the patient' (p. 326) and are therefore not being "genuine". How psychiatric/mental health nurses can overcome this conflict and practice "non-judgemental" "genuine" relationships is unclear in the research literature.

PROMOTING EQUALITY

Intrinsically, the relationship between the psychiatric/mental health nurse and the patient is imbalanced in power. The psychiatric/mental health nurse role as "helper" unavoidably places the nurse in a position of power ([34]); with some clinical situations such as involuntary detainment, bestowing an ominous amount of power. When used judiciously, power can be a prevailing tool to drive the success of the therapeutic relationship. Successful applications of power include offering expert knowledge through teaching and mentoring patients to problem solve and assume control over their lives ([26]). Power can also be used as a benevolent action to protect the patient from harm ([22]). As indicated early by Jackson and Stevenson ([20]), "mothering" or protecting vulnerable patients, through actions such as disciplining medication compliance and making sure patients eat, can be very therapeutic. Importantly, in all situations where power was used to facilitate care,

psychiatric/ mental health nurses required advanced practice skills to ensure power was not removed but borrowed, with control shifting from the psychiatric/mental health nurse back to the patient as treatment progressed ([26]).

Disturbingly, a propensity exists for some psychiatric/mental health nurses to abuse power. References of power misuse include denying requests for help ([26]), avoiding interactions ([23]), enforcing rules in a demoralizing manner ([2326]) being rude and condescending ([26]) and projecting a superior attitude ([31]). Patients were dissatisfied when the relationship was characterised by control, leading to a deterioration of the therapeutic relationship ([26]). Accordingly psychiatric/mental health nurses need to promote equality with patients ([31]) to drive a positive therapeutic relationship.

To promote equality in the therapeutic relationship, the substantive literature revealed the importance of acknowledging the relationship as mutually beneficial. This mutuality is grounded in the belief that the patient's role is as important as the psychiatric/mental health nurses; while patients need psychiatric/mental health nurses to support their recovery, psychiatric/mental health nurses need patients to develop skills and experience ([35]). Ultimately psychiatric/mental health nurses should convey themselves as team members; facilitators of the relationship rather than the leaders ([15]), empowering the patient with a sense of control ([15]) and involvement ([16]). Psychiatric/mental health nurses encourage the patient's independence ([7]), offering suggestions without taking control ([31]).

Fundamental nursing skills performed by psychiatric/mental health nurses to facilitate an equal relationship were readily identifiable in the research literature. Skills included to facilitate an equal interaction include ordinary talk or casual conversations; speaking to patients about experiences other than their current problems ([1422]) taking time to ask patients how they are doing ([26]), allowing patients to be heard ([21]), closing the space; such as sitting on the floor with the patient ([29]), spending time with the patient ([18]), creating the "illusion of choice"; giving the patient options, even if limited or confined within structure ([29]) and introducing self in a similar manner to any other encounter ([27]). In addition, both patients and psychiatric/mental health nurses made reference to having a cup of tea together which for them symbolizes humanness and civility ([20]). Likewise, Martin and Street ([30]) referred to the importance of shared

activities such as playing sport or going for a walk, which psychiatric/mental health nurses believed strengthened the quality of the relationship with patients.

One of the few studies that gave specific details about how advanced practicing psychiatric/mental health nurses have an equal relationship while being sensitive to power issues was O'Brien's ([24]) study. O'Brien ([24]) described that psychiatric/mental health nurses related to patients as an equal human being by "minimizing visibility". Minimizing visibility entails such actions as making assessments an unobtrusive process that occurs in the context of ordinary conversation. Minimizing visibility also involves being sensitive to power issues. For example, community psychiatric/mental health nurses described not taking signifiers of power, such as brief cases, with them when they make community visits ([24]).

DEMONSTRATING RESPECT

To develop a quality therapeutic relationship psychiatric/mental health nurses need to make patients feel respected and important ([13]). Behaviours used by advanced practice psychiatric/mental health nurses found in the research literature to convey respect include active listening ([731]) being accessible ([7]), being consistent, following through ([31]), taking patients seriously and interacting in an equal partnership ([33]). In addition, accepting the patient with their faults and problems ([18]) is vital to convey respect; helping the patient see themselves as worthy and worthwhile ([18]). Notably these behaviours are echoed throughout the applications of other attributes. As discussed previously, Walsh ([17]) found active listening to be important to convey understanding, while Schafer and Peternej-Taylor ([21]) found being consistent demonstrated "genuineness".

DEMONSTRATING CLEAR BOUNDARIES

Attributes such as understanding, being there, being genuine, and interacting in an equal partnership are maintained through boundaries. Boundaries are essential to protect both the patient and the psychiatric/mental health nurse, and to maintain a functional therapeutic relationship. For instance, limit setting helps to shield the patient from embarrassing behaviour ([22]) and instills the patient with feelings of safety and containment ([28]). Limit setting also protects the psychiatric/mental health nurse from "burnout" ([28]), preserving personal stability; thus promoting a quality relationship. Importantly, to maintain appropriate

boundaries, psychiatric/mental health nurses must only do things in the relationship they are comfortable with. As found by Scanlon ([8]), each psychiatric/mental health nurse should practice within their own scope of practice.

However, while maintaining a professional relationship with patients is essential to psychiatric/mental health nursing practice, an overtly professional role can conflict relationship development ([16]). Accordingly, a delicate balance is required between attributes such as understanding, being there, being genuine, and practicing in an equal partnership and boundaries. For instance, psychiatric/mental health nurse self disclosure ([162029]) and vulnerability ([19]) promote the relationship and understanding, however in applying self disclosure and vulnerability there is a potential for boundary violation. Thus, while psychiatric/mental health nurses need to promote a close and warm co-operation with patients ([36]), they need to know how far they can be self disclosing while maintaining professional boundaries. Thus, the application of a range of highly developed skills is required.

DEMONSTRATING SELF AWARENESS

In order to deal with the competing demands of the attributes required to develop a therapeutic relationship in psychiatric/mental health nursing, the research literature indicates that psychiatric/mental health nurses need to be self aware ([7]), ([21]). Each of the studies that included self awareness as a finding stressed how important being self aware was to the therapeutic relationship; but all were unclear about how self awareness is behaviourally manifested by the psychiatric/mental health nurse. Hem and Heggen ([19]) found that an important element for advanced practicing psychiatric/mental health nurses was to recognize personal vulnerability in order to survive and develop professionally. Rask and Aberg ([36]) concluded that in order to improve care, psychiatric/mental health nurses required knowledge on humanistic, basic human values and self knowledge. O'Brien ([16]) found that all of the psychiatric/mental health nurses in her study identified that their personalities could affect the way they respond to their patients and that had to be self aware to know how to approach interactions with different patients. Similarly, Scanlon ([8]) concluded the interpersonal skills to form relationships with patients were acquired through learning about oneself.

While the reviewed literature did not specify how self

awareness is manifested, many studies referred to the use of clinical supervision to support therapeutic relationship development, which may foster self awareness. For example clinical supervision was found to provide the opportunity for nurses to reflect on the relationship ([23]), to improve clinical skills ([36]), and to help repair difficult relationships ([31]). Thus, the reflections ([23]) articulated by psychiatric/ mental health nurses through clinical supervision may help foster self awareness.

Notably, Berg and Hallberg ([7]) found, when discussing the working relationship with patients, psychiatric/mental health nurses tended to refer to stories of doing rather than being. Berg and Hallberg ([7]) suggested that the being aspects of the relationship are more difficult to grasp and articulate than the doing aspects. This assertion tends to explain the paucity of papers devoted to the application of self awareness in the research literature.

CONCLUSION AND RECOMMENDATIONS

In conclusion, nine multifaceted constructs of a therapeutic relationship in psychiatric/mental health nursing were identified, with several overlapping concepts. For example, active listening was found to convey both respect ([731]), and understanding ([17]); while “being consistent” was found to reflect both being genuine ([21]) and being respectful ([31]). In addition, attributes can be self-contradictory. For example, Scanlon ([8]) noted if psychiatric/mental health nurses are to be non-judgmental they are ultimately sacrificing their beliefs and therefore are not being genuine.

The literature indicated that advanced practice skills are required to apply many of the attributes described in this paper. For example, the ability to perform a mental health assessment as a discreet process is a highly developed skill ([24]) utilized by advanced practice psychiatric/ mental health nurses. Similarly, certain elements of understanding require highly developed skills. The ability to understand a patient’s needs from non-verbal cues ([720]) and to ascribe meanings to behaviours ([18]) requires the sophisticated skill of the advanced practice psychiatric/ mental health nurse. Furthermore, the interface of certain attributes with others requires the psychiatric/ mental health nurse to have specialized skills. For instance, advanced skills are required to enable the psychiatric/ mental health nurse to maintain empathy for patients who may be projecting fierce verbal attacks ([19]) or disclosing disturbing information ([15]).

The typology of advanced practice attributes of a therapeutic

relationship in psychiatric/mental health nursing were developed from a heterogeneous sample of studies, including studies which sampled patients with mental illness, psychiatric/ mental health nurses, other psychiatric/mental health professionals, families and carers; and of services in forensic, inpatient, adolescent and community settings. All these participants provide essential data regarding the therapeutic relationship. However, the different samples may be responsible for the apparent conflict of attributes. For example, the use of therapeutic touch was often found important in studies focusing on depressed and vulnerable patients ([6]); while experienced psychiatric/mental health nurses used “rule bending” as an advanced practice means to individualize care ([24]). Ultimately some attributes may come to the fore in specific situations; suggesting their individualized application by advanced practice psychiatric/mental health nurses.

The development of a therapeutic relationship within the mental health setting requires a complex interplay of skills, adapted by the advanced practice psychiatric/ mental health nurse to meet the requirements at hand. The constructs contributing to the development of a quality therapeutic relationship presented in this paper provide a framework from which advanced practice clinicians can conceptualise their practice. This paper provides evidence that specific constructs might be more applicable in some contexts than others; and for some individuals than others. Thus, a strong recommendation is that advanced practice clinicians continually refine and review the critical elements of the therapeutic relationship relevant to their own and each client’s needs.

CORRESPONDENCE TO

Fiona Dziopa School of Nursing University of Queensland
11 Salisbury Road Ipswich 4305 Tel: (+61) 0438 106 962
FAX: (+61) 7 3381 1166 f.dziopa@bigpond.com

References

1. Forchuk C, Reynolds W. Clients' reflections on relationships with nurses: comparison from Canadian and Scotland. *Journal of Psychiatric and Mental Health Nursing*. 2001;8:45-51.
2. Cleary M, Edwards C. 'Something always comes up': nurse-patient interaction in an acute psychiatric setting. *Journal of Psychiatric and Mental Health Nursing*. 1999;6:469-477.
3. Cleary M, Edwards C, Meehan T. Factors influencing nurse patient interaction in the acute psychiatric setting: an exploratory investigation. *Australian and New Zealand Journal of Mental Health Nursing*. 1999;8:109-116.
4. McGuire R, McCabe R, Priebe S. Theoretical frameworks

What Makes a Quality Therapeutic Relationship in Psychiatric/Mental Health Nursing: A Review of the Research Literature

- for understanding and investigating the therapeutic relationship in psychiatry. *Social Psychiatry Psychiatric Epidemiology*. 2001;36:557-564.
5. McCabe R, Priebe S. The therapeutic relationship in the treatment of severe mental illness. A review of methods and findings *International Journal of Social Psychiatry*. 2004;50(2):115-128.
 6. Moyle W. Nurse-patient relationship: a dichotomy of expectations. *International Journal of Mental Health Nursing*. 2003;12:103-109.
 7. Berg A, Hallberg IR. Psychiatric nurses' lived experiences of working with inpatient care on a general team psychiatric ward. *Journal of Psychiatric and Mental Health Nursing*. 2000;7:323-333.
 8. Scanlon A. Psychiatric nurses perceptions of the constituents of the therapeutic relationship: a grounded theory study. *Journal of Psychiatric and Mental Health Nursing*. 2006;13:319-329.
 9. Rask M, Brunt D. Verbal and social interactions in Swedish forensic psychiatric nursing care as perceived by the patient and nurses *International Journal of Mental Health Nursing*. 2006;15(2):100-110.
 10. Welch M. Pivotal moments in the therapeutic relationship. *International Journal of Mental Health Nursing*. 2005;14:161-165.
 11. Weissmark MS, Giacomo DA. Measuring therapeutic interaction: Research and clinical applications. *Psychiatry*. 1995;58(2):173.
 12. French P. What is the evidence on evidence-based nursing? An epistemological concern. *Journal of Advanced Nursing*. (2002);37(3):250-257.
 13. Johansson H, Eklund M. Patients' opinion on what constitutes good psychiatric care. *Scandinavian Journal of Caring Sciences*. 2003;17:339-346.
 14. Shattell M, McAllister S, Hogan B, Thomas SP. "She took the time to make sure she understood: Mental health patients' experience of being understood. *Archives of Psychiatric Nursing*. 2006;20(5):234-241.
 15. Shattell M, Starr SS, Thomas SP. "Take my hand, help me out": Mental health service recipients' experience of the therapeutic relationship. *International Journal of Mental Health Nursing*. 2007;16:274-284.
 16. O'Brien L. Nurse client relationships: the experience of community psychiatric nurses. *Australian and New Zealand Journal of Mental Health Nursing*. 2000;9:184-194.
 17. Walsh K. Shared humanity and the psychiatric nurse-patient encounter. *Australian and New Zealand Journal of Mental Health Nursing*. 1999;8:2-8.
 18. Geanellos R. Transformative change of self: The unique focus of (adolescent) mental health nursing. *International Journal of Mental Health Nursing*. 2002;11:174-185.
 19. Hem MH, Heggen K. Being professional and being human: one nurse's relationship with a psychiatric patient. *Journal of Advanced Nursing*. 2003;43(1):101-108.
 20. Jackson S, Stevenson C. What do people need psychiatric and mental health nurses for? *Journal of Advanced Nursing*. 2000;31(2):378-388.
 21. Schafer P, Peternelj-Taylor C. Therapeutic relationships and boundary maintenance: the perspective of forensic patients enrolled in a treatment program for violent offenders. *Issues in mental health nursing*. 2003;24(6):605-625).
 22. Rydon SE. The attitudes, knowledge and skills needed in mental health nurses: The perspectives of users of mental health services. *International Journal of Mental Health Nursing*. 2005;14:78-87.
 23. Muller A, Poggenpoel M. Patients' internal world experiences of interacting with psychiatric nurses. *Archives of Psychiatric Nursing*. 1996;10(3):143-150.
 24. O'Brien AJ. Negotiating the relationship: Mental health nurses' perceptions of their practice. *Australian and New Zealand Journal of Mental Health Nursing*. 1999:153-161.
 25. Thomas SP, Shattell M, Martin T. What's therapeutic about the therapeutic milieu? *Archives of Psychiatric Nursing*. 2002;14:99-107.
 26. Coastworth-Puspoky R, Forchuk C, Ward-Griffin C. Nurse-patient process in mental health: recipients' perspectives. *Journal of Psychiatric and Mental Health Nursing* 2006;13:347-355.
 27. Yamishita M, Forchuk C, Mound B. Nurse case management: negotiating care together within a developing relationship. *Perspectives in Psychiatric Care*. 2005;41(2):62-70.
 28. Langley GC, Klooper H. Trust as a foundation for the therapeutic intervention for patients with borderline personality disorders. *Journal of Psychiatric and Mental Health Nursing*. 2005;12:23-32.
 29. McAllister S, Matarasso B, Dixon B, Shepperd C. Conversation starters: re-examining and reconstructing first encounters within the therapeutic relationship *Journal of Psychiatric and Mental Health Nursing*. 2004;11(5):575-582).
 30. Martin T, Street AF. Exploring evidence of the therapeutic relationship in forensic nursing *Journal of Psychiatric and Mental Health Nursing*. 2003;10:531-551.
 31. Forchuk C, Westwell J, Martin M, Azzopardi WB, Kosterewa-Tolman D, Hux M. Factors influencing movement of chronic psychiatric patients from the orientation to the working phase of the nurse-client relationship on an inpatient unit. *Perspectives in Psychiatric Care*. 1998;34(1):36-44.
 32. Adams R, Tilley S, Pollock L. Person first: what people with enduring mental disorders value about community psychiatric nurses and CPN services. *Journal of Psychiatric and Mental Health Nursing*. 2003;10:203-212.
 33. Horberg U, Brunt D, Axelsson A. Patient's perceptions of patient-nurse relationships in local authority psychiatric services: A qualitative study. *International Journal of Mental Health Nursing*. 2004;13:9-17.
 34. Peternelj-Taylor CA, Younge O. Exploring boundaries in the Nurse-Client relationship: Professional roles and responsibilities. *Perspectives in Psychiatric Care*. 2003;39(2):55-66.
 35. Hostick T, McClelland F. 'Partnership': a co-operative inquiry between community mental health nurses and their patients. 2. The nurse-client relationship. *Journal of Psychiatric and Mental Health Nursing*. 2002;9(1):111-117).
 36. Rask M, Aberg J. Swedish forensic nursing care: nurses' professional contributions and educational needs. *Journal of Psychiatric and Mental Health Nursing*. 2002;9:531-539.

Author Information

Fiona Dziopa, BPsyc, BN (Hons), RN

School of Nursing & Midwifery, The University of Queensland

Kathy Ahern, Ph.D., RN

School of Nursing & Midwifery, The University of Queensland