An interpretive hermeneutic phenomenological exploration of patients' and student mental health nurses' lived experiences of the time they share together on secure personality disorder units for men

By

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Abstract

Background: Unlike more general consideration of caring relationships, the important experience of the *time* patients and students share together in mental health services has not been specifically explored before. This study was focused on student nurses within medium secure personality disorder placements for men. Students represent the present and future of nursing, often having greater patient contact than registered nurses, and this is appreciated by patients.

Methodology: Interpretive Hermeneutic Phenomenology was the underpinning philosophy of this research, woven throughout; with the aim of exploring the participants' lived experiences and illuminating present phenomenon/s, with reflexivity central to the process. National Health Service and university ethical approval was granted. Seven patients and five student mental health nurses participated in unstructured interviews.

Findings: Three themes were illuminated. Everyday stuff with three subthemes; '*Just being around'*; '*Having a laugh';* and '*The way you speak to people is important'*. Balance with three subthemes; Recognition: '*We're just people'* and they're the same as us; Identities: '*More like us';* and Weathering the ride: '*Sponges'* to holder of keys. The third overarching theme Impact has three subthemes; Time; Having value and feeling valued: '*Damn well not useless now*' and The landscape.

The findings illuminate that when students and patients shared time together they were *being-with* in their own time and space, where they shared an experience of togetherness*,* enabling them to feel that they were '*just people'* and valued, which had lasting impact*.* Interpersonal connections created a *bubble,* despite experiences of *thrownness* into the world and landscape, or the bearing of diagnostic labels. Together, the participants engaged in the

mundane everyday, sharing activities, connecting over common interests and having a laugh. Reciprocal identities of teacher and learner were obtained within shared experiences of being assessed. The time students and patients shared together was a gift, powerfully impacting on their sense of humanness, value and worth.

Students experienced a balance between *therapeuticness* (*leaping-ahead*) and professionalism (*leaping-in*). *Therapeuticness* involved an all-encompassing, supportive and humane approach via everyday *being-with,* creating a *bubble* and enabling recognition. Professionalism encompassed risk aversion, restricting identities and roles, and power constructs. A balance was struck through innovative practices and patient involvement.

The landscapes of secure settings, housed the pivotal panoptical eye of the staff office, sucking in staff and blowing patients away. Students were immune to the vacuum of the office and were viewed as '*sponges'*. Students were available, had time, were learners and not paid; elements not fully present for other staff due to set roles. Students can become *holder of keys* on becoming staff, however, can '*weather the ride'* by focusing on the everyday mundane, *being-with* and connecting with patients to create *bubbles.*

Conclusion: This study is a call to all to foster the mundane, the everyday and recognise the humanity in others. Student nurses can balance *therapeuticness* and professionalism, be themselves, have a laugh with patients, connect over shared interests and make *bubbles*. This study is a message of hope for people residing in often dehumanising settings, who may have experienced *thrownness,* trauma and othering, that they can experience humanity and have worth and value.

Key words

Time, therapeutic relationships, patients, student mental health nurses, personality disorder, secure services/ forensic nursing, phenomenology, hermeneutics, Heidegger.

Contents

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Statement on terminology

'*Patients', 'service users', 'clients*', '*refusers*', '*customers',* '*consumers'* or '*survivors'* are all terms used to describe people, and used by people, who are eligible to or access health care services. I will refer to *'patients'* throughout for consistency and reflecting the terminology used by the participants in this study. There is no term that suits everyone, and each have limitations, hence the decision to be led by the participants.

'*Nurses'* will be referred to as such, other practitioners/ workers/ clinicians/ professionals such as '*occupational therapists*', '*psychologists*', '*therapists*', '*psychiatrists*', '*social workers'* etc. will be referred to as '*staff*'.

'*Forensic'* and '*secure services'* or '*settings'* are often used interchangeably, for the purpose of this project '*secure services'* will be used.

There are a number of terms used to describe the time people spend together and associated '*relationships'* they may build in health care. These include '*time', 'interaction', 'engagement', 'therapeutic relationship', 'nurse-patient relationship', 'helping/ working relationship',* and *'therapeutic/ working/ helping alliance'*. The above terms and others are explored in the background chapter[1] and searching discussed in the integrative review chapter[2].

Throughout I have chosen not to abbreviate personality disorder to 'PD' as a further demonstration of othering, explored further in the thesis.

[1] Chapter 2.
[2] Chapter 3.

As this is an interpretive hermeneutic phenomenological study, Heideggarian terms will be in italics for clarity, in addition to terms I have developed. A glossary of terms is provided to support the reader with common terms used throughout the thesis[3]. Page numbers for quotes from Being and Time will be presented as p. 350/401; the first number refers to German edition pagination and the second is the Macquarrie and Robinson 2019 edition pagination.

[3] Please refer to appendix 1.

Abbreviations

APA- American Psychiatric Association

DH- Department of Health

DSM- Diagnostic and Statistical Manual of Mental Disorders

HMPPS- Her Majesty Prison and Probation Service

ICD- International Classification of Diseases: Clinical Descriptions and Diagnostic Guidelines for Mental and Behavioural Disorders

NHS- National Health Service

NICE- National Institute for Health and Care Excellence

NMC- Nursing and Midwifery Council

UCLan- University of Central Lancashire

WHO- World Health Organisation

1. Introduction

This thesis presents findings of an interpretive hermeneutic phenomenological study of lived experiences of the time patients and student mental health nurses share together on secure personality disorder units for men. The study is grounded in interpretivism; hence the introduction presents pre-understandings which guided the direction and subsequent development of the research. In this chapter I aim to give you my personal and professional positioning, a brief background to the study and its contributions to practice[4].

The study aimed: *To illuminate the lived experiences of the time patients and student mental health nurses share together on secure personality disorder units for men.*

1.1 Why interpretive hermeneutic phenomenology?

Interpretive hermeneutic phenomenology enables an exploration of the lived experience and thus can provide answers to the research question as posed. Heideggarian philosophy as a methodology must be clear at all stages of the research process to ensure fidelity to the philosophical underpinnings (Dibley, Dickerson, Duffy, & Vandermause, 2020), hence, I have threaded references to Heidegger's work through my research. Hermeneutic phenomenology is grounded in interpretation[5]. Heidegger (1927/2019) proposed we interpret everything we experience, as we experience it. Connectedness between hermeneutic researchers and their research is an essential component, disavowing reduction in embrace of the interpretive (Dibley et al., 2020).

[4] I have included a visual presentation of the study in appendix 31.
[5] As explored in chapter 4.

My *fore-structures* (past, present and future) are essential parts of the study (Peoples, 2021). It is therefore important to highlight this in my writing. The pronouns *I* and *my* are used to signify this. I am part of the interpretive process; my pre-understandings and ongoing emerging interpretations are made explicit throughout the thesis. Without my pre-understandings there could be no beginning to the study (Crowther, 2014) as research questions do not come out of nowhere (Dibley et al., 2020).

There '*is no one phenomenology'* (Dibley et al., 2020, p. 167) or '*no one way of undertaking'* phenomenological research (Dowling, 2011, p. 72). We are unique and bring our experience and understanding of the world we live in (Dibley et al., 2020). As Awty, Welch, and Kuhn (2010) state, although people may choose mental health nursing without a clear understanding for their choice, they suggest that it is an intuitive one based on a philosophical disposition, similarly researchers' choice of methodology. I am drawn to striving to understand lived experience and this methodology facilitates such exploration. My way of thinking has guided me to researching in a particular way, my view of the world drives my interest and connection to the research (Dibley et al., 2020). The decision to use phenomenology is not one to be taken lightly, for me it was a pull or a call. I found an affinity to hermeneutic phenomenology and found a congruence of values in exploring peoples' experiences while acknowledging my own positionality and interpretations.

You cannot simply *do* phenomenology as research, the decision is not merely a choice but '*one that carries an implicit set of values'* (Thomson & Dykes, 2011, p. 234). In undertaking phenomenological research, it is potentially life changing and life enhancing (Thomson & Dykes, 2011).

1.2 Personal and professional positioning

I am situated within the world I seek to research and I am connected to it on a personal and professional level (Dibley et al., 2020). Declaring positionality assists a reflexive approach, allowing the researcher to focus on how knowledge is acquired, organised and interpreted (Altheide & Johnson, 1994; Cousin, 2010; Pillow, 2003). It is important I commence the study by reflecting on my own positioning and impact of my pre-understandings on the topic, design, collection, and interpretation.

Beginning with the most important identities I must provide my *fore-structures* (my past, present and future); I am a mum, a daughter, a sister, a partner, a friend, and a colleague. I am lucky to have many people around me, all impacting on my life, my understandings, and personal development. This is important within mental health nursing and particularly when working with patients carrying a diagnosis of personality disorder. We are social beings whose interpersonal relationships impact on us; arguably of increased importance in the context of personality disorder, conceived as an interpersonal diagnosis[6]. I am interested in such topics, as a mental health nurse and, as nurse educator I am immersed in salient professional ideas and values. In completing this study I am also a researcher, a student and a learner. These are important to me as they are a large part of my life, my career, my passion and my future hopes.

Other identities I feel are important to mention are my love of hobbies I participate in. I am a swimmer, particularly an open water swimmer, creating space for me to be mindful. Linking with some Heideggerian principles, I become at one with nature when swimming in a lake or the sea, and dwell (Dibley et al., 2020). I also like running, long walks and bike rides with

[6] Explored in chapter 2.

friends and family. Being active outdoors is key for managing my own mental health and hones my reflexivity.

My Master's study explored the topic of personality disorder and influenced the focus of this research. I clearly have previous knowledge about this subject matter. In developing this study, I was mindful that focusing on a '*relationship'* presumed that there is one, which may not always be the case. Also, patients and students may use different terminology, referring to the relational. I therefore developed the aim of this research from learnings from my Master's study. I previously was course leader for a Masters exploring *personality disorder* following being a student on the course myself. I am passionate about the subject and tackling stigma patients experience. I valued working as a nurse in a secure unit[7], supporting students, other staff and patients, and experienced environmental and relational challenges. I needed to be aware of such experiences and ensure I was open to them when engaging in the interviews and my interpretation. Nevertheless, being an insider and connected to the field can bring huge benefits to uncovering meaning (Dibley et al., 2020).

It is important now to be open about and consider some aspects of my character that I struggle with. It is important to ask what is it about me that helps or hinders the study, and do I need to do anything about it? Such reflexivity requires honesty and vulnerability which can be challenging (Dibley et al., 2020). Certainly, unpicking these characteristics was a challenge initially, though in attending hermeneutic courses I was able to identify these, accept them and try to understand and make sense of them in the context of the study. These include being a perfectionist and wanting to do everything to the best of my ability, which can be a struggle when I am trying to manage time and well-being. Perfectionism may be due to a lack of confidence. Associated with this, I can struggle with criticism, it was important I was aware of this, so I could be open to developing ideas and accepting other ways to do things. Cultivating

[7] Not the sites approached for recruitment to the study.

self-awareness and dialogue in supervision assisted my decision making and interpretations, enabling me to manage such characteristics in relation to my research.

1.3 Rationale and areas of consideration

When conducting hermeneutic research it is imperative to consider the rationale for the choice of research area and for the researcher to reflect on their experiences, and lens in which the research is undertaken. Identifying motivations is important, hence exploration of my personal and professional positioning to foreground the rationale for the study above. I had a long-standing interest in people and the relational from my personal and professional experiences, congruent with hermeneutic phenomenology. I essentially chose areas I was most interested in; experiences of patients who carry a diagnosis of personality disorder, student nurses and the relational.

From my experience as a student and a mental health nurse working with people with a personality disorder diagnosis, mainly men, I have found that the *therapeutic relationship*[8], including humour, can be hugely effective for supporting someone working towards their recovery; however, this may not be the case for all patients or students. I have also seen, through working with and teaching students and staff, negative attitudes towards the term '*personality disorder'*. Therefore, I needed to be open that I may have expected to find this (*fore-conception)*, and ensure my analysis was directed by the participants.

1.4 Brief background

The experience of the '*time'* students and patients share together in mental health services is an area not specifically explored before, hence this study offers a unique contribution to

[8] The term explored in depth in chapter 2.

knowledge. Other studies have explored experiences of the '*relationship'* (Aiyegbusi & Kelly, 2015; Horberg, Brunt, & Axelsson, 2004; Jones & Wright, 2017) but clearly assume a relationship exists and focus solely on participants' experiences of relationships rather than shared experiences of time. Students are both the present and future of nursing, and have greater contact with patients compared with registered nurses (Jones & Black, 2008; Mukumbang & Adejumo, 2014). They are new and fresh into nursing and may not have developed engrained views like some qualified staff (Bowers, Alexander, Simpson, Ryan, & Carr-Walker, 2007). More importantly patients welcome interactions with students finding their presence facilitative (Andersson, Ekebergh, & Hörberg, 2020; Mukumbang & Adejumo, 2014; Speers & Lathlean, 2015). The temporal nature of helping relationships and the passage of time in certain care settings has hitherto been remarked upon (Chandley, 2000) but not with respect to patients and student encounters. It is therefore important to consider experiences of the *time* patients and students share together.

Many patients of mental health services will, as part of their treatment, be given a diagnosis of a mental health problem, however, it is useful to consider mental health problems on a continuum (Boullier & Blair, 2018; DeLisi et al., 2017; Sweeney, Clement, Filson, & Kennedy, 2016). Health care staff roles are to work with the person, their strengths and needs rather than focus on a label, which may not tell you very much (Johnston et al., 2018).

Personality disorder is a diagnosis attracting particular criticism and associated stigma; its utility has been questioned (Bolton, Lovell, Morgan, & Wood, 2014; Tyrer, Mulder, Kim, & Crawford, 2019), being described as the most ambiguous diagnostic category in psychiatry (Benedik & Dobnik, 2014). Conversely, having a diagnosis of personality disorder can enable access to appropriate services, helpful treatment, or welfare benefits (National Institute for Health and Care Excellence, 2009, 2013; Sheridan Rains et al., 2021) or help explain otherwise inexplicable feelings or responses (Bolton et al., 2014; Gillard, Turner, & Neffgen,

2015). A term is also needed for research to be clearly focused and the evidence base to grow (Claridge & Davis, 2003). However, many argue that formulation[9] is a more useful tool than simple diagnosis (Haigh & Benefield, 2019; Houghton & Jones, 2016; Royal College of Psychiatrists, 2020). There are movements, particularly on social media which are strongly opposed to the diagnosis.

The term '*personality disorder'* can cause patients to be stigmatised and excluded (Eren & Sahin, 2016; National Institute for Mental Health In England, 2003b; Sheridan Rains et al., 2021), or cause trauma or re-traumatisation (Johnston et al., 2018; Sheridan Rains et al., 2021). Indeed, mental distress, however categorised, can be seen as an understandable response to adverse experiences such as trauma (Boullier & Blair, 2018; DeLisi et al., 2017; Sweeney et al., 2016) leading to the development of notions of trauma informed care (Sweeney et al., 2016). Haigh and Benefield (2019) developed a general theory of human development with wider social appeal, beginning with learning gleaned from relational and democratising tendencies in clinical work with individuals who carry a diagnosis of personality disorder. Indeed, going back to the seminal paper by Main (1957) there has been interest in the relational challenges of caring for this patient group, yet literature on temporal aspects of salient nursing relationships remain lacking.

Individuals studying to become registered mental health nurses across a variety of different courses in the UK spend a substantial amount of their time allocated to clinical placements (Nursing and Midwifery Council, 2018b). When student nurses are on placement, they are expected to spend time with patients and support them towards recovery. In the UK this is part

[9] Formulation is a process of attempting to understand the person, their past experiences and influences that impact on their present (Houghton & Jones, 2016). Hence, the links to Heidegger's term *thrownness,* explored in later chapters. Formulation can be conceived as a psychologically informed structured process for making sense of individuals' mental distress. In practice, formulation of patient's problems and needs can be undertaken by individual practitioners, coproduced with patients, or produced by whole teams.

of their completion of proficiencies for registered nurses (Nursing and Midwifery Council, 2018b). Annex A of the UK Nursing and Midwifery Council standards is specific for communication and relationship management skills which are congruent to the topic areas being explored.

In the time patients and students share together they may '*interact'*, '*engage'* and develop a '*relationship'.* Importantly, there may be a presumption made by other studies that every member of staff or student will develop a therapeutic/ helping relationship with every patient they spend time with, however this may not be the case, highlighting the value of exploring these shared experiences.

1.4.1 Significant contribution to professional practice

So, just what is the relevance of this study? One might argue that as a small qualitative study of a snapshot in time, in particular context, that it is not of much relevance to the vastness of professional practice. Certainly, phenomenological studies do not aim to be generalisable or make bold claims of contribution (Dibley et al., 2020), however, unique use of hermeneutic phenomenology illuminates in-depth experiences, which are essential to explore and can show us rich and meaningful insights that can enhance people's understanding and learning around the time shared between patients and students. Such experiences have not been explored before. Minimal previous research has explored patients carrying a personality disorder diagnosis views of the '*relationship'* (Aiyegbusi & Kelly, 2015); none focused on '*time'* people share. Students' views of relationships with patients with personality disorder have been explored before (Jones & Wright, 2017) but not concerning lived experiences of time shared with patients. Much of the literature focuses on attitudes towards people with a personality disorder; this study takes a holistic approach, including the temporality of relationships.

There is growing interest in relational practice (Benefield & Haigh, 2020; Haigh & Benefield, 2019), trauma informed practice (Sweeney et al., 2016; Sweeney, Filson, Kennedy, Collinson, & Gillard, 2018), recovery and discovery (Bolton et al., 2014), and coproduction and patient involvement, which will continue to gain interest, and these interests will grow in value, hence the importance of this study.

Students spend a greater amount of time with patients than other staff (Jones & Black, 2008; Mukumbang & Adejumo, 2014), and this is greatly valued by patients (Andersson et al., 2020). Students become practicing nurses, and are the future workforce, supporting and advocating for patients, leading and managing teams and services, directing, teaching and researching on all aspects of patient care. Through exploring students' experiences and patients experiences with them, understanding can be gained, impacting on understanding of the quality of care patients receive; the ultimate aim of practice. In addition to this, patients in secure services with personality disorder diagnoses can be the most stigmatised group in mental health care and exploration of their experiences lacking (Long, Knight, Bradley, & Thomas, 2012; Scholes, Price, & Berry, 2021), it is vital these are explored.

1.5 Thesis structure

Chapter two offers an overview of the main concepts and context germane to this study. It is structured by each topic of relevance, personality disorder diagnosis, student mental health nurses and time. Although this study is exploring the experiences of people within a secure service the chapter provides general and focussed information by way of introduction to the study.

Chapter three provides an integrative review of relevant literature[10], conducted systematically to inform the research, including discussion of specific literature explored and strategy for locating this and critical appraisal of included studies. Review findings are presented and discussed with recourse to identified themes. The chapter concludes by suggesting the potential contribution my study can make to the evidence base.

Chapter four considers why phenomenology was the appropriate methodology. In this chapter, I re-present the aim of the study and then discuss an appraisal of the underpinning methodology and potential to achieve the stated aim. I give an overview of phenomenology, with an emphasis on hermeneutics and rationale for this chosen approach.

Chapter five discusses ethical considerations relevant to conducting the study, leading on to choice of methods and design. Sections on interviews and research rigour follow this before discussing recruitment and data collection. The hermeneutic interview and my analytic process are outlined and discussed alongside underpinning approaches.

Findings of the study are detailed in chapter six, presented in narrative from selected participant quotes. Organised as themes and subthemes, a thematic map ensures a logical

[10] As published in Nurse Education Today (Jones, Wright, & McKeown, 2020), included in appendix 23.

order to presentation of these findings. A concluding summary highlights the key points from the themes discussed.

Chapter seven presents a synthesis of the experiences of the participants along with key concepts from Heidegger and other phenomenologists, broader philosophy, sociology, psychology and pedagogy and key studies explored in the integrative review amongst other research. Discussion is structured by the themes outlined in the findings chapter.

Chapter eight offers my conclusions, illuminates the unique contributions of the research, outlines strengths and limitations and offers selected recommendations for further research, practice and education. This final commentary includes my reflections on completing the study.

Footnotes will be used to direct the reader to relevant chapters, themes, or appendices.

2 Background

The previous chapter presented pre-understandings which guided direction and subsequent development of the research. I gave you my personal and professional positioning, a brief background to the study and potential contributions to practice.

2.1 Introduction to the chapter

This chapter provides an overview of some main concepts to give context to the study. It is structured by each topic of relevance; personality disorder diagnosis, student mental health nurses and time. Although this study explores experiences within a secure service it provides both general and focussed information by way of introduction.

2.2 Mental health and mental health services

People may need support from mental health services at some point in their lives. There are various services that provide care across the life span including services for people in crisis in the community or recovery services for people who need less input. Inpatient services and secure services provide care for patients[11] often, but not always, detained under the Mental Health Act (1983, 2007). Mental health services are provided either by the National Health Service [NHS] or third sector or private organisations funded by the NHS. Specialised inpatient and community services work with people with complex needs. This study is based within '*secure services'*[12]*.* These include low, medium, and high secure services (each increasing in physical, procedural, and relational security) as well as step down services and community specialist secure teams. Secure services have different security levels, risk assessments and

[11] See statement on terminology for rationale for use of the term patients.
[12] Sometimes referred to as '*forensic services'*. Secure services provide care for people who pose a risk of harm to themselves and the community (Markham, 2021).

related management strategies compared to local acute mental health units (McGregor Kettles, 2008; Reavey, Brown, Kanyeredzi, McGrath, & Tucker, 2019). Patients are admitted to secure units due to needing additional support levels of physical and relational security not available mainstream services (National Health Service, 2010; Reavey et al., 2019). Not all people detained in secure units have been through the criminal justice system but the majority in high and medium secure will have been.

People within these services have mental health problems[13]. It is useful to consider mental health problems on a continuum. Ideally, health care staff work with the person, their strengths and needs rather than focus on labels, which may not tell you very much (Johnston et al., 2018). People with mental health problems often feel excluded from society, experiencing prejudice and discrimination associated with labels (Tee & Uzar Ozcetin, 2016). The social construction of mental illness in popular culture underpins stigma, and people in secure settings can be seen as nonhuman or even monstrous (Jacob, Gagnon, & Holmes, 2009). It is important to focus on a person's quality of life and recovery (Castillo, Ramon, & Morant, 2013; McKeown et al., 2016). '*Concepts of recovery increasingly inform the development and delivery of mental health services'* (Gillard et al., 2015, p. 1). Though critics believe it is an overused term of diminished meaning (Recovery in the Bin, 2018).

Simplistic medical models and flawed categories and processes of diagnosis are open to critique (Hyman, 2010; Rogers & Pilgrim, 2021). Indeed, mental health nurses argue that the discipline has failed to find its own voice or identity (Hurley & Lakeman, 2021) because of subordination to psychiatry and timidity in challenging its power to invalidate and re-traumatise (Williams, Gadsby, & Bull, 2018).

[13] There are various terms used to explain '*mental ill health'*, these include but are not limited to; '*mental illness'*, '*mental health problem',* '*mental disorder'* and '*mental health difficulties'*. I will use the term '*mental health problem'* for the purpose of consistency to ensure understanding.

Going back to Thomas Szasz who argued mental illness is a myth, not fulfilling criteria required by scientific medicine to describe pathology. Szasz (1961) positing mental illness as a metaphor rather than a valid concept. At the individual level, diagnosis can change, and comorbidity is commonplace, questioning precision and validity of diagnostic practices (Anderson et al., 2021; Weaver et al., 2003).

There are two diagnostic manuals in contemporary use, the International Classification of Mental and Behavioural Disorders [ICD] (World Health Organization, 2018) and Diagnostic and Statistical Manual of Mental Disorders [DSM] (American Psychiatric Association, 2013). These categorical classification systems are criticised for inaccuracy, reifying presumed difference, and associated stigma attached to the diagnostic labels (Bach et al., 2017; Gaebel, Zielasek, & Reed, 2017; Ryrie & Norman, 2018); categories of personality disorder in many ways exemplify such shortcomings (Tyrer, Crawford, & Reed, 2015; Tyrer et al., 2019).

Alternatively, critical clinicians, academics and researchers suggest mental health problems are better viewed on a continuum and seen as a '*normal'* response to adverse experiences such as trauma[14] (Boullier & Blair, 2018; DeLisi et al., 2017).

2.3 Personality disorder

Given my focus on secure personality disorder units for men, it is particularly important to contextualise the term '*personality disorder'*. We must consider and explore critique and uses of the term, as the patients in this study carry such a diagnosis and the students are on placement on designated personality disorder units.

[14] '*One in three diagnosed mental health conditions in adulthood are known to directly relate to adverse childhood experiences'* (Bush, 2018, p. 5).

2.3.1 What is personality disorder?

According to the two diagnostic manuals the ICD and DSM (American Psychiatric Association, 2013; World Health Organization, 2018) personality disorders are described as deeply engrained abnormalities, maladjustments or exaggerations of personal attributes with enduring characteristics that can impair behavioural and social functioning. Researchers have considered several potential causes of '*personality disorder'* including; biological[15], psychological and social and these are influenced by a person's vulnerability and resilience to stress (Alwin, 2006; Chanen & Nicol, 2021).

The ICD 11, adopted in 2019 and to replace all earlier revisions in 2022, boasts a dimensional approach as opposed to the criticised categorical approach, persisting in DSM 5 (Tyrer et al., 2019). Though, of course, as a new approach to a diagnosis that had been relatively unchanged for more than 40 years, some criticism was expected (Tyrer et al., 2019). Chanen and Nicol (2021) argue that there is now a broad evidence-based consensus that personality disorder is a reliable, valid, common and treatable mental disorder. Tyrer et al. (2019) review of developing the ICD 11 highlights how the categories had no evidence base and were rarely used due to associated stigma and overlap between categories. In addition to the implication that the condition was pervasive and untreatable, thus becoming a reason for not promoting appropriate interventions. The ICD 11 also includes the condition; personality difficulty, defined as *'a subsyndromal condition, not a personality disorder'* to truly highlight the dimensional aspect (Tyrer et al., 2019).

People who may carry a diagnosis of personality disorder might have experienced trauma in their early years (Bolton et al., 2014; Boullier & Blair, 2018). They may have difficulties in

[15] There is some, though controversial, evidence of biological influences on the development of personality disorder, based on genetic studies (Royal College of Psychiatrists, 2020).

developing relationships, struggle with their emotions, feel rejected or hurt and at times avoid people. They may feel distressed in various aspects of their life, for example, at work or with family or friends and can have difficulties coping with this (Alwin, 2006; Bolton et al., 2014).

> '*We all have personalities, and we all have aspects of our personalities that are troublesome at times. People with personality disorder are not fundamentally different from anyone else, but might, at times, need extra help*' (Bolton et al., 2014, p. 9).

There is a prevalence of approximately 4-7% of the adult population in the community diagnosed with personality disorder (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006; Evans et al., 2017; Tyrer et al., 2015; Winsper et al., 2020). Newton-Howes, Cunningham, and Atkinson (2020) states that the World Health Organisation review by Huang et al. (2009) is the most comprehensive, albeit limited, epidemiological study to date, stating 6.1% prevalence across 13 countries. The prevalence of personality disorder in the community is higher in high income countries as compared to low to middle income countries (Winsper et al., 2020). In a review by Beckwith, Moran, and Reilly (2014) between 40 and 92% of people using community and outpatient services in Europe and the United States are eligible for a personality disorder diagnosis. Within the UK 30-40% of mental health patients are thought to have a personality disorder (HMPPS & NHS, 2020). It is therefore important for staff members (including students) in mental health services to have relevant understanding and skills to support such patients.

The reliability of the diagnosis of personality disorder is limited as most people do not fit in to set categories and comorbidity is common (Livesley, 2001b; Widiger, Simonsen, Krueger, Livesley, & Verheul, 2005; Winsper et al., 2020; Woods, 2001; Yakeley, 2019). There is considerable overlap not only within personality disorders but with other disorders also (Tyrer et al., 2015; Tyrer et al., 2019). Hence, the move to such terms as Complex Emotional Needs (Botham et al., 2020; Sheridan Rains et al., 2021; Troup et al., 2020).

Several policy documents produced over the past two decades focus on personality disorder[16]. These reflect aforementioned complexities and controversies due to the continued lack of consensus on diagnosis, classification and definition (National Institute for Mental Health In England, 2003b; Royal College of Psychiatrists, 2020).

Diagnosis can be a good starting point, though can hugely depend on how a person is told about their diagnosis (Lester, Prescott, McCormack, Sampson, & North West Boroughs Healthcare NHS Foundation Trust, 2020; Sheridan Rains et al., 2021). Formulation, however, can help staff understand individuals, explain what has happened to them and guide interventions that may be helpful (Bolton et al., 2014; Houghton & Jones, 2016). Formulation can be more useful in building shared understanding of a person's strengths and needs rather than simply applying a stigmatising label (Houghton & Jones, 2016). Flick Grey (2017) for example, discusses an alternative view of having personality disorder. She believes that *madness* is a deeply generative space and, in some ways, finds her *madness* a positive thing (Grey, 2017).

2.3.2 Recovery and personality disorder

Due to the contested nature of the diagnosis of personality disorder, recovery can be a challenging concept (Gillard et al., 2015). Neither the capabilities framework (National Institute for Mental Health in England, 2003a) nor National Institute for Health and Care Excellence [NICE] guidelines (National Institute for Health and Care Excellence, 2009, 2013) specifies how recovery is to be understood in the context of people carrying a diagnosis of a personality

[16] (Bolton et al., 2014; Bradley, 2009; Consensus Statement, 2018; Department of Health, 2009; Home Office & Department of Health, 1999; National Institute for Health and Care Excellence, 2009, 2013; National Institute for Mental Health in England, 2003a, 2003b; National Offender Management Service & NHS England, 2015; Royal College of Psychiatrists, 2020). The Bradley report discusses how the Mental Health Act (2007) established the principle that personality disorder as a mental disorder is a main stream condition requiring equal and appropriate consideration for assessment and treatment.

disorder (Gillard et al., 2015). In Gillard et al. (2015) patients with a personality disorder diagnosis described recovery in terms of their thinking, feeling and behaviour, where they could safely coexist in both their world and their external worlds without damage to themselves. A key finding in their study was the impact of positive relationships and social interaction. However, recovery is a unique and personal experience (Scotish Recovery Network, 2018), for some, their experiences are so traumatic they can never see a way to '*recover'* as others have defined it, hence the proposal to name the journey as discovery, rather than recovery (Bolton et al., 2014).

2.3.3 Gender

Antisocial personality disorder is a diagnosis generally associated with men and borderline personality disorder with women (Newton-Howes et al., 2020; Rogers & Pilgrim, 2021). Statistically, it is more likely for men in secure settings, the setting for this study, to have a diagnosis of antisocial personality disorder (National Collaborating Centre for Mental Health, 2018), hence further consideration of antisocial and dissocial personality disorders. Moran, Rooney, Tyrer, and Coid's (2014) Adult Psychiatry Morbidity Survey found that 3.3% of 18-64-year olds would screen positive for antisocial personality disorder and found that this was more common in men aged 18-34, than in older age groups or in women. However, as varying tools are used for diagnosis, the accuracy of such percentages are arguable (National Collaborating Centre for Mental Health, 2018). As Anderson et al. (2021) states diagnostic clarity may be particularly difficult in secure settings and there is problematic diagnostic overlap and lack of differentiation between antisocial and borderline constructs, hence borderline/ emotionally unstable personality disorder is discussed below.

2.3.4 Borderline personality disorder/ Emotionally unstable personality disorder

The most common personality disorder diagnosis is borderline (American Psychiatric Association, 2013; Newton-Howes et al., 2020) or borderline pattern (World Health Organization, 2018). Previously referred to as emotionally unstable borderline type (World Health Organization, 1992). The criteria include someone who may have unstable relationships, self-image, emotional and impulsivity difficulties (American Psychiatric Association, 2013; Bolton et al., 2014; World Health Organization, 2018). Often patients with this diagnosis present to services due to distress or attempting to gain support (Bolton et al., 2014; Newton-Howes et al., 2020). It is generally thought to be more common among women (National Collaborating Centre for Mental Health, 2009), however, the Adult Psychiatric Morbidity Survey (Moran at al., 2014) found no statistical difference between men and women screened positive for borderline personality disorder, hence the importance of its consideration here.

Many patients who carry a diagnosis of borderline personality disorder have experienced significant trauma (Bolton et al., 2014; Boullier & Blair, 2018). Due to the element of trauma being a strong feature of borderline personality disorder, there are similarities to Post Traumatic Stress Disorder [PTSD] (Bolton et al., 2014; Porter et al., 2020). There have been researchers who have considered borderline personality disorder as Complex PTSD [C-PTSD] as similar in presentation (Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Ford & Courtois, 2014; McLean & Gallop, 2003). Even decades ago, Herman, John, and van der Kolk (1989) found that 81% of patients with borderline personality disorder reported severe histories of child abuse or neglect (most of which began before aged 7 years). This has been further recognised more recently (Bellis, Lowey, Leckenby, Hughes, & Harrison, 2013; Boullier & Blair, 2018; DeLisi et al., 2017; Porter et al., 2020).

2.3.5 Adverse childhood experiences

There are strong links between experiences of trauma and adversity and development of mental health problems (Boullier & Blair, 2018; Young Minds, 2016) including personality disorder (Royal College of Psychiatrists, 2020). Adverse Childhood Experiences[17] [ACEs] are adverse or traumatic experiences that children may have that can affect them mentally and physically (Bush, 2018; Young Minds, 2016). The impact of adversity varies and may not be obvious (Haigh & Benefield, 2019; Sweeney et al., 2016). Sweeney et al. (2016) found that not only is there strong evidence to link experience of trauma and mental health problems but also that mental health services can retraumatise people[18]. Taggart (2018) argues for staff to see the person as they are, not how we think they should be, to free us from misrepresenting them as survivors. How people respond to those who have experienced trauma can mitigate or exacerbate loss of trust they feel as a result of trauma (Ratcliffe, Ruddell, & Smith, 2014). By building trust, a person who has experienced trauma can work towards relating to others and moving forward into their future (Ratcliffe et al., 2014). Awareness of ACEs is as relevant for men carrying antisocial personality disorder as for women carrying a borderline diagnosis (Ramsden, 2018). Particularly as there is high comorbidity present for patients in secure settings (Tyrer et al., 2019).

[17] As experienced as part of a person's *thrownness* into the world, as explored later in the thesis.
[18] Iatrogenic harm is the '*harm associated with the provision of care and treatment* [provided] *such as adverse reactions'* to medication, in addition to experiences of discrimination, stigma and aggression (Markham, 2021, p. 3). Put more simply, it is the harm (physically, emotionally, psychologically, spiritually etc.) caused by services. Various practices legitimated in services, such as restrictive or restraining interventions, can replicate previous experiences of trauma and abuse for individuals, and are hence retraumatising for such people.

2.3.6 Antisocial personality disorder

Antisocial personality disorder[19] is highly stigmatised[20] (National Institute for Health and Care Excellence, 2013). This may be due to the associated traits, including irresponsible and exploitive behaviour, recklessness, impulsivity, high negative emotionality, and deceitfulness (American Psychiatric Association, 2013). What is important to note, is that people so diagnosed have often experienced inconsistent and traumatic childhoods, where violence and aggression are normalised (National Institute for Health and Care Excellence, 2016; Ramsden, 2018). They can struggle managing distressing emotions and may react in what are viewed as extreme ways of coping with hugely traumatic upbringings (de Brito & Hodgins, 2009). Consequently, people with antisocial personality disorder can particularly find it difficult to build trust and maintain positive relationships (Austin, Goble, & Kelecevic, 2009; Kaylor, 1999; Ramsden, 2018). Hence, patients with the diagnosis are often viewed as rejecting of interventions (McRae, 2013) or difficult to reach (Thomas & Jenkins, 2019).

Prison services and secure mental health services have the highest percentage of patients with antisocial personality disorder at over 50%[21] (Fazel & Danesh, 2002; HMPPS & NHS, 2020; National Collaborating Centre for Mental Health, 2018; National Institute for Health and

[19] Antisocial personality disorder shall be referred to throughout as there is limited research specifically on dissocial personality disorder (de Brito & Hodgins, 2009) or as the new ICD 11 terms it; dissociality in personality disorder or personality difficulty (World Health Organization, 2018). The two diagnoses significantly overlap, the main difference is that in order to meet the criteria for antisocial personality disorder as compared to dissocial it requires evidence of conduct disorder before the age of 15 (American Psychiatric Association, 2013; World Health Organization, 1992). Perdikouri, Rathbone, Huband, and Duggan (2007) did not find any clinically important differences when they compared those with and without conduct disorder, however discuss that the criteria of dissocial is more reflective of core traits rather than behaviour. Although compared to dissocial personality disorder there is more research on antisocial, this remains a scarce area.

[20] In the DSM 5, antisocial personality disorder is categorised alongside histrionic, narcissistic, and borderline, in “cluster B” of the personality disorders, which are referred to as the dramatic and erratic cluster of personality disorders (American Psychiatric Association, 2013). There are three “clusters” of personality disorders: A, B, and C (American Psychiatric Association, 2013); patients with cluster B diagnoses are considered more likely present to services (National Collaborating Centre for Mental Health, 2009, 2018).

[21] Prisoners are ten times more likely to have antisocial personality disorder than the general population (Fazel & Danesh, 2002).

Care Excellence, 2013). Black, Thornicroft, and Murray (2013) found that patients report negative effects of having a personality disorder in the context of a secure service and pejorative attitudes experienced. However, this is an area with a paucity of evidence as the opinions of secure patients has been under researched (Long et al., 2012; Scholes et al., 2021), hence the important of this study. Cochrane reviews exposed a paucity of literature on antisocial personality disorder and therefore expanded searching to include childhood conduct disorder[22] (Gibbon, Khalifa, Cheung, Völlm, & McCarthy, 2020; Khalifa, Gibbon, Völlm, Cheung, & McCarthy, 2020).

Kaylor (1999) identifies that antisocial personality disorder is particularly difficult to diagnose however Coid (2003) states it is one of the most reliable of all diagnostic categories, and is based on robust scientific evidence (de Brito & Hodgins, 2009). It may be viewed as a commonly understood term, amongst health care staff, however accuracy is contested, and interchangeable use with '*psychopathy'* has been criticised (Bowen & Mason, 2012; Fitzgerald, 2008). Psychopathy can be considered as an extension of conduct disorder and antisocial personality disorder (Blair, Mitchell, & Blair, 2005; HMPPS & NHS, 2020) or on a spectrum of antisocial personality (Coid & Ullrich, 2010). Though psychopathy, is not embraced in any formal classifications (Abdalla-Filho & Völlm, 2020; Tyrer et al., 2019).

Services for people with a diagnosis of antisocial personality disorder

Services for people carrying any personality disorder diagnosis, though there has been increased provision, is variable (Dale et al., 2017). Services for people carrying an antisocial personality disorder diagnosis are often in criminal justice services, including secure services (National Collaborating Centre for Mental Health, 2018), the site of this study. Patients in secure services are often a neglected group (MacInnes, Courtney, Flanagan, Bressington, &

[22] Conduct disorder usually emerges in childhood or adolescence and characterised by severe antisocial and aggressive behaviour (Fairchild et al., 2019).

Beer, 2014; Reavey et al., 2019), despite often experiencing more severe adversity in addition to the most severe personality disorders (Tyrer et al., 2019). People who have experienced four or more adverse childhood experiences are eleven times more likely to be involved in criminal justice services (Bush, 2018), requiring increased support.

Duggan (2009) found staff in secure services can view therapeutic intervention as antagonistic for those with the diagnosis. Many staff believe that patients carrying an antisocial personality disorder should be managed by the criminal justice system[23] or are ambivalent in their response to treating them (McRae, 2013). Patients with a personality disorder diagnosis are more likely to be viewed as inmates as compared to other patients viewed as mentally ill, which results in more stringent practices (Jacob, 2012).

The context of secure services is distinct from other settings as it involves various restrictions (National Health Service, 2010; Rose, Peter, Gallop, Angus, & Liaschenko, 2011). For patients, secure services can feel like prison, like serving time (Chandley, 2000). Previous studies have found care in secure settings is not perceived as care but as punishment or containment (Hörberg & Dahlberg, 2015). Chandley (2000) explored the experience of time in secure settings, where patients are '*judged'* on the acceptance of an external view of time in that they are bound by others timetables of events, mealtimes, medication times, visitation times etc. They are assessed based on their acceptance or refusal of this state of time. For example, they are referred to as non-compliant if they do not follow the set timetables or seen as compliant if they '*conform'* (Hörberg & Dahlberg, 2015).

[23] Previously, treatment in the criminal justice system was often under-prioritised and under resourced (McRae, 2013). Following the close of the dangerous and severe personality disorder programme (Royal College of Psychiatrists, 2020), funding secured Offender Personality Disorder services in the United Kingdom, which provides screening, consultation and formulation, and joint working (HMPPS & NHS, 2020; National Offender Management Service & NHS England, 2015).

2.3.7 Attitudes

When discussing the term personality disorder, it is important to consider attitudes towards the term and towards the patients who carry the diagnosis. Attitudes are enduring thoughts and our thoughts we hold correspond with how we evaluate something; either positively or negatively (Edelmann, 2000). Attitudes and beliefs are overlapping constructs about acquired dispositions, and to some extent are implicated in how people behave towards the object of the attitude or belief. They can vary in strength of conviction, are learned or transmitted through culture, and, despite some being relatively impervious to change, even in the face of contrary evidence, they can be unlearned, modified or replaced by alternative views (Bergman, 1998).

A large amount of research on personality disorders have focused on '*attitudes'* towards the label (Eren & Sahin, 2016; Finamore, Rocca, Parker, Blazdell, & Dale, 2020; Murphy & McVey, 2003; Sheehan, Nieweglowski, & Corrigan, 2016), most typically in relation to borderline personality disorder (Dickens, Hallett, & Lamont, 2016; Ociskova et al., 2017; Ring & Lawn, 2019; Romeu-Labayen et al., 2020; Weight & Kendal, 2013; Westwood & Baker, 2010; Woollaston & Hixenbaugh, 2008). Hence Sheridan Rains et al. (2021) caution that generalisability of studies to other personality disorder is limited due to such a focus. Generally it is widely concluded that staff and public perceptions are negative (Rogers & Pilgrim, 2021). Conversely, a contemporary study exploring public perception of personality disorder, found that disclosing a diagnosis ameliorated negative responses to the individual (O'Connor & Murphy, 2020). In addition, Stevenson and Taylor (2020) report negative staff attitudes towards people carrying the label of borderline personality disorder have reduced due to more trauma informed thinking[24].

[24] See appendix 2 for exploration of trauma informed care.

There is limited research exploring staff attitudes towards antisocial personality disorder in secure services, despite it being an even more stigmatising label (Duggan, 2009; National Institute for Mental Health In England, 2003b). However other research (Ociskova et al., 2017; Sansone & Sansone, 2013; Sheehan et al., 2016) argues borderline is the most stigmatised, more strongly among health care staff, as compared to the public, aligning with O'Connor and Murphy (2020) findings. Nevertheless, negative attitudes are present towards both borderline and antisocial, in addition to the term personality disorder in general and therefore an important consideration in the context to any study in the area.

Despite a policy document going back some time, '*No longer a diagnosis of exclusion'* (National Institute for Mental Health In England, 2003b), problems of parity of care across services, negative attitudes and continued rejection persist (Consensus Statement, 2018; Royal College of Psychiatrists, 2020; Tyrer et al., 2019). Harking back to 1988, Lewis and Appleby (1988) found that patients given a diagnosis of personality disorder were regarded as more difficult to manage and less deserving of care. They criticised the diagnosis as a pejorative judgement rather than a clinical diagnosis. A more recent study using Lewis and Appleby's original questionnaire found psychiatrists continue to have poor attitudes towards individuals with a personality disorder diagnosis (Chartonas, Kyratsous, Dracass, Lee, & Bhui, 2017). However, despite calls for a change of terminology, Tyrer (2020) argues that any replacement would describe the same condition and would only be a matter of time before stigma was attached. Similarly, the Royal College of Psychiatrists (2020) report suggests such a change would cause confusion, diverting attention and funding away from those in need.

Nevertheless, negative attitudes create unnecessary barriers in services (Purves & Sands, 2009). Bowers et al. (2006) found that if staff have positive attitudes they will be less stressed and perform better[25]. Hence, it is crucial attitudes are explored and all efforts are made to

[25] See appendix 2 for further exploration of measuring attitudes.

present a non-stigmatising and positive view of people with a personality disorder diagnosis (Department of Health, 2009; Finamore et al., 2020).

Countertransference is often associated as the cause of negative attitudes and cultures (Yakeley, 2019). Many staff can struggle explaining and rationalising their feelings towards patients who have personality difficulties and this can be implicated in negative attitudes towards patients and burnout (Finamore et al., 2020; Murphy & McVey, 2003). Countertransference can be explained as the emotional reactions and responses of one person when interacting with another person, stemming from prior experiences (McCallum, 2010; Rayner, Allen, & Johnson, 2005; Yakeley, 2019). When thinking about mental health care, it is explained as the thoughts and feelings of staff when working with a patient, which are relevant to the patient's experiences, and illuminating these (Fonagy, 1998). A person's past experiences and relationships can impact on their future relationships, termed transference. Object relations theory postulates that these representations are often formed from significant people from our past and are experienced as good or bad (experienced as splitting) (Diamond & Hersh, 2020). In future interactions this can be silently projected on to others (Radcliffe & Yeomans, 2019). Often for people with a personality disorder diagnosis such experiences can be more intense and hence, countertransference is a common experience encountered by mental health nurses (Abram & Jacobowitz, 2021; Ens, 1999; Freestone et al., 2015; Garnham, 2009; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2013) and thus students (Abram & Jacobowitz, 2021; Scheick, 2011).

Staff can experience emotional labour, risk of violence, ethical implications of custodian roles and supporting patients who may harm themselves[26] (Delgado, Upton, Ranse, Furness, &

[26] In addition to burnout factors experienced by other health care staff, such as staffing, workload, poor leadership, lack of support and opportunity for development (Johnson et al., 2018; Pirelli, Formon, & Maloney, 2020). Healthcare staff can experience a dulling of ethical sensitivity as a result of moral distress where they experience feelings of pain in response to making decisions in morally difficult

Foster, 2017; Hammarstrom, Devik, Hellzén, & Häggström, 2020; Johnson et al., 2018; Lovell, 2017; Rayner, Beaumont, & McAndrew, 2021; Rayner, Allen, & Johnson, 2005). It can be distressing for staff to see patients struggling, and supporting them while managing their own reactions (Rayner et al., 2005; Vincze, Fredriksson, & Wiklund Gustin, 2015), in addition to risks posed from patients to themselves and sometimes others (Royal College of Psychiatrists, 2020). Staff can feel hopeless, resulting in negative service culture, defensive practices and risk aversion (Royal College of Psychiatrists, 2020). Such defensive practice can perpetuate staff anxiety (Menzies, 1960). Clinical supervision[27] and reflective practice are essential countervailing processes to such hazards (Pettman, Loft, & Terry, 2020; Scholes et al., 2021; Troup et al., 2020) necessary to reduce interference with the development of the therapeutic relationship and patient care (Mirhaghi, Sharafi, Bazzi, & Hasanzadeh, 2017; Rose et al., 2011; Royal College of Psychiatrists, 2020).

I have considered the term and controversy of '*personality disorder'*, specifically exploring antisocial and borderline diagnoses, and negative attitudes often present in health care services. Despite debates over the term, what is important here is salience to individuals and their perceived usefulness of the term, which is determined by them alone. I now turn to student mental health nurses who share time with patients carrying personality disorder diagnosis.

situations (Austin, Kagan, Rankel, & Bergum, 2008; Hammarström, Häggström, Devik, & Hellzen, 2019; Peternelj-Taylor, 2004).

[27] Clinical supervision refers to a professional relationship where a supervisor facilitates a supervisee to critically reflect on their practice within a safe space to enable learning opportunities (Markey, Murphy, O'Donnell, Turner, & Doody, 2020). However, supervision can be poorly planned and unsupportive (Turner & Hill, 2011). Nurses need to acknowledge and reflect on the feelings provoked to understand how they can impact on care (Benefield & Haigh, 2020; Jacob et al., 2009; Rayner et al., 2005) or they risk repeating toxic relationship styles (Royal College of Psychiatrists, 2020).

2.4 Student mental health nurses

Student mental health nurses complete the minimum of a bachelor's degree and also the professional qualification of registered adult, child, learning disability or mental health nurse by meeting the professional standards set by the Nursing and Midwifery Council[28] (Nursing and Midwifery Council, 2018b). The pre-registration nursing programme includes periods spent in university completing *'theory'* time, amounting for 2300 hours and the other 50% in *'practice'* spent on clinical placements in a variety of settings, including secure services (Nursing and Midwifery Council, 2018b). Of the staff working in mental health teams, student nurses often spend the most amount of time face to face with the patients (Jones & Black, 2008; Mukumbang & Adejumo, 2014). Students can closely work with health care assistants/ support workers who also have plenty of patient contact compared to registered staff (Wright & McSherry, 2013).

Students can experience various placements ranging from Child and Adolescent Mental Health services [CAMHs] to older adults, from primary care centres, to community or crisis team, to secure services. Often students in their second or third year of the programme may be allocated placements in secure units. On each placement they have set learning outcomes to achieve and observed assessments for example regarding care planning, medication and leadership (Nursing and Midwifery Council, 2018b). While on placement student nurses abide by the same code as registered nurses (Nursing and Midwifery Council, 2018a). Student mental health nurses may have experience of mental health work before and some may not. Many work alongside completing their degree, most in health care positions. Although Stickley

[28] Nursing education across the globe has unique elements, for example in some countries students study a generic nursing programme rather than in specific fields of adult, child, learning disability and mental health (as in the United Kingdom) (Palmer, Hutchings, & Leone, 2020). Mental health specific placements are included in generic nursing programmes (Happell, Moxham, & Clarke, 2011).

et al. (2010) states that working with mental health patients may be difficult for students, it can be rewarding for both students and patients through development of transferable skills (Andersson et al., 2020; Speers & Lathlean, 2015; Suikkala & Leino-Kilpi, 2001).

2.4.1 Contemporary issues in nurse education

Evidence based practice [EBP] has become a dominant focus in the education of nurses. However, some commentators feel this has devalued the complex interpersonal components of mental health nursing (Bell, Campbell, & Goldberg, 2015; Hewitt, 2009; McAllister, Robert, Tsianakas, & McCrae, 2019). Nevertheless, nurses not only need to have good practical and interpersonal skills but also to understand the evidence behind their roles, in addition to leading their teams (Moreno-Poyato et al., 2021). Mental health nurses have a responsibility in ensuring the future of the profession is informed, not only by evidence, but the right evidence (McKenna, 2017). This means not just focusing on hierarchical '*gold standard'* approaches such as randomised control trials, but most appropriate approach aligned with study aims (McKenna, 2017). Further to this, responding to the Francis report[29], Rolfe (2015) extends to nursing what Laing, drawing on Buber, argued about psychiatry in the 1950s; it privileges the scientific over the personal. Rolfe urges nursing moves away from such an uncritical standpoint and re-introduces some of Gadamer's ideology, the philosophical basis for human science; grounding nursing curriculum in the humanities rather than empirical sciences (Rolfe, 2015). There are undoubtedly important questions asked; whether nursing is an art or a science (Jasmine, 2009). Certainly, Rolfe (2015) considers '*I-Thou'* relationships as the foundation in nursing practice. Science can supplement this rather than override or replace it, which may be difficult in a culture dominated by a superficial evidence-based practice.

[29] Inquiry into the care at Mid Staffordshire NHS Foundation revealing profound failings of the NHS and recommendations of a cultural revolution (Francis, 2013).

Nevertheless, research informed teaching while linking to practice experiences can help bridge the theory-practice gap in higher education (Huston et al., 2018).

Reflective practice is also an essential part of student nurse training and indeed being a nurse (Cooke & Matarasso, 2005; Hwang et al., 2018). With encouragement given to complete reflective diaries throughout training (Hwang et al., 2018). Nursing students who reflect while in clinical settings find it effective for both personal and professional development (Karimi, Haghani, Yamani, & Najafi Kalyani, 2017) and the importance for understanding relationships (Ferrari, 2006; Perry, Watkins, Gilbert, & Rawlinson, 2013).

It is important to involve patients in student nurse education (Horgan et al., 2018; Kuti & Houghton, 2019; McMahon-Parkes, Chapman, & James, 2016; Perry et al., 2013) and assessment (Speers & Lathlean, 2015; Stickley et al., 2011). Although the importance of such involvement is recognised, support processes are variable (Debyser, Grypdonck, Defloor, & Verhaeghe, 2011). Happell, Byrne, Platania-Phung, et al. (2014) found when comparing a traditionally taught nursing programme to one that was lived-experience-led, a more positive outcome with regards to negative stereotypes and intentions to pursue mental health nursing from the lived-experience-led programme. An international collaboration for implementing consumer coproduced participation, the COMMUNE project (Co-production in Mental Health Nursing Education) has showcased best practice (Happell, Platania-Phung, et al., 2019; Happell, Waks, et al., 2019; Horgan et al., 2018).

2.4.2 Work/ practice-based learning (placements)

Placement experiences give students authentic opportunities to engage with patients with lived experience of mental health problems (Perlman, Patterson, et al., 2017; Perlman, Taylor, et al., 2017) and aid in increasing positive attitudes towards such individuals (Demir & Ercan,

2018; Martin, Krause, Chilton, Jacobs, & Amsalem, 2019; Martínez-Martínez et al., 2019) . Importantly, patients welcome interactions with students, find their presence facilitative, and are willing to participate in students' learning and believe they can contribute (Andersson et al., 2020; Richards, 1993). Students also believe patients have a valuable role to play in their learning (Andersson et al., 2020; Morgan & Sanggaran, 1997). Interpersonal relationships between students and patients are crucial for the development of a positive practice learning environment for the students (Andersson et al., 2020; Dunn & Hansford, 1997).

Placements can be challenging for students (Al-Zayyat & Al-Gamal, 2014; Tremayne & Hunt, 2019) and processes need to be in place to ensure students experiences are meaningful for learning (Manninen, 2016). The clinical learning environment is complex; it can be unpredictable and stressful (Baraz, Memarian, & Vanaki, 2015; Galvin, Suominen, Morgan, O'Connell, & Smith, 2015; Tremayne & Hunt, 2019). Students can have a nomadic existence, having to constantly adapt, adding to stress they feel (Tremayne & Hunt, 2019).

Students can feel fearful starting placements (Tremayne & Hunt, 2019) and can feel inadequate (Stickley et al., 2010). In clinical settings, students must face complex problems that can cause distress (Hung, Huang, & Lin, 2009; Melrose & Shapiro, 1999; Tremayne & Hunt, 2019). Students can express concern about engaging with patients with mental health problems; they can feel unprepared, unsure of what to say, have a fear of making a situation worse or of making mistakes (Abram & Jacobowitz, 2021). They can feel anxious from lack of confidence, skills or experience giving them a feeling of inadequacy (Suikkala, Leino-Kilpi, & Katajisto, 2020). Within such challenging environments, students can experience emotional distress and require additional support (Janse, Rensburg, Poggenpoel, & Myburgh, 2012). A key reason for students discontinuing nursing programmes can be poor placement experiences (James & Chapman, 2009). This can often be during the first placement experience, particularly if the student has never previously experienced mental health services

(Hung et al., 2009; Tremayne & Hunt, 2019; van Rhyn & Gontsana, 2004). However clinical placements have many benefits (Donnelly & Wiechula, 2013) and are crucial to forming a professional nursing identity (Pearcey & Draper, 2008; Terry, 2020).

To ensure student nurses are supported on placements, each is allocated a practice assessor (mentor) responsible for ensuring an effective learning environment and assessment of the students' skills (Nursing and Midwifery Council, 2018b). This clinical evaluation is an important aspect of a student's nurse training (Lewallen & DeBrew, 2012). Developing good communication skills is an integral component of nursing education and this assessment (Kameg, Mitchell, Clochesy, Howard, & Suresky, 2009; Nursing and Midwifery Council, 2018c).

McAllister and McCrae (2017) argue for more focus in nursing education on therapeutic engagement, however with a radically changing landscape in mental health services, including low levels of staffing and closure of units, other education methods for developing communication and engagement skills are needed. Research has been completed on the use of simulations[30] to bridge the theory-practice gap (Alexander, Sheen, Rinehart, Hay, & Boyd, 2018; Choi, 2012; Gaylle, 2019; Liaw, Palham, Chan, Wong, & Lim, 2015; Webster, 2013; Webster & Carlson, 2020). Liaw et al. (2015) found that simulation programmes used as an enhancement for student nurses improve transition from theory to practice. However, many argue that simulations are not a replacement for actual patient contact (Donnelly & Wiechula, 2013), hence the importance of involving patients in nursing education (Happell, Waks, et al., 2019).

[30] Simulated practice of clinical skills has been common practice for many years and there is evidence to suggest it can be effective (McNiesh, 2015).

Although students receive feedback from practice assessors, Debyser et al. (2011) and Stickley et al. (2011) found that patient feedback can be very meaningful for students' learning and development on placements. Warne and McAndrew (2007) discuss how patient '*expertience'* should be the centre of training and development as this risks becoming lost in '*doing'* nursing (p. 225). Few studies have investigated patient perspectives of supporting students learning in practice (Andersson et al., 2020).

Suikkala et al. (2020) state there is limited robust evidence about the relationship between patients and students, hence the relevance of this study. Nevertheless, student mental health nurses are taught about relationships[31] with patients as being different from other relationships they may have, for example with family members, friends or romantic partners (Ashton, 2016). Building relationships takes time (Shattell, Starr, & Thomas, 2007), which can be difficult for students who may have limited time on placement. This is an important consideration to discuss during a first encounter (Hubbard, 2016). In addition, if the nature of staff relationships is not clarified for students there is potential for confusion or boundary violations, which may be severely detrimental to both patients and students (Ashton, 2016; Valente, 2017). Boundaries are a particularly important consideration in relation to personality disorder (Livesley, 2003) and secure services (Jacob & Holmes, 2011; Kurtz & Jeffcote, 2011).

2.4.3 Secure mental health services' work-based learning

Many students are allocated to secure mental health services placements[32]. Students would be expected to get involved in every part of the placement area where possible[33]. Secure services are a complex field of nursing due to the psychological and ethical impact (Jacob et

[31] This '*relationship'* is discussed in more depth later.
[32] These can include; high, medium and low secure services as well as step down services and community specialist secure teams. They may also request to have placements in local prison services.
[33] Often 2nd and 3rd year students would be placed in secure units due to the nature of the ward environment and risks associated, rather than first year students.

al., 2009). There can be psychological impact on staff working in mental health settings and this can be heightened in secure services with powerful reactions to interpersonal relationships (Kurtz & Jeffcote, 2011). Exposure to violence affects staff, having implications for quality of care provided (Forte, Lanctot, Geoffrion, Marchand, & Guay, 2017). For students, there can be increased risk of experiencing aggression (Hopkins, Fetherston, & Morrison, 2018; Nau, Dassen, Halfens, & Needham, 2007), therefore, universities must prepare nurses to recognise and prevent forms of violence on placements (Hinchberger, 2009; Hopkins et al., 2018).

Developing a '*relationship'* can be especially challenging and complex in secure environments (Jacob & Holmes, 2011; Kurtz & Jeffcote, 2011). Often the focus can be on ensuring safety and managing risk rather than working therapeutically[34] (Hörberg, 2018; Jacob, 2012; Royal College of Psychiatrists, 2020; Tomlin, Egan, Bartlett, & Völlm, 2019), particularly for nurses for whom security and limit setting are priorities (Davies, Heyman, Godin, Shaw, & Reynolds, 2006; Holmes, 2005; Maguire, Daffern, & Martin, 2014). However, despite nursing teams' emphasising security and safety, a therapeutic ward atmosphere can be maintained (Muir-Cochrane, Oster, Grotto, Gerace, & Jones, 2013).

Previous studies show nurses in secure services can distance themselves from patients as a result of viewing them as dangerous based on criminal histories (Harris, Happell, & Manias, 2015; Jacob & Holmes, 2011; Vincze et al., 2015). Nurses can struggle supporting patients who have committed offences, leading to dehumanising practices (Austin et al., 2009; Jacob et al., 2009; Peternelj-Taylor, 2004; Rose et al., 2011). They can feel fearful which negatively affects the therapeutic relationship (Hammarström et al., 2019; HMPPS & NHS, 2020; Jacob et al., 2009; Jacob & Holmes, 2011; Lammie et al., 2010). Such anxieties can make it difficult for nurses to empathise, hence detachment becomes a coping strategy (Stevenson & Taylor,

[34] There can be negative beliefs about people's ability to recover if they are in secure services (Lammie, Harrison, Macmahon, & Knifton, 2010; McKeown et al., 2016). However, despite there being a long way to go on the road to recovery for patients in secure services, it is worth trying (McKeown et al., 2016).

2020). In a study of my own such fearful feelings on the part of students were not unique to secure services (Jones & Wright, 2017). This was related to anxiety over starting new placements in any area, hence the importance of further exploration of students' experiences in secure settings specifically.

I have considered student nurses and their learning within university and practice areas. I now consider the concept of time in the relational context of practice settings.

2.5 Time

The focus of this study is the '*time'* patients and students share on personality disorder units, it is therefore important to unpick what '*time'* means.

In the time patients and students share they may '*interact'*, '*engage'* and develop a '*relationship'.* Such terms have been identified in other similar studies and, often with a presumption a relationship typically exists in the first place. Relationships between staff and patient may be expressed as simply working together (Cook, Phillips, & Sadler, 2005). In my study I did not want to be restricted to simply exploring the relationship, rather wishing to explore the experience of time shared together in depth. I will, however, explore related commonly used terms as it is important to consider their context and then to consider them with regard to my study.

Chandley (2000) reflects that time can dominate our lives yet we are often ignorant of its meaning in context (Gibson, 1994; Waterworth, 2003). Jones (2010) writes about time and explores time, in the '*physical sense'*, as a structure conceived as a series of sequentially ordered points, measured numerically. More interestingly, '*psychological time'* is considered '*private time'* or '*phenomenological time',* how we experience time (Heidegger, 1927/2019), which is subjective and internal (Jones, 2010). It is how *we* experience time which may be different to time in the physical and measurable sense. Heidegger (1927/2019) wrote about time in relation to death[35]. Jones (2010) also considers '*social time'* being the time we experience through social interactions that is mutually agreed upon and driven by society. Humans are shaped by and shape these structures.

[35] Explored further in chapter 4.

The work of health care is embedded in time, arguably essential for the quality of care provided (Jones, 2015). Jones (2001) argued for attention to be given to the temporal character of matters such as nursing identity and the nature of nursing, and how this impacts both practice and research. Terry Jones has published several articles focusing on the issue of '*time'* in nursing (Jones, 2010, 2015, 2016), discussing both physical and psychological forms of time and the value of this time for patients (Jones, 2010). '*Time scarcity'* (p. 449) refers to a common occurrence in nursing that can reduce quality-of-care and the support nurses can access (Jones, 2016). Other writers have explored time in relation to the measurable time nurses spend with patients (Whittington & McLaughlin, 2000; Wright & McSherry, 2013). Various studies suggest very little time is spent delivering therapeutic activities and that patients spend a substantial time apart from staff or other patients (Cutler, Sim, Halcomb, Moxham, & Stephens, 2020; Moreno-Poyato et al., 2016; Sharac et al., 2010). Certainly, nurses working in areas where lengths of stay are increasingly shortened, struggle to spend time with patients (Suter et al., 2020).

2.5.1 Interaction

When staff spend time with patients they communicate and '*interact'*. They may engage[36] in conversation, make eye contact or sit with each other. Compassionate interactions are vital when working in health care to help ensure people feel supported and cared for (Barker & Williams, 2018; Rayner et al., 2021). Skills nurses use during such interactions include active listening, validation, clarification of understanding, use of silence among many more (Barker & Williams, 2018; Videbeck, 2009). Good communication skills, including non-verbal communication skills are vital (Chan, 2013). Interpersonal interactions are influenced by a person's values which are formed from their experiences (Stenhouse & Muirhead, 2017). Whatever the form of interaction it is vital that the person feels the nurse is present for them

[36] Further exploration of engagement is in appendix 2.

in that time. Communication is central to mental health nursing and through this process relationships can be enhanced and developed (Barker & Williams, 2018).

2.5.2 The '*relationship'*

For the purpose of this exploration I will focus on the relationship between health care staff and patients within mental health services, which has been explored by many authors and termed the *therapeutic relationship* (Barker & Buchanan-Barker, 2005; Farrelly & Lester, 2014; Forchuk et al., 1998; Freshwater, 2002; Freud, 1936; Peplau, 1988; Welch, 2005). This is presented here, for background[37].

It is hoped that, during the time patients and staff share together; during interactions and engagements, nurses will build relationships[38] with the patients they work with. The term used varies widely across articles, books and other documents and its meaning can vary (McAndrew, Chambers, Nolan, Thomas, & Watts, 2014; Wright, 2021). It is generally considered that this '*relationship'* is the relationship between health care staff and patients with the aim of supporting the patient to work towards their goals (Arnold & Boggs, 2015; McAndrew et al., 2014). However, this is not to say that the relationship cannot be between any two people and is helpful for either person or both, or, indeed, reflect group relations. Many relationships are therapeutic or helpful, even though they might be far removed from a professional context, for example, those that exist with pets. Also, the therapeutic relationship is not the only way a therapeutic effect can be achieved; computer programs, journaling and activities, for example, can be therapeutic and reduce distress, though even these can have relational elements (Carey, Kelly, Mansell, & Tai, 2012).

[37] A focused review of the literature pertaining to the study can be found in chapter 3.
[38] This '*relationship'* is referred to using a number of terms, for example; the '*therapeutic relationship'*, '*helping relationship'*, the '*working alliance'*, the '*nurse-patient relationship'* and the '*professional relationship'* (Forsyth, 2007; Kozart, 2002; Perraud et al., 2006; Wright, 2010).

There is no doubt that the *therapeutic relationship* is fundamental to nursing (O'Brien, 2001; Perraud et al., 2006; Stenhouse & Muirhead, 2017; Welch, 2005; Wright, 2010). It has been described as '*a cornerstone of nursing'* (Welch, 2005, p. 161) and at the heart of mental health nursing for over 50 years, remaining the core (Boggs, 2011; O'Brien, 2001; Perraud et al., 2006; Ross & Goldner, 2009; Stenhouse & Muirhead, 2017; Wright, 2021). However despite it being widely emphasised, there is difficulty in explaining what it is (Welch, 2005) or measuring it (McAndrew et al., 2014; Moreno-Poyato et al., 2016). Hence, there are varying perspectives of the therapeutic relationship (Barker & Buchanan-Barker, 2005; Peplau, 1988; Rogers, 1951). These established theories, amongst others, attempt to give understanding about the coexistence of patients and staff (Wright, 2010, 2021).

Freud (1936) was early in recognising the therapeutic value of relationships and the popular framework of Peplau (1988) is centred on the interpersonal relationship between nurse and patient (Gastmans, 1998; Stenhouse & Muirhead, 2017). Peplau's influential theory of interpersonal relationships is an essential nursing theory framework for the study of caring relationships, seen as vital to nurses work (Arnold & Boggs, 2015; Wright, 2021). Peplau's (1988) stages of the relationship are orientation, identification, exploitation/ working and resolution/ termination. However, Walsh (1997) found that relationships between patients and mental health nurses did not end at the termination stage and were not necessarily experienced in the linear way Peplau described. Delaney and Ferguson (2014) argue that interpersonal neuroscience revitalises Peplau's notion of relationships bringing new language to her concepts. Travelbee (1966) also extended the theoretical literature on the therapeutic relationship in nursing, however as she died at a young age, Shattell et al. (2007) notes her work is less known. Buber (1937) writes of an *'I-Thou'* relationship and coming to a shared understanding through dialogue, discourse and reason (Rolfe, 2015).

Rogers (1951) also promoted the patient centred (person centred) hypothesis that is now considered fundamental to the development and sustainability of therapeutic relationships. A further theory important to therapeutic engagement and relationships is the Tidal Model (Barker & Buchanan-Barker, 2005), this extends and develops some traditional assumptions concerning the centrality of interpersonal relations within nursing practice (Barker, 2001).

Good interpersonal skills and effective communication are essential when staff engage with patients and can result in improved relationships (Ellis & Day, 2018; Peplau, 1988; Rogers, 1951). It is paramount (Ross & Goldner, 2009), seen as the foundation of care and, even described as healing (Benner, 1984/2001; Wright, 2010), and the form of particular interventions is not as important as the underpinning therapeutic relationship (Browne, Cashin, & Graham, 2012; Cahill, Paley, & Hardy, 2013).

2.5.3 Therapeutic milieu/ landscape

Experienced with therapeutic relationships; a therapeutic milieu, landscape or climate promotes a healing environment and holistic support framework supporting positive outcomes (Banks & Priebe, 2020; Hallett & Dickens, 2021; Mahoney, 2009). However, Thibeault, Trudeau, d'Entremont, and Brown (2010) criticised the concept for having a lack of relevance to mental health environments due to patients being admitted for shorter periods of time. Nevertheless, a therapeutic landscape is a space with social conditions conducive to healing (Gesler, 1992); where the person feels safe and that they belong (Relph, 1976). Hence, in longer term placements like secure services, it has the potential to improve outcomes for patients by considering importance of people's interconnected nature and environments (de Vries, Brazil, van der Helm, Verkes, & Bulten, 2018; Dickens, Suesse, Snyman, & Picchioni, 2014).

The notion of therapeutic landscapes was originally introduced by Gesler (1992), examined by Moos and Houts in the 60s in mental health settings (Dickens et al., 2014) and more recently applied to mental health hospitals (Muir-Cochrane et al., 2013) and secure units (Bressington, Stewart, Beer, & MacInnes, 2011). Banks and Priebe (2020) argue that therapeutic milieus are a treatment in their own right, encouraging recovery, though can highly depend on nurses' skills in managing difficult situations or utilising transparency (Snell, Crowe, & Jordan, 2010).

There are various tools for assessing ward climate (the therapeutic landscape), though according to Dickens et al. (2014) are unvalidated and there is limited evidence. de Vries et al. (2018) recommend interviews to explore more detailed information about ward climate. Ward climate or social climate are other terms used to describe the interactions between the material, social and emotional conditions of a space that influence the people in it (de Vries et al., 2018). The importance of milieu within such landscapes can be traced in a lineage of relational approaches from therapeutic communities (Benefield & Haigh, 2020; Haigh & Benefield, 2019) to the development of psychologically informed environments (Banks & Priebe, 2020). Safewards are an example of how milieu factors can contribute to safety as a further element of benefit (Bowers, 2014).

2.5.4 Potential difficulties in developing relationships

Despite the suggested importance of therapeutic relationships and landscapes within nursing practice, Moyle (2003) disputes these occur effortlessly. There can be several potential difficulties in establishing and maintaining a therapeutic relationship with patients. These can include failing to establish a connection or common ground to build upon, patients' willingness and readiness to engage (Ellis & Day, 2018), differences in values (Forchuk et al., 1998), responses to communication for both the nurse and patient (Sheldon et al, 2006), conflicting

personalities, and perceived attitudes of the nurse (Forchuk et al., 1998). Needleman (2006) discusses '*roadblocks'* (p. 3) as problematic beliefs and responses and how staff need to identify their own personal and emotional schemas that may interfere in developing relationships.

Power dynamics can negatively influence relationships (Mann, Matias, & Allen, 2014; Pieranunzi, 1997; Simms-Sawyers, Miles, & Harvey, 2020). McCaffrey (2014) explored the host and guest roles for mental health nurses, replete with hierarchy and power. Various authors have historically theorised a relationship between power, oppression and mental distress in psychiatry, nursing and wider society (Fanon, 1952/1967; Foucault, 1975/1977; Hopton, 1995), persisting within current mental health care (Cheetham, Holttum, Springham, & Butt, 2018; Hörberg & Dahlberg, 2015; McKeown et al., 2020). Even therapeutic relationships resonate with power, and such relationships can be a means for staff to exercise control (Cutcliffe & Happell, 2009). Critical pedagogy questions inequalities of power, access to knowledge and prevailing cultures: empowering people to resist their disempowerment (Burbules & Berk, 1999; Freire, 2007; Rogers & Pilgrim, 2021).

2.5.5 Building relationships with people with a diagnosis of a personality disorder

The value of therapeutic relationships assumes particular importance when supporting patients carrying a personality disorder diagnosis (Benefield & Haigh, 2020; Bowen & Mason, 2012; Jones & Wright, 2017; Livesley, 2003; Royal College of Psychiatrists, 2020; Sheridan Rains et al., 2021; Skodol & Bender, 2016). In a study by Helleman, Goossens, Kaasenbrood, and van Achterberg (2014), the patients who participated emphasised quality of contact with nurses as the most important aspect of their care. Helleman et al. (2014) concluded that, due to interpersonal hypersensitivity patients with personality disorder traits can experience, the connection with nursing staff is vital. Having a strong connection can support a patient in

working towards recovery and a positive quality of life (Benefield & Haigh, 2020; Katsakou & Pistrang, 2017). The effectiveness of treatment can be hugely impacted by the therapeutic relationship (Ramsden, 2018; Wenzel, Jeglic, Levy-Mack, Beck, & Brown, 2008). However, poor relationships can reinforce patients' psychopathology, causing further damage and distress (Ramsden, 2018; Rapp, 2001; Ross & Goldner, 2009).

For patients with traumatic histories, building relationships and trust with others can be particularly difficult (Bolton et al., 2014). For patients with traits of antisocial personality disorder, developing relationships can pose significant difficulties (Kaylor, 1999; Ramsden, 2018). Hence, a greater emphasis needs to be given to this relationship in working with patients with a personality disorder diagnosis as compared to other mental health problems (Livesley, 2007). The therapeutic relationship can improve concordance and is part of the common factor approach Livesley (2007) argues as the basis for the treatment of personality disorder, yet there are few studies that review this.

More attention needs to be given to this relationship as every patient and each staff member is individual, the dynamics in each relationship are very different making it impossible to measure, resulting in gaps in the evidence base (McAllister et al., 2019; McAndrew et al., 2014; Thomas, 2007). This relationship can be less therapeutic when there are notable prejudices and negative attitudes towards patients diagnosed with personality disorder (Ross & Goldner, 2009).

2.6 Conclusion

In this chapter I have accounted for the context important to consider for this study. Patients are people who may need support at some point in their lives from mental health services. Many will, as part of their treatment, be given a diagnosis of a personality disorder, which is a

term that attracts much criticism. Student mental health nurses complete a professionally regulated education and will spend 50% of their learning time on clinical placements. When there, they are expected to spend time with patients, many with a personality disorder diagnosis, support and help them work towards recovery or discovery. When patients and students share time together, they interact, engage, and may form relationships, which are potentially therapeutic. The necessary efforts required to craft such caring relations would appear to have a strong temporal dimension, though this is under-researched.

The following chapter will now consider specific literature focused on studies exploring the time patients and students share together on personality disorder units and what is already known.

3 Integrative review

In the previous chapter I explored relevant context by discussing the main concepts in this study. I investigated each topic of relevance, personality disorder diagnosis, student mental health nurses and time. It provided both general and focussed information by way of introduction to the study area.

3.1 Introduction to the chapter

Here I present an integrative review of relevant literature, conducted systematically to inform the research, including discussion of the specific literature explored and the strategy used to gain such literature. The review also involved critical appraisal of included studies, using the Walsh and Downe (2006) framework. The findings of this review are presented and discussed with recourse to identified themes. The chapter concludes by suggesting the potential contribution my study can make to the evidence base. The integrative review presented here was published in the journal Nurse Education Today[39] (Jones et al., 2020).

3.2 Introduction to the integrative review

It is important to begin this chapter by addressing that in phenomenological studies the participants' experiences are the focus, other evidence simply provides resonating elements to demonstrate understanding and transferability (Dibley et al., 2020). The researcher brings their own subjective experiences to bear within this interpretive and reflexive context, and is typically cautioned to be mindful of the hazards of bias and undue influence (Holloway & Wheeler, 2010). Therefore, prior consideration of various studies, already completed, can

[39] Included in appendix 23.

raise an immediate concern for some (Holloway & Wheeler, 2010). Moreover, in approaching the literature (and the study) my location as an academic with specialist interest in the field and respected practice experience and expertise with the relevant patient group, adds a further layer of complexity to considerations of my positioning within phenomenological inquiry. I already had a starting place and understanding of the area, or as Heidegger would suggest a '*fore-grounding*'[40] (Smythe & Spence, 2012).

A case can be argued for the appropriateness of undertaking literature reviews in advance of phenomenological studies. Walsh and Downe (2006) argue that conducting a literature review is an essential component of the research process and it is important to conduct a review to identify what has been done already; allowing identification of any gaps in the research area, supporting the rationale for undertaking the intended research (Hart, 2018). There are some who would argue that phenomenology does not fit with empirical research which is about a persons' lived experiences not a comparison of various and different experiences (Smythe, Ironside, Sims, Swenson, & Spence, 2008). However, it is an important part of conducting a doctorate to ensure the particular focus of the research is original (Hart, 2018). Additionally, Smythe and Spence (2012) argue the purpose of a literature review in hermeneutic research is not only to show a gap but to provoke thinking. I have therefore conducted an integrative literature review for this reason; to invoke thinking in the reader, in addition to move between what I already know and what I am yet to know to enable me to deepen my knowledge and understanding of the field. This involved a systematic search strategy to ensure a robust exploration of evidence. The ability to include more diverse methodologies and combine analysis is particularly important for a comprehensive overview of the literature and understanding of the topic areas (Haracz, Ryan, Hazelton, & James, 2013; Whittemore & Knafl, 2005).

[40] As identified in chapter 1 and further explored in chapter 4.

3.3 Integrative review

There are various types of literature reviews that can be conducted. An integrative review was chosen as the focus was across different areas (time, student mental health nurses, patients, and personality disorder) and methodologies. An integrative review utilises a systematic method and thorough search strategy (Noble & Smith, 2018). Gildberg, Elverdam, and Hounsgaard (2010) note analysing findings from a spread of methods can have limitations. However, including diverse methodologies and analysis enables a comprehensive overview of the literature and understanding of the topic area (Haracz et al., 2013; Whittemore & Knafl, 2005). Qualitative research has previously been excluded from systematic reviews, however researchers are trying to move towards more inclusive reviews (Dixon-Woods et al., 2006).

The review followed appropriate principles from Joanna Briggs standards (Lizarondo et al., 2017) and completion of a Preferred Reporting Items for Systematic Reviews and Meta-Analyses [PRISMA] flow diagram (Moher, Liberati, Tetzlaff, & Altman, 2009; Page et al., 2021) (figure 2). Medical Subheadings [MeSH] terms were utilised to ensure the search strategy was robust. The notion of '*time'* presented a lexicological challenge in selecting appropriately alike alternative search terms (see table 3). In addition to this, if the focus had been solely on either quantitative or qualitative studies, important and enlightening papers may have been missed, hence an integrative review was appropriate. Publications from peer-reviewed journals were reviewed and a quality appraisal tool was used. Databases searched are included in table 1. Inclusion and exclusion criteria were applied to ensure focus (see table 2).

Following Jensen and Laurie (2016), preparing the literature review involved circling back to make adjustments, to refine the focus and confirm evidence. It can be difficult to maintain focus and not get caught reading unrelated articles (Jensen & Laurie, 2016). In a reflexive process, I continually made notes, recording my thinking on choices made for including articles

or not. It is important to make notes of such decisions when searching literature (Jensen & Laurie, 2016).

3.3.1 Aim of integrative review

To explore evidence about the time patients and student mental health nurses share together on secure personality disorder units.

3.3.2 Resource searching

A combination of search terms were used, table 1 below shows the databases searched. To supplement these searches, forward and backward chaining of reference lists were also completed.

Table 1: Databases searched

Academic Search Complete
AMED - The Allied and Complementary Medicine Database
British Education Index
Child Development & Adolescent Studies
CINAHL Complete
Criminal Justice Abstracts with Full Text
eBook Collection (EBSCOhost)
Education Abstracts (H.W. Wilson)
Educational Administration Abstracts
ERIC
Humanities International Complete
MEDLINE with Full Text
PsycARTICLES
PsycINFO
SocINDEX with Full Text
Social Sciences Full Text (H.W. Wilson)
Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to Present

3.3.3 Inclusion and exclusion criteria

Because such searching typically locates a mixture of relevant and irrelevant papers, inclusion and exclusion criteria are required. To ensure appropriate papers were selected inclusion and exclusion criteria were set (see the table below).

Table 2: Inclusion and exclusion criteria

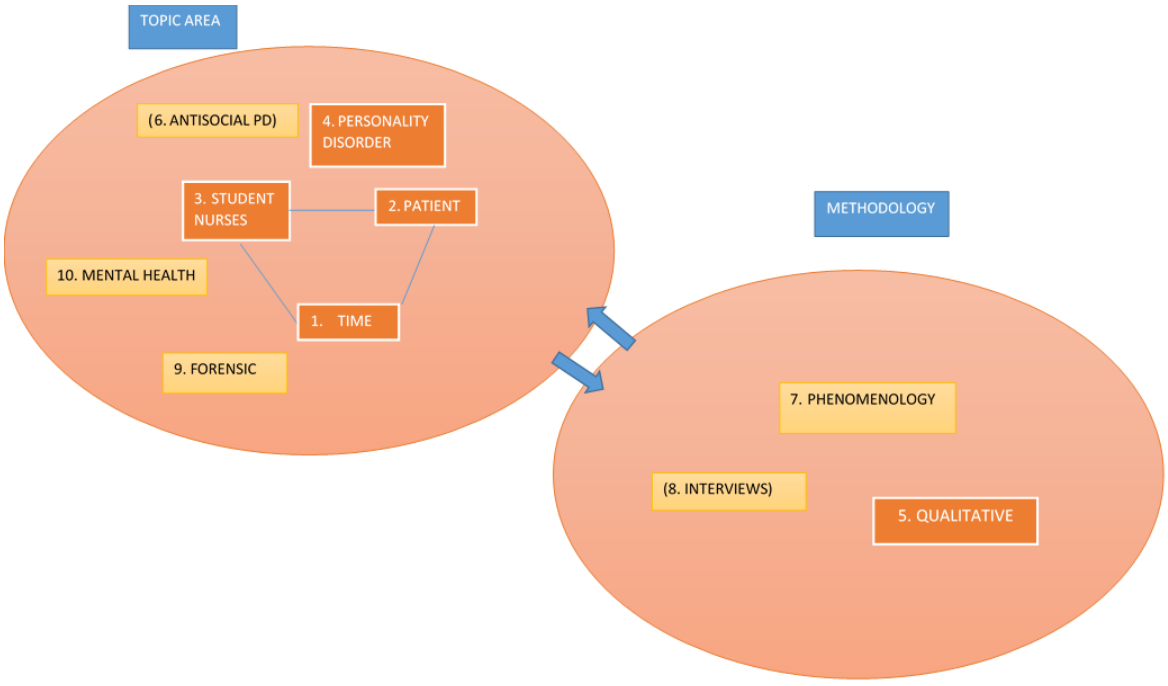
Inclusion Criteria	**Exclusion Criteria**
Studies reported in English Studies published from 1946 to the present to ensure thorough searching and of older texts Studies using the terms identified in the search terms tables Boolean restrictions were used	Studies that focused solely on psychopathy Studies that focused solely on adolescents Studies that focused solely on therapeutic communities, specific therapies or prisons Studies that focused solely on addiction Studies focused solely on self-harm or suicide Studies focused purely on other disciplines other than nursing Studies not written in English not translated

3.3.4 Search terms

A search term diagram was completed to support the search strategy and to ensure a robust search was conducted, based on Hart (2018).

Figure 1: Search term diagram

The terms in orange denote the primary search terms and the terms in yellow denote the secondary search terms. I used this exercise to help visualise the search to determine search terms. As there was a paucity of evidence surrounding the time patients and students share together on secure personality disorder units, broader searching was required using the secondary search terms.



Following this, Medical Subheadings [MeSH] terms were reviewed to ensure the search terms were correct (see table 3 below[41]). I then completed three searches, the first in Ovid 1946 until

[41] In addition to more detail provided in appendix 3.

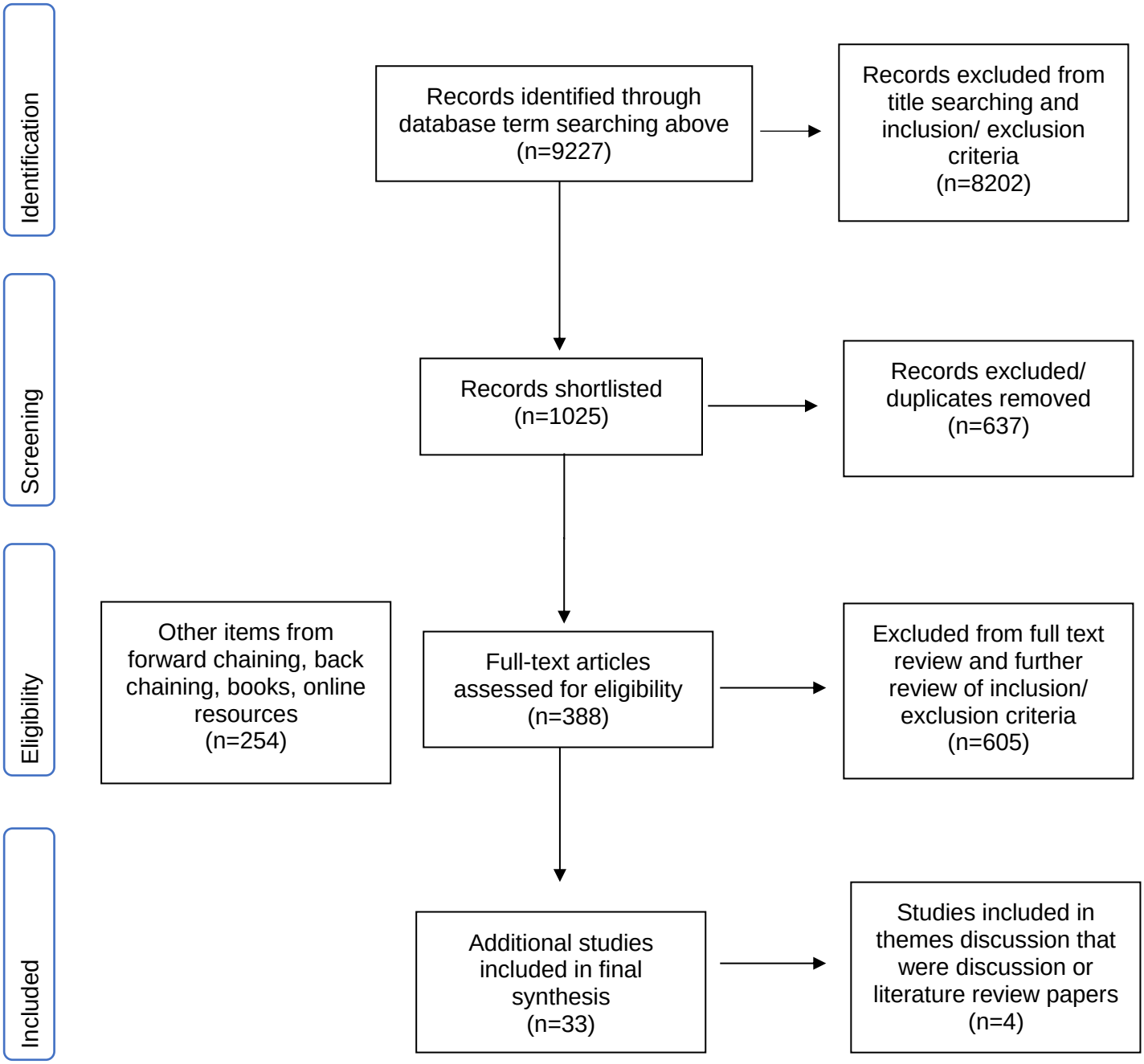
31.05.17, an updated Ovid search from 2017 until 03.02.20 and an EBSCO search 1946 until 03.02.20. For each of these I completed narrowed searches using the search terms[42]. In addition to this I also completed a study eligibility flow diagram (PRISMA flow diagram) for each search. Figure two is the PRISMA diagram for all the searches completed.

Table 3: Search terms

Search terms
Time OR Interact* OR Engag* OR Trust* OR Relation* OR Allianc* OR Nurse-patient relation* OR Therapeutic relation* OR Therapeutic alliance OR Helping relation* OR Working relation* OR Helping alliance OR Working alliance OR Professional relation* OR Professional-client relation* OR Student-Patient relation* OR Dual relation* OR Client relation* OR Interpersonal relation* OR Therapeutic milieu OR Therapeutic landscape OR Therapeutic environment OR Connect* OR Click* OR Talk* OR Temporal* AND Patient* OR Patient* OR Client* OR Service user* AND Nurs* student* OR Nurs* education OR Students, nurs* AND Personality disorder*
Additional search terms to refine searching
Mental health service* OR Psychiatric nurs* OR Psychiatric hospital* OR Psychiatr* Patient* OR Hospital*, psychiatry* OR Mental institution* AND Secure OR Forensic OR Secure mental health OR Forensic mental health OR Forensic nurs* AND Qualitative OR Qualitative research OR Qualitative Stud* (to refine)

[42] See appendices 4-6.

Figure 2: PRISMA flow diagram (All searches)



3.3.5 Search outcome

A screening process was followed, reflecting the above inclusion and exclusion criteria and applied first to the title and abstracts (please refer to above PRISMA). Following this, the criteria was applied to the full papers. Once full papers were identified, data was extracted using a proforma structured around the following headings: authors, year, country, service, study type, sample, students, patients, time, therapeutic relationship, personality disorder, theme. In addition to this, EndNote[43] was used to store the key papers and the key paper table[44] supported thematic analysis of the findings.

Following the above process, 37 papers were selected, reviewed and discussed within the integrative review included: 23 qualitative papers with approaches: phenomenology (5), interpretative phenomenology (4), content analysis (2), journal analysis (1), phenomenology discussion paper (1), participatory research (1), grounded theory (1), qualitative-visual study (1) and generic qualitative methodology (7). There were 4 mixed methods, 3 cross sectional studies, 3 survey studies, 2 discussion papers, 1 qualitative review and 1 literature review. There were 15 studies completed in the UK, 5 in Sweden, 4 in America, 3 in South Africa, 3 in Australia, 2 in Denmark, 2 in Norway, 1 in Canada, 1 in Turkey and 1 in the Netherlands. The discussion and literature review papers (4 from the 37) were included in a separate key paper and quality appraisal process to ensure the robustness of the quality appraisal of this review, however they have been included in the discussions of themes as they provide interesting information that is important to review. The studies date from 1996 to 2020 with the majority being published between 2010 and 2020[45].

[43] Referencing software.
[44] Appendix 7.
[45] Please refer to appendix 7.

24 studies explored the therapeutic relationship either initially or it was identified as a theme. An additional 12 refer to interactions, communication or engagement. Only 1 paper specifically explored time as a concept however this came up in the results of 9 other papers. Eighteen of the studies were completed in mental health services. 16 were focused on secure care: 3 of which looked specifically at personality disorder, another 2 papers also had patients carrying a diagnosis participating or staff who were working with patients with a diagnosis of personality disorder. 6 studies involved student nurses. 20 studies interviewed patients.

3.4 Quality appraisal

Quality appraisal is a process whereby the methodology, research design and findings from research studies are assessed critically for their quality, clarity and comprehensiveness of reporting (Petticrew & Roberts, 2006). Walsh and Downe's (2006) critical appraisal framework, based on a review of available quality frameworks and recognition of the complexities of meta-synthesis, was utilised to review the research studies shortlisted[46]. This framework is designed primarily for the critical appraisal of qualitative studies, but is useful as part of an integrative review, being concise, robust, and flexible.

Others have been criticised for being either too lengthy (Sandelowski & Barroso, 2002; Spencer, Ritchie, Lewis, & Dillon, 2003) or lacking in robustness (Critical Appraisal Skills Programme, 2014). It is, however, important to note, that there is no standardised tool free from limitations (Walsh & Downe, 2006). As argued by Morse (2021), and Rolfe (2006), particularly in relation to qualitative research, checklists and tools ignore the value of the research and undermine their contribution. Hence my approach to use the Walsh and Downe (2006) summary framework without the specific grading criteria (Downe, Simpson, & Trafford, 2007), feeling it was important to apply common sense (Morse, 2021; Sandelowski & Barroso,

[46] See appendix 8.

2002) and take caution not to reject studies purely on a grading system (Morse, 2021; Pawson, 2006). I did, however, make a broad judgement of '*high'*, '*medium'* or '*low'* quality for clarity and consideration. In addition to this, due to the large area reviewed, some studies were discussion papers and quantitative papers and it was important not to dismiss them as their conclusions were of relevance.

3.5 Themes

In reviewing the key papers, a thematic analysis process (Braun & Clarke, 2006) identified four distinct but inter-related themes under which the reviewed studies will be discussed[47]. I read and re-read the articles, generated initial key themes (codes) across the papers, through supervision reviewed the themes and began producing an analysis[48] which subsequently lead to the discussion below.

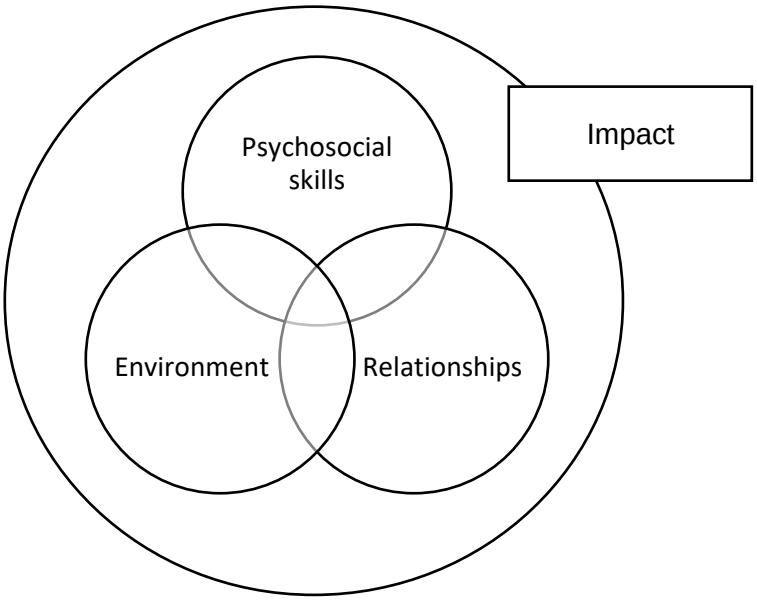
1. '*Psychosocial skills'*
2. '*Relationships'*
3. '*Environment'*

'*Impact'* (overarching theme connecting 1-3)

[47] Please refer to appendices 7-9 for further details about the studies being discussed and the appraisal of their quality.
[48] Please refer to appendix 9 for detailed consideration of the key papers which supported this process.

Figure 3: Thematic map

The thematic map shows the interlinking nature of the themes identified in the integrative review and how '*Impact'* straddles all themes.



3.5.1 Development of themes

To ensure rigour a reflexive process was undertaken throughout (Jensen & Laurie, 2016). Findings of the articles were read, and notes made to identify common themes. A synthesis of findings are provided below[49]. I provide a conclusion at the end to complete the discussions.

[49] Detailed exploration of main elements of the appraisal and findings of each study can be found in appendices 8 and 9.

3.5.2 Theme 1: Psychosocial skills

The articles reviewed described a range of psychosocial skills all staff and therefore students need to practice. These skills include: maintaining thoughtful professional boundaries, and the development of self-awareness to monitor and manage the impact of countertransference and interpersonal style (Bowen & Mason, 2012; Kurtz & Turner, 2007; Scheick, 2011). Managing the impact of countertransference is of particular importance when supporting patients carrying a diagnosis of personality disorder (Kurtz & Turner, 2007). A high proportion of patients carrying a personality disorder diagnosis are supported in secure services, as well as local inpatient settings (National Institute for Health and Care Excellence, 2009, 2013). Bowen and Mason (2012) and Kurtz and Turner (2007) differentiate skills needed in secure services compared to non-secure services (Cleary, Hunt, Horsfall, & Deacon, 2012), emphasising skills to manage security, such as maintaining boundaries, rather than communication and personal skills, referred to in Cleary, Hunt, et al. (2012) review of acute adult services. Ketola and Stein (2013) found that if student nurses developed such listening, communication and self-reflection skills on their placements they were able to be empathic of patients thus enhancing the time spent together, which enabled the students to grow, personally and professionally.

Bowen and Mason (2012), although having a large sample of nurses completing their survey, did not explore the thoughts of patients about the skills needed by staff, as is missing from the other studies in this theme. Bowen and Mason (2012) also group '*personality disorder'* with '*psychopathy'* a questionable decision, though they do explore their rationale for this in the background. Kurtz and Turner (2007) further address requisite skills, as compared to Bowen's study, to explore necessary supportive systems in order for staff to cope, including coping with reported feelings of vulnerability. This includes good multidisciplinary working and group supervision utilising a reflective approach. Reflective discussion was recommended in

Oostvogels, Bongers, and Willems (2018) study to enhance compassionate behaviour of staff working with patients carrying a personality disorder diagnosis.

Yildiz (2019) highlight students' need for supervision due to their encounter of communication barriers when caring for patients and experiencing the effects of countertransference. Having the skills to manage the impact of various interpersonal dynamics is common across both Kurtz and Turner (2007) and Scheick (2011) papers. Scheick (2011) complex mixed methodological study specifically considers the impact of countertransference in mental health services and how self-awareness and mindfulness are key areas for students to explore. In using a template designed by the author the students' ability to self-monitor countertransference was enhanced and had a positive effect on their learning and thus their practice.

3.5.3 Theme 2: Relationships

The second theme identified was '*relationships'*. Such human relations are made through our communications and interactions with others in our lifeworld (van Manen, 1997). Building relationships within mental health care, and especially in working with people with a personality disorder diagnosis, is vital. The articles reviewed considered aspects of relationships such as attachment styles and seeing the person. Aiyegbusi and Kelly (2015) and Evans, Murray, Jellicoe-Jones, and Smith (2012) discuss the importance of staff being aware of attachment styles of the patients they are supporting, when building relationships. Aiyegbusi concluded that training should be accessed by staff to build resilience and increase awareness of attachment processes, which will enhance understanding of the patient. Indeed, developing an understanding of the patients is also important for student nurses (Johansson & Martensson, 2019). Aiyegbusi integrated a Delphi study with a phenomenological approach with patient and staff participants. Some research phenomenologists would propose that phenomenology should not be part of a mixed method approach which risks detracting from

the authentic nature of lived experience (Moran, 2000). However Mayoh and Onwuegbuzie (2015) argue that phenomenological methods work extremely well as a component of mixed methods research. Jenkins and Coffey (2002) also completed a mixed methodology approach highlighting the importance of the therapeutic relationship in often complex situations and how education and preparation should include reference to the value of this relationship. McAllister and McCrae (2017) ask for more emphasis of therapeutic engagement in nurse education. Rask and Brunt (2006) also recommend priority for skills training to promote effective interactions, aligning with theme one.

Bacha, Hanley, and Winter (2019) conclude that services should be focused more upon care rather than power and control. Equally, Evans et al. (2012) and Gildberg et al. (2010) found that being mindful of relationship security including managing risk and maintaining boundaries was significant. Evans et al. (2012) do, nonetheless, discuss the impact of seeing the person and being present when spending time with patients, which is also highlighted by Salzmann-Erikson, Rydlo, and Wiklund Gustin (2016), Shattell et al. (2007) and Walsh (1999). Unlike Walsh (1999), Langley and Klopper (2005) interviewed both patients and staff to ensure experiences were gained from both parties involved in the relationship. They highlighted trust as being a foundation for any relationship. Cameron, Kapur, and Campbell (2005) stress the importance of getting to know individuals, in addition to considering countertransference, for optimising therapeutic relationships between patients and nurses, improving interpersonal experiences.

Three of the studies explored student nurses experiences of the therapeutic relationship, including the importance of talking about '*normal stuff*' (Johansson & Martensson, 2019; Jones & Wright, 2017; Looi, Savenstedt, & Engstrom, 2016). It has been noted more broadly that patients often value ordinary talk and interaction (Cleary, Hunt, et al., 2012), and this may even be associated with distinct therapeutic gains (Lakey & Orehek, 2011). New sociological interest

in the mundane materialities of care emphasises the importance of such, often taken for granted, aspects of the everyday, and their impact on relationships (Brownlie & Spandler, 2018; McKeown et al., 2020). Jones and Wright (2017) found that students' perceptions of building a relationship with patients carrying a personality disorder diagnosis were impacted upon by other staff. However, despite other staff '*clouding their judgment'*, the students saw the importance of seeing the person rather than the diagnosis. The students in Johansson and Martensson (2019) study also saw the value of getting to know the patient to create good relationships, which can only be done by spending time together.

3.5.4 Theme 3: Environment

The impact of the environment on interactions is important within mental health care to ensure patients feel valued and that students and staff have the time to spend with patients. In this sense, the environment comprises an amalgam of material and psychosocial attributes, or '*lived space'* (spatiality) (van Manen, 1997). Patients in two focus groups in the Long et al. (2012) study highlighted the importance of hope, engagement in treatment and developing a sense of self-worth as essential to a positive treatment milieu. Shattell, Andes, and Thomas (2008) found that a key environmental element relevant to nurses was the therapeutic relationship, as discussed in theme two, however the patients in the study did not discuss the relationship at all. The patients found that their caring experience was derived from other patients in their environment rather than nurses. Their experiences of the mental health unit were not described to be a therapeutic milieu; patients felt bored, that their needs were unmet, and the environment was not only ineffective but harmful. These findings align with Mollerhoj and Os Stolan (2018) study, in the theme '*Impact'* (below), where patients felt dehumanised. In Hörberg, Sjögren, and Dahlberg (2012) study, patients were lacking meaningful relationships and having to adapt to demands of staff, viewed as '*non-caring',* despite a

compassionate approach being a central component to the Nursing and Midwifery Council proficiencies for nurses (Nursing and Midwifery Council, 2018b).

Though the respective caring environments are complex, internationally there are certain common features, spanning America (Shattell et al., 2008) Australia (Cleary & Edwards, 1999), UK (Chandley, 2000; Long et al., 2012; Reavey et al., 2019) and Sweden (Hörberg et al., 2012). Cleary and Edwards (1999) found both patients and nurses identified that because nurses are busy, other pressing tasks take time away from relational support. These findings intersect with Chandley (2000) enquiry into the impact of the experience of passage of time in a secure hospital for patients and staff; with the time staff spend with patients objectified as a commodity. In Looi et al. (2016) Swedish study the provision of nursing care based on therapeutic relationships need not be a challenging task, but it takes place in a complex environment with a propensity to make easy things complicated. Reavey et al. (2019) concludes that by increasing a greater sense of physical movement and liberty there can be improvements in the therapeutic landscape, and thus reversal of any effects of narrowing patients' sense of agency. Environments and activities in these environments should be designed based on mapping of relations and patients' experiences.

3.5.5 Overarching theme: Impact

Patients emphasise the impact of trust, empathy, understanding of historical experiences, and positive perceptions and interactions in their time with staff. Bressington et al. (2011) and Lord, Priest, and McGowan (2016) both refer to the impact a positive social environment can have for patients (Shattell et al., 2008) which ultimately aids in the development of therapeutic relationships (Long et al., 2012) and higher levels of satisfaction of their care. Other factors that enhanced patients' satisfaction were honesty, care and interest from staff (MacInnes et al., 2014) and a recovery-focused approach that conveyed hope and sense of common

humanity by dual sharing of self (Borg & Kristiansen, 2004). In contrast to such approaches, Wright, Haigh and McKeown (2007) refer to dehumanising factors affecting those carrying a personality disorder diagnosis. This aligns with the experiences of patients in secure services, as explored by Mollerhoj and Os Stolan (2018) who found that patients in secure services specifically, can feel dehumanised and monstrous, and other commentators on secure care have noted staff may react in ways that reflect such constructions of the monstrous other (Jacob et al., 2009). Interestingly Borg and Kristiansen (2004) use the term '*humanity'* as does Walsh (1999). In this context, humanity implies factors such as just being with people, sharing common ground, being human, and respectfully recognising and responding to difference (Rashed, 2019; Wright et al., 2007). The respective authors suggest such basic human concern for patients and associated support and interaction should be at the forefront of any student, nurse/ staff and patient encounter, as referred to by Mollerhoj and Os Stolan (2018) and Eldal et al. (2019) who's participants were patients. The patients in Eldal's study stated the impact of being recognised as a person. Walsh (1999) interviewed nurses, not patients, limiting full understanding of the encounter as only exploring one side of the relationship.

The patients in Borg and Kristiansen (2004) study discuss developing relationships based on '*common factors'*, which is also noted in theme two (Jones & Wright, 2017). Patient participants in the Schafer and Peternelj-Taylor (2003) study offered a multidimensional view of time. The time nurses spent with them was perceived as indicating a measure of their personal value. They also felt time was used by the staff to assert their power, mirroring aspects of Chandley (2000) findings regarding temporality. Certainly, van Manen (1997) offers reflection that the way we experience constraints and demands imposed by time can influence how we feel.

Muller and Poggenpoel (1996) found that interactions with nurses promoted '*good mental health'* in the patients. The majority of the above studies were focused on patients' experience of care from nurses, explored mainly with interviews, with the exception of MacInnes et al.

(2014) and Bressington et al. (2011) who completed surveys. Although useful as a research approach, it may be useful to combine surveys with other more qualitative methodologies to allow for an exploration of issues in detail (Munro & Baker, 2007). Particularly when exploring a person's experiences, interviews can enable participants to voice their experiences (Marshall & Rossman, 2011; Peyrovi, Yadavar-Nikravesh, Oskouie, & Bertero, 2005).

Mukumbang and Adejumo (2014) explored patients' experiences of being cared for by student nurses, which considered how they identified the students, for example by their badges or if they introduced themselves; and their perceptions of them whether positive or negative because of this. Their experiences varied greatly, though self-introduction was seen as important. Mukumbang and Adejumo (2014) highlight that previous studies exploring interactions between patients and students have focused on the experience of students rather than patients, hence, wider exploration is needed.

3.6 Conclusion

This integrative review highlights that matters of trust, empathy, understanding of historical experiences, positive perceptions and interactions with students and staff are deemed important for all patients, not just those who carry a personality disorder diagnosis. The impact of the environment on those interactions can have both negative and positive implications, especially relational components of the environment. In addition to this, the skills needed for students, in services, including being mindful of professional boundaries, and impact of countertransference and interpersonal style are also evident in the literature.

A positive environment with consideration of time and focus on seeing the person, can lead to the development of therapeutic relationships with patients carrying a diagnosis of personality disorder. Student nurses attempting to build such relationships need to be mindful of patients

and their own attachment experiences, as well as the impact these can have on experiences of countertransference. It is important for student nurses and staff to be aware of the supportive impact of positive environments and how doing '*everyday stuff*' can bolster recognition and identity; making a person feel human in potentially dehumanising places.

This review marshals' contributions to knowledge, potentially illuminating of student preparation/ education in appropriate skills. Such impacts are relevant for wider nursing education, particularly given the focus on communication skills and relationship building in the Nursing and Midwifery Council proficiencies in the UK, and thus, this review has broader reach than the specific groups identified (patients carrying a personality disorder diagnosis and student mental health nurses).

This chapter has highlighted a robust searching strategy completed to identify the specific gap in the research field and relevant methodologies. Furthermore, the papers selected for inclusion within the review have been critically appraised for quality and subject to analytic synthesis resulting in articulation of the themes. The review highlights that no papers have looked at the experiences of students and patients and the time they share on secure personality disorder units suggesting an area in need of exploration. As identified as a key marker for quality in qualitative research; the topic is worthy of exploration (Tracy, 2010). As highlighted, there is a gap in the literature exploring the topic area, hence my study is unique, enabling the contribution of new knowledge to the current body of evidence.

The methodology chapter will now follow where I re-present the aim of this study and discuss an appraisal of the underpinning methodology in order to achieve the stated aim of the project. I discuss hermeneutics, the chosen approach, for which a rationale is given.

4 Phenomenology as methodology

In the previous chapter I considered specific literature related to my research question which followed the context of the research areas. The main themes arising from the literature were hence discussed following an overview of the robust literature search strategy and appraisal of literature. These were '*Psychosocial skills'*, '*Relationships'*, '*Environment'*, and '*Impact'*. The review highlighted a gap in current knowledge about the experiences of patients and student mental health nurses of the time they share together on personality disorder units identifying need for further research.

4.1 Introduction to the chapter

In this chapter, I re-present the aim of the study and discuss an appraisal of the underpinning methodology and potential to achieve the stated aim. I give an overview of phenomenology, with an emphasis on hermeneutics and rationale for this chosen approach.

4.2 Research question

The research question was: *'What are the lived experiences of the time patients and student mental health nurses share together on secure personality disorder units for men?'*

4.3 Aim

This study aimed: *'To illuminate the lived experiences of the time patients and student mental health nurses share together on secure personality disorder units for men.'*

4.4 Grounding stance

This study aimed to explore the participants' lived experience and therefore was informed by a phenomenological perspective (Dowling, 2007). By exploring and interpreting the experiences of the participants I hoped to illuminate the phenomena/s present (Tuohy, Cooney, Dowling, Murphy, & Sixmith, 2013) which made phenomenology a fitting underpinning philosophy. The experiences of participants cannot be studied by quantitative research because it is highly subjective and needs to be interpreted (Peyrovi et al., 2005). However, as Rolfe (2006) states the distinction between qualitative and quantitative paradigms is unhelpful, as there is no single paradigm. Equally Benner (1994) posits that the debate between subjective and objective paradigms or qualitative or quantitative methods is fruitless. Nevertheless, it is important to consider the stance of research to ground the study. Consideration of epistemology was explored to develop my knowledge and understanding, such writings are included in the appendices[50], by way of providing context behind the thinking process.

It has been recognised that mental health nurses tend to gravitate to more qualitative research methodologies (Cutcliffe & Goward, 2000). My way of thinking guided my research choice (Dibley et al., 2020), or as Smythe (2012) states the methodology chooses you. Mental health nurses form interpersonal relationships with patients in an attempt to gain a sense of their world, they use themselves in their role (Freshwater, 2002; Travelbee, 1969), and they accept the uncertainty and individuality of the patients they work with, which is akin to a phenomenological approach (Cutcliffe & Goward, 2000; Morck, 2016). It is therefore implicit that I would be drawn to such research (Dibley et al., 2020). Nurses may already align themselves phenomenologically, as understanding each patients' lived experience evolves from nurse's communication (Finch, 2004; Lopez & Willis, 2004). Ontological hermeneutics, in

[50] Appendix 10.

particular, merits being at the heart of mental health nursing which aims to understand the being of people (Chang & Horrocks, 2008; Holm & Severinsson, 2011). Hence my approach is to consider philosophical underpinnings alongside nursing and such literature in this chapter as it is nursing research.

We are interpretive beings and always already there (Heidegger, 1927/2019). We constantly interpret the world we engage with and meanings are only constructed when we encounter them (van Manen, 1990). Heidegger's philosophy is an ontological one (Laverty, 2003), exploring the meaning of being:

> *'Our provisional aim is the interpretation of time as the possible horizon for any understanding whatsoever of being.'* (Heidegger, 1927/2019, p. 1/19)

As stated by Dibley et al. (2020) '*humans are self-interpreting beings that make sense of our world through our experiences and interpretations of it*' (p.114). Hence the paradigm underlying this research is interpretivism. Nursing particularly is an interpretive practice (Benner, Tanner, & Chesla, 2009). However, there is much debate surrounding paradigms and various terms used interchangeably, including constructionism, constructivism, subjectivism and interpretivism (Creswell, 2017; Crotty, 1998; Guba, 1990; Lincoln & Guba, 2000). Therefore, I focus on phenomenology as methodology and hermeneutics in this chapter, while referring the reader to such discussions on terminology included in the appendices[51]. I will now explore phenomenology and hermeneutics in more depth.

4.5 Phenomenology as methodology

'*Phenomenology'* derives from the Greek words phainoemn and logos meaning appearance and reason. To bring into the light (Heidegger, 1927/2019). The term was used widely by philosophers such as Kant and Hegel, though Husserl's use of the term came from Brentano

[51] Appendix 10.

(Dowling, 2011). Moran (2000) describes phenomenology as a historical movement '*exemplified by a range of extraordinarily diverse thinkers*' (p. xiv).

It is widely accepted that phenomenology is difficult to understand (Cohen & Omery, 1994; Corben, 1999; Ihde, 2012; Merleau-Ponty, 1945). Phenomenology has meant many things to many people in that it has become difficult to define precisely (Ihde, 2012). For some, it is more a style of thought and is open ended, hence a final definition is problematic (Moran, 2000). Even Merleau-Ponty (1945) questioned if phenomenology deserves discussion as a philosophy that cannot define its' own scope. Merleau-Ponty, Sarte and Ricoeur made phenomenology more accessible and engaging, helped by its translation from German (Dowling, 2011). van Kaam and Scheler are further phenomenologists often missed in the history of phenomenology. van Kaam who crossed over from philosophy to research and Scheler, could be described as the number two phenomenologist rather than Heidegger, according to some (Dowling, 2011).

As the term '*phenomenology'* is used within philosophy and also within research (Mackey, 2005; Reiners, 2012), it can be challenging for new researchers, academics, and health care workers. Some would argue that phenomenology is not a research methodology and to do so changes the meaning of phenomenology (Crotty, 1996; Moran, 2000). Neither Husserl or Heidegger aimed to produce research methodologies specifically, they were philosophers (Dibley et al., 2020; Dowling, 2007; McConnell-Henry, Chapman, & Francis, 2009). It may even been seen as more than a philosophical system, and most certainly a doctrine, and as a '*movement'* in itself (Merleau-Ponty, 1945). Nevertheless, it has become an increasingly popular research approach in nursing (Benner, 1994; Tuohy et al., 2013).

Despite such a connection for nurses and phenomenology, there has been criticism of nurse researchers for doing phenomenological research without understanding phenomenology,

betraying its fundamental concepts (Crotty, 1996; McNamara, 2005). However it can be a valuable research methodology with many strengths (Lewis-Hickman, 2015). Phenomenological researchers can use their personal interests and motivation to support the completion of the study (Maxwell, 2013). This human factor is the greatest strength of phenomenological research while some argue also being the fundamental weakness (Lewis-Hickman, 2015). Potential bias is often raised as a weakness of interpretive phenomenological studies, however in hermeneutic studies this '*bias'* is the interpretation of the research and a core component (Carman, 2003; Neubauer, Witkop, & Varpio, 2019).

There are many writers of phenomenology from Husserl (1859-1938) to Heidegger (1889-1976) and more recently van Manen (1942-present)[52] (Caelli, 2000). Descriptive (Husserl) and hermeneutic or interpretive[53] (Heidegger, Gadamer), are the two main phenomenological approaches (Duckworth, 2015).

Unlike other forms of research, phenomenology is not about proving something, it is about provoking thought (Smythe et al., 2008). '*To understand the complex nature of 'being human' questions must be addressed as to how we understand, and therefore how we think'* (Smythe et al., 2008, p. 1391). Heidegger was interested in what it meant to '*be human'*. This took his philosophy back a step from Husserl who did not consider this concept. The concept of '*being human'* is important because it looks at '*us'* and our experiences, which is what my study aimed to explore.

On the opposing side (as some would argue (Crotty, 1998; Guba, 1990)) are positivistic views, where randomised control trials often sit, focused on gaining statistical differences (Crotty, 1998). As argued by Rolfe (2015) nursing made a wrong choice in opting for the social science

[52] Further exploration of such phenomenologists can be found in appendix 11.
[53] Terms often used interchangeably.

research paradigm which has been detrimental to good practice, due to the focus on technical and generalisable knowledge rather than patients. Phenomenological studies explore a small number of participants' experiences, their raw narratives. It gives the why, the feelings behind experiences, rather than just a yes or no or numerical value, which in mental health care is in opposition to the notion of person centred care (Cutcliffe & Goward, 2000). As argued by Dibley et al. (2020) reducing a person to measurable units disregards their own context of possibilities; their complex, colourful and rich lives.

Phenomenology means letting things become manifest as they are and letting things show themselves (Naden, 2010). The things themselves means getting to the essence of experience itself (Dibley et al., 2020). Essentially, phenomenological research explores participants' experiences in order to bring out/ uncover and illuminate a *phenomenon* (Benner, 1994; Dibley et al., 2020; Duckworth, 2015; Smith, Flowers, & Osborn, 2009). In order to fully explore a person's experiences, lived and felt, a phenomenological approach is essential (Creswell, 2017).

As this study is not only about understanding the participants' stories and experiences but about my interpretation of them, a hermeneutic approach is ideal (Chang & Horrocks, 2008). In hermeneutic research the values of the researcher and participants, impact on all aspects of the research, it is important to acknowledge this (Morgan, Felton, Fulford, Kalathil, & Stacey, 2015).

4.6 Hermeneutic phenomenology

Hermeneutics is the philosophy of interpretation, it is from the Greek work '*hermenuin'* which refers to explanation or interpretation (Moran, 2000). Like Hermes interpreted messages from the Gods. It is strongly associated with language and the written word (Naden, 2010). It moves

beyond description (that of Husserl's descriptive phenomenology) of essences to look for meanings embedded or hidden in life experiences (Lopez & Willis, 2004). Hermeneutics is complex and traces back to Schleirmacher in the 19th century, who defined hermeneutics as the art of understanding (Palmer, 1969).

Hermeneutics was not originally proposed as a way of doing research, it is an explication of human existence (Palmer, 1969), a way of understanding the world we are situated in, as humans (Dibley et al., 2020). Though it is not specifically intended for applied research, it can be used as a foundation to inform rich, meaningful and insightful research (Crowther & Thomson, 2020; Thomson, 2011). A hermeneutic methodology aims to reveal and enhance human experiences of understanding (Thompson, 1990) and to explore what it means to live experientially at a specific point (Dibley et al., 2020).

Diekelmann, Benner and Allen among others, were pivotal in bringing hermeneutics into nursing research (Benner, 1984/2001; Dibley et al., 2020). Through hermeneutics, the nurse can gain an understanding and interpretation of patients' values and beliefs (Finch, 2004), that may be hidden or overlooked (Dibley et al., 2020). Our historical and cultural situatedness of our social environment is important to how we understand hermeneutically (Dibley et al., 2020). Hence, I have supported people carrying a personality disorder diagnosis and spent time with patients as a student and nurse, and then since supported students. My pre-understandings are present and therefore reduction is not possible[54], thus an interpretive phenomenological approach was essential. I believe we are continuously interpreting our experiences, when we contemplate our experiences; we are automatically interpreting what it is we have seen, heard, or felt.

[54] See Husserl in appendix 11.

My study aimed to explore, understand and interpret participants' experiences, not just describe them; it seeks to go further than description. The hermeneutic approach attempts to understand phenomena not just explain it. Mental health nursing is dependent on the development of hermeneutic understanding of deeper meaning of a person's experiences (Holm & Severinsson, 2011). However researchers must make the underlying hermeneutic philosophy clear rather than minimally addressing or simply describing the methodology to avoid criticism (Chang & Horrocks, 2008).

Hermeneutic phenomenology as a research methodology can be a powerful approach to use. A main weakness, albeit strength, lies in the interpretation, each researcher can interpret findings differently (Moule, Aveyard, & Goodman, 2017). It is therefore crucial to ensure this is clearly stated and acknowledged (Dibley et al., 2020). The approach is interpretivist and I, the researcher, am '*in'* the research in addition to the participants[55].

I now consider hermeneutic philosophers Heidegger and Gadamer and some of their core concepts of relevance in this study.

4.7 Heidegger, chosen underpinning approach (1889-1976) (Interpretive hermeneutic phenomenology)

4.7.1 Language

Philosophers have long debated the ontology of language and the role language plays (Santana, 2016). McConnell-Henry et al. (2009) claim that Husserl and Heidegger are difficult to read because of the dense language, invention of language, in addition to the variances in

[55] Interpretive analysis is discussed in depth in chapter 5.

translation. Such is reported on many occasions (Cerbone, 2008; Dibley et al., 2020). Heidegger's writings are complicated and complex, in fact others have argued that he used language as a barrier (Moran, 2000). Dreyfus (1991) however, as personally resonates, would choose to believe that he found language restrictive in expressing what he aimed to and therefore developed language to best express himself. Dreyfus argued that if Heidegger could have used more understandable terms/ ways to describe what he was talking about, he would have (Dreyfus, 1987). He suggests that at Heidegger's time, there was not the language for describing the way everything is when it is going well, and that it is the right vocabulary and is elegant once you understand it (Dreyfus, 1987).

> … '*reading Heidegger is not easy, but the insights gained are worth the effort*.' (Smythe & Spence, 2020b)

Language does not correspond with reality, hence Heidegger's use of metaphors (Blattner, 2006; Dreyfus, 1987). Cerbone (2008) posits that Heidegger's writings are perplexing as that is precisely the state Heidegger wants to cultivate, and without being sufficiently perplexed we are not ready for philosophy.

In addition to Heidegger's use of language, many of Heidegger's works have been translated, however cautiously, due to the array of language used and, as Dreyfus (2007d) refers to, have often been translated incorrectly, in his opinion. A further caution as indeed a thought in phenomenology; '*we find in texts only what we put into them'* (Merleau-Ponty, 1945, p. viii). Each translator interprets Heidegger's work, as well as each reader of such translations, possibly taking the meaning further away from what was intended.

Dreyfus (2007d) also speaks of Heidegger's own contradictions and struggle to make sense of things. Dreyfus himself, a well-regarded teacher of Heideggarian concepts, humbly amends his commentaries once he further understands Heidegger over three decades. Such is true to Husserl's development in thinking and Heidegger's *'turn'* (Moran, 2000). I therefore provide an

overview of my understandings at this time of Heideggarian concepts, without the statement of absolute truth to my understandings as an early researcher rather than practiced philosopher. Also acknowledging that any conclusions in hermeneutic phenomenological research are not final or fixed, there is the possibility of new interpretations over time (Gadamer, 1967/1976). We are never experts in hermeneutic phenomenology, we are always becoming (Dibley et al., 2020).

4.7.2 Heidegger's influences

Heidegger (1889-1967) was a German phenomenologist. He believed that the world '*is always already there'* and we, as human beings create meaning (Carman, 2003; Moran, 2000). He was a former student of Husserl[56] and questioned his reductionist attitude (bracketing/ epoch). The core difference between Husserl and Heidegger is bracketing, Heidegger did not believe that humans can bracket their previous experiences (Heidegger, 1927/2019). His seminal work Being and Time (Heidegger, 1927/2019), was considered as a betrayal of Husserl's principles of phenomenology, it is however regarded as one of the most important philosophical texts of the 20th century (Blattner, 2006; Wrathall, 2005). Like Nietzsche, Heidegger wished to call the whole Western metaphysical tradition into question (Palmer, 1969).

Rolfe (2015) proposed that Being and Time was written '*as a reaction to Dilthey's attempt to put phenomenology on a rational scientific footing'* (p. 144). Heidegger was focused on the ontological meaning of '*being'* and interpretation that leads to understanding, far from scientific rationalism (Carman, 2003; Dibley et al., 2020). Heidegger considered *thoughtfulness* as a mindful, caring, wondering about life and experience (Duckworth, 2015; Wright, 2013). He looked for the thought behind thoughts (Polt, 2005). He wanted *things* to reveal themselves (Bakewell, 2016). Heidegger was an existentialist philosopher, like Nietzsche (1844-1900) and

[56] See appendix 11 for exploration of Husserl.

Kierkegaard (1813-1855), who he was heavily influenced by (Moran, 2000). Karl Jaspers is viewed alongside Heidegger as a founding father of existential philosophy, though Heidegger resented being referred to as an existentialist and Jaspers, resented being referred to alongside Heidegger (Mundt, 2013). Heidegger was also influenced by the hermeneutic writings of Schleiermacher (Healy, 2011). Importantly, Heidegger was heavily influenced by Aristotle's writings, who argued that perceptions are always interpreted and connected to our experiences of the world (Healy, 2011).

Heidegger, stood apart from other philosophical stances (Dibley et al., 2020) and took Husserl's views deeper, advising us before contemplating our experiences, we need to understand the lens we experience things through. He questioned what it means to exist, what it means to be human. This took Decartes questions deeper, before you find you are a thinking thing, you exist, you are '*being-there'* (*Dasein*).

4.7.3 *Dasein*

Heidegger wanted to raise '*the question of the meaning of Being'* (Heidegger, 1927/2019, p. 19). *Dasein* is the notion of the existence of *being*. It means '*being-there'*, being present or '*being-in-the-world',* which is interlinked/ joined (Carman, 2003). There is no separating *Dasein* and the world (Dibley et al., 2020). *Dasein* exists because we ask, we already possess an understanding of *being* (Cerbone, 2008). Some interpret *Dasein* as human being or human subject (Critchley, 2020; Dibley et al., 2020; Stewart, 2012), and although Dreyfus (2007e) states *Dasein* is '*us',* and Heidegger thought that there is not anything but people who have an interpretation of what it is to be a person built into their practices, it is more complex than meaning human being. Heidegger used a term without prior connotations or ideas that would only serve to distract (Cerbone, 2008).

Dasein is a *being* that relates itself to/ toward itself, taken from Kierkegaard (Dreyfus, 2007e). Other texts (Cerbone, 2008) state that *Dasein* takes a stand on itself, or that *being* is an issue for it. Dreyfus (2007e) states it is misleading, as it makes you think *Dasein* is worrying, which it can but Heidegger meant that it is about relating to what it is to be *Dasein*, or to have an understanding of *being*. *Being* is to ask questions and to be constantly engaged (Blackburn, 2008).

Dasein is interconnected with the world and *being-in-the-world* temporally (Cerbone, 2008; Heidegger, 1927/2019). Dreyfus (2007c) describes getting *Dasein* gradually, from when you are born, to gain enough familiarity to have a world. The world is an interconnected context of involvements that gives meaning to everything encountered (Molloy, Bankins, Kriz, & Barnes, 2020). As described by Heidegger (1927/2019, p. 7/27):

> *'This entity which each of us is himself and which includes inquiring as one of the possibilities of its Being, we shall denote by the term 'Dasein''.*

Our *being-in-the-world* is always a matter of care (the care structure[57]), which includes facticity (the '*givens'* of our lives that we cannot change, like where we were born, our *thrownness* in to the world, our familiarity with the world); *fallenness* (how we exist *inauthentically*, doing what '*the one'* does); and *existentiality* or *understanding* (*authenticity*; living towards one's potentials) (Heidegger, 1927/2019). These three elements mirror the *fore-structures; fore-sight* (past)*, fore-having* (present) and *fore-conception* (future) (Heidegger, 1927/2019). Though Dreyfus (2007c) criticised Heidegger's use of these terms, as simply repeating what he had already laid out in Being and Time.

Heidegger's phenomenology is the phenomenology of *everydayness*, the showing and interpretation of *Dasein* '*in its average everydayness'* (Heidegger, 1927/2019, p. 16/38) and its encounters in the world (Cerbone, 2008; Dibley et al., 2020; Dreyfus, 2007e). As *Dasein,*

[57] See appendix 1 for a visual representation of the care structure.

we are always *being-with* others and those experiences give meaning to us. To exist is to exist-*with*. We always inhabit a shared world (Smythe & Spence, 2020a), and the way we exist in the world is always structured and influenced by others (Dreyfus & Wrathall, 2008). We are, by nature, social beings who share a world, time and space with others, some near and some far (Crowther & Thomson, 2020). On the ontological level, just as *Dasein* is never without a world so too it is never without others (Heidegger, 1927/2019). *'Dasein is essentially for the sake of others'* (p. 123/160); others matter to us (Heidegger, 1927/2019). Our relation to others is understood under the notion of '*care'* (solicitude), where in *being-with* we leap in for the other (Moran, 2000). This kind of solicitude takes over, takes away or dominates, in contrast '*there is also the possibility of a kind of solicitude which does not so much leap in for the other as leap ahead of him',* it leaps forth and liberates (Heidegger, 1927/2019, p. 122/158).

4.7.4 *Authenticity* and Heidegger's involvement with the Nazi party

Authenticity as a term is used in many contexts that poses difficulty in confirming a definition (Golomb, 2012). In addition to Heidegger, other philosophers and psychologists explored what it means to be *authentic*, including Maslow, Kierkegaard and Sartre (Golomb, 2012). Heidegger moved beyond traditional definitions (Dibley et al., 2020). Being *authentic,* in a Heideggarian sense, is '*characterised by mineness'*, as '*its own most possibly'* or '*something of its own*', it is a way of being in the world (Heidegger, 1927/2019, p. 43/68):

> *'Authenticity is about our approach in the world and the challenge of bringing ourselves back from the lostness in the one'* (Riahi, Thomson, & Duxbury, 2020, p. 1222)

Heidegger (1927/2019) wrote about being caught up in the world and ignoring our *Dasein*, which he calls '*fallenness'*, where we are rendered *inauthentic* (Mulhall, 2005). Other philosophers may infer that Heidegger himself was '*fallen'* as a member of the Nazi party (Moran, 2000; Sheehan, 1993). Heidegger's involvement with the Nazi party was during a historical time when philosophy and politics intersected (Sluga, 1993). There are critics of

Heidegger and his philosophy purely based on his involvement with the Nazi party and debates persist on the impact of his political affiliation on his philosophy (Dibley et al., 2020; Sheehan, 1988). Recently Randall and Richardson (2021) caution that Heidegger's political context is dangerous and nurse researchers should reject Heidegger's interpretivism.

An alternative view is that his symbolic gesture was a survival tactic (Dibley et al., 2020) and the critique should lie with his behaviour rather than his writing (Smythe, 2011). Although his political history is important to be aware of and always remain open and vigilant to, I am focused on his philosophical notions which provide invaluable depth to my research. While acknowledging concerns raised.

When *inauthentic* we are conforming and adopting what others do without challenging why. By doing this every day we experience a state of *fallenness* (Moran, 2000). By the individual taking more agency over their life and questioning what they do; they are making their own decisions and being *authentic*. Sartre said that any meaning your life has, has to be given it by you (Onof, 2018).

From *inauthenticity* and experience of angst and a loss of self, comes a strive for *authenticity* to fulfil our own potential (Thomson, 2007). Heidegger makes it clear *inauthenticity* is not a negative state, it is a state of coping. People may become *fallen* to be absorbed in *the one* (*Das Man*) as a way of coping in the world. Being *authentic* is to be our own, which could be a lonely place. It is not about being morally good or doing the right thing, it is living as identified as one's own (Heidegger, 1927/2019).

4.7.5 Hermeneutic circle

The Hermeneutic circle was developed by Heidegger and his student Gadamer (Gadamer, 1967/1976). The process is used to help achieve understanding in phenomenology. Where narratives are examined in parts and then as a whole, moving between (Dibley et al., 2020), for example, in a circular type motion when the researcher revisits/ re-examines the parts in a way that is not linear (Moran, 2000). It can be thought of as a spiral as each turn goes deeper (Spanos, 1976). It is an iterative approach. As new meanings emerge and are discovered and interpreted, the process continues and the understandings achieved are challenged continuously, where the parts and the whole are understood together. By considering the whole we have a deeper sense of the parts, they are as one (Dibley et al., 2020). The hermeneutic approach is an attempt to understand phenomena rather than just the description (Duckworth, 2015; Wright, 2013). How we interpret and understand our experiences influences how we experience things, which influences how we interpret our experiences and so on. Heidegger's interpretation of the Hermeneutic circle is at the heart of his belief of returning '*to the things themselves*' (Heidegger, 1927/2019, p. 34/58), considering '*us'*, our experiences and understandings (Spanos, 1976).

Heidegger's concept of '*fore-structures of understanding'* (sometimes referred to as care structure or the Hermeneutic circle, see above) is an important concept (Dreyfus, 2007b; Horrigan-Kelly, Millar, & Dowling, 2016). Often people diagnosed with a personality disorder have experienced trauma when young, which therefore impacts on their perception of themselves, others and the world around them (Bolton et al., 2014). We are *thrown* or delivered over into the world and into life and circumstances, we exist in the ways made available by this *thrownness* (Blattner, 2006; Wrathall, 2005). Hence, '*we are subject to things about which we have little if any say'* (Wrathall, 2005, p. 35).

Heidegger wrote about humans having a pre-understanding of a situation or experience; a historicity (Heidegger, 1927/2019). He said that because we have familiarity with the phenomenon from our previous experiences we have an understanding of the phenomenon, a *fore-grounding* to it (Heidegger, 1927/2019).

4.7.6 Time (temporality)

A hermeneutic approach acknowledges temporal situatedness and it is this centrality of time that differentiates hermeneutics from descriptive phenomenology (Diekelmann & Ironside, 1998). There is no beginning or end but a continuing experience central to *being* (McConnell-Henry et al., 2009). *Being is* time; each *Dasein* is itself time (Heidegger, 1924/1991, p. 47). Being and Time the key text written by Heidegger highlights the temporal nature of *being* (Heidegger, 1927/2019; Richardson, 1999). Rather than chronological or measured, Heidegger viewed time as significant, salient or permeating (Dibley et al., 2020).

Past experiences influence both the present and future (McConnell-Henry et al., 2009). Heidegger spoke of the everyday happening in the world as encountered in the present time, and this *everydayness* lives by a clock, which is focused on the now, the present. By watching a clock, time is already interpreted now, the past is no longer present and irretrievable, and the future is not yet present (Heidegger, 1924/1991). We agree on '*then'* and '*now'* by using clocks, where time becomes encountered in a more explicit way; as measured duration (Heidegger, 1924/2011). However, Heidegger saw temporality as the fundamental ontological structure of *Dasein*:

> *'The future is not later than having been, and having been is not earlier than the present. Temporality temporalizes itself as a future which makes present in a process of having been.'* (Heidegger, 1927/2019, p. 350/401)

Human beings exist temporally and come to an end with our death. Death is one of the principles boundaries of *Dasein's* temporality, which links to the care structures of *Dasein*

(Alweiss, 2002). We can only become what we truly are (*authentic*) through the confrontation with death. We are always on the way towards death, that is the human condition, the progression of life (Dibley et al., 2020). *Being* can only exist in time. Heidegger's beliefs about time shows his grounding in existential philosophy. Our interpretations in the present determine how we make sense of the past (Richardson, 1999). Gadamer (1975) also comments on the relationship between the past and present, and that it is reciprocal. van Manen took forward Merleau Ponty's four pillars; including temporality. Again, accepting that our experiences are affected by the past, present and future, considering future as our hopes. Knowledge and experience are not gained statically but temporally (McConnell-Henry et al., 2009).

A further element of temporality, Heidegger refers to, is the Greek concept of *Kairos* time; a moment that holds in memory and experience (Dibley et al., 2020). Heidegger (1984/1992), and more recently, Crowther, Smythe, and Spence (2015), use the term kairos time to describe an existential temporal experience that is rich in significant meaning, that is rarely spoken about yet touches those present. van Manen (2007/1990)[58] describes lived time (temporality) as felt experience, an ontological phenomenon.

4.7.7 Gadamer (1900-2002) (Hermeneutic philosophy)

Hans-Georg Gadamer studied as a philosopher under Heidegger and added to hermeneutic phenomenology (McConnell-Henry et al., 2009). He argued that science could not be free from subjectivity as all studies rely on humans and therefore their interpretations of their world (Gadamer, 1967/1976). Gadamer, in agreement with Heidegger, also proposed that bracketing is not possible and would interfere with the interpretation process (Dowling, 2007; Peoples, 2021).

[58] See appendix 11.

When discussing past knowledge Gadamer talks about *horizons*. He states that our understanding is based on our past knowledge and new knowledge and there is an interplay, which results in a '*fusion of horizons'*. The integration of one thing and another is a *fusion of horizon* (Austgard, 2012; Dibley et al., 2020). In thinking of the other in the context of our own understanding leads to awareness and co-creation of a new situation (Dibley et al., 2020). When we comprehend something new it provides us with a new *horizon* of understanding (Thomson, 2011).

Fusion of horizons is closely linked to the Hermeneutic circle and the influence of Heidegger's *fore-structures*. Gadamer moved away from Heidegger's idea of existence and focused on the practical notion of understanding (Richardson, 1999). Gadamer wrote of *prejudices*, what we already know about the world, and how our knowledge of the world is constructed and interpreted, and how our ability to interpret the world is our *horizon*; which is everything we see from a particular vantage point (Gadamer, 1975). Gadamer states it is impossible to be aware of a *prejudice* while unnoticed, only once provoked (Dibley et al., 2020).

In relation to research, according to McConnell-Henry et al. (2009), understanding is gained only through dialogue, and the openness of the researcher. Gadamer emphasized the importance of language as the key to understanding (Rolfe, 2015). In research a *fusion of horizons* is experienced when the researcher and the text meet as one (McConnell-Henry et al., 2009). Dibley et al. (2020) describes the *fusion of horizons* in relation to the stories the participants share being their interpretation through language and their understanding, and the researcher having their own *horizon*, each unique and formed by backgrounds, which become a *fusion of horizons* between the interpreter and the participants.

4.8 Conclusion

In this chapter, I have re-presented the aim of the study and then discussed the underpinning methodology which was adopted in order to achieve the stated aim of the project. I have explored interpretive hermeneutic phenomenology and provided a rationale for being guided by this philosophical stance.

Although it is questioned whether phenomenology should be considered a research methodology, it aligns nicely with mental health nursing (and research in this field), which focuses on a person's experiences. Of the many phenomenological approaches, an interpretive hermeneutic approach is the underpinning philosophical and methodological standpoint of this research. I believe our experiences impact on our interpretation of the world around us and we cannot bracket or suspend this. As beings we are always *being-in-the-world* and our interpretation of this and our experiences are dependent on our *fore-structures*. To develop our understanding, we need to consider the whole and the parts of our experiences together and separately.

The following method chapter will discuss the ethical considerations relevant to conducting the study, leading on to the choice of methods and design for this. Sections on interviews and research rigour follow this before discussing recruitment and data collection. The hermeneutic interview and my analytical process will be outlined and discussed alongside underpinning approaches.

5 Methods

In the previous chapter I discussed the phenomenological methodology underpinning the study; interpretative hermeneutic phenomenology. I gave an overview of Heidegger and his interpretive stance to give a contextual background. Such methodological considerations ought to be congruent with methods applied in the study. It is to these which I now turn.

5.1 Introduction to the chapter

This section will discuss choice of methods and design for the study, starting with how ethical considerations underpinned those choices, in addition to ethical theories in the context of the study. Sections on interviews and research rigour follow, before discussing recruitment and data collection. The hermeneutic interview and my analytic process will be outlined and discussed alongside underpinning approaches.

5.1.1 Ethical approval and permissions

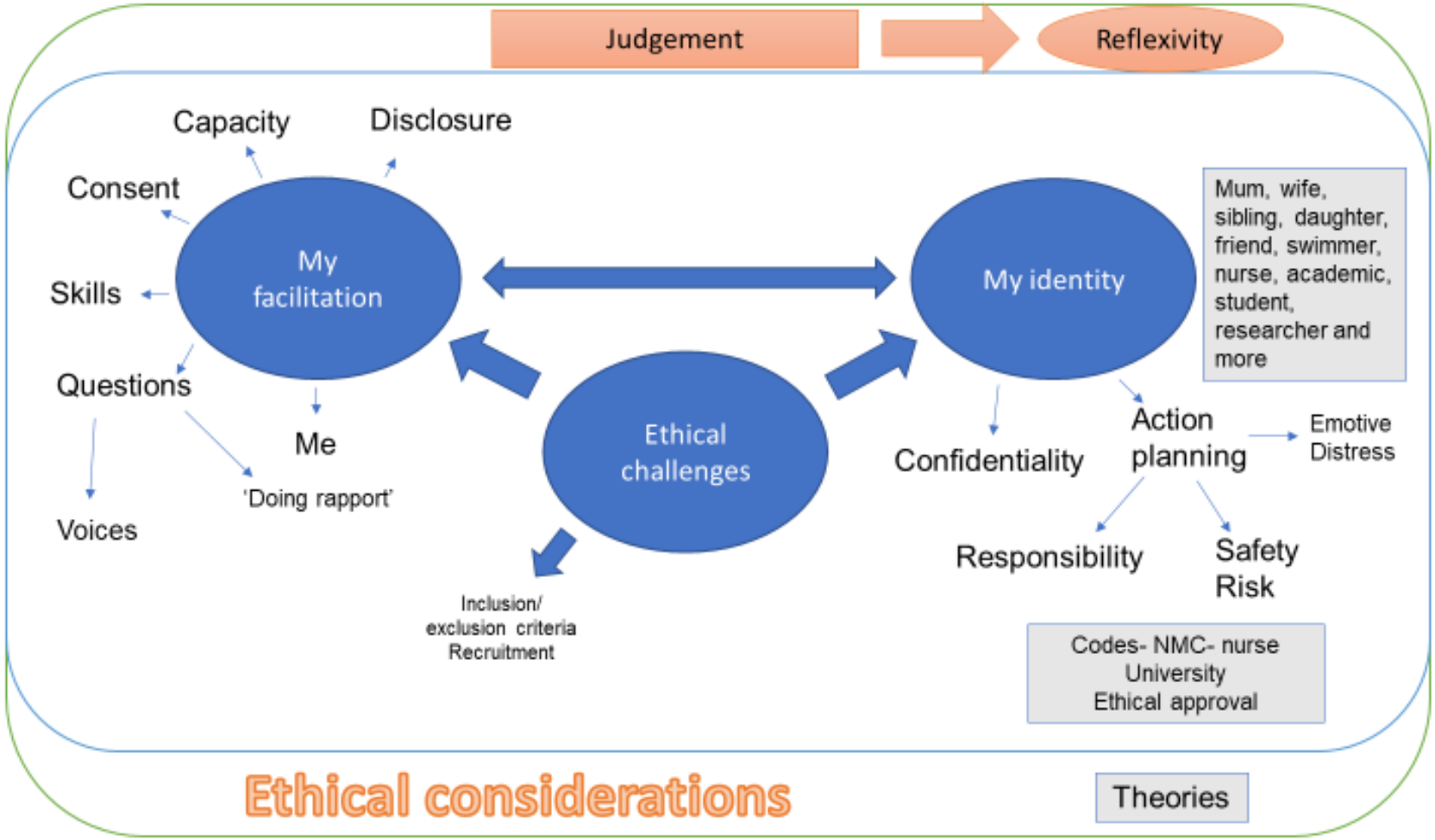
Prior to conducting any form of research, approval from the appropriate bodies must be sought (Robson, 2011). I was granted NHS Research Ethical Committee [REC] and Health Research Authority [HRA] approval for completing the study[59]. Ethical approvals aim to '*protect the rights, safety, dignity and well-being of research participants and to facilitate and promote ethical research that is of potential benefit to participants, science and society'* (Health Research Authority, 2021b).

[59] See appendices 13-21 for the relevant documents. University of Central Lancashire ethical approval was additionally approved.

5.2 Ethical considerations

When approaching research, the researcher must first consider relevant ethical concerns (Moule et al., 2017). Hence, I reflected on these and completed a visual representation of my thoughts; my ethical considerations (see figure 4). Reflecting on implications assisted exploration of potential challenges, influential theories and codes, areas of conflict and, finally the appropriate resolutions. Resolutions are discussed throughout at appropriate points, with a specific consideration of reflexivity. However, despite action plans and appropriate resolutions, ethical issues are nevertheless complex, particularly when considering the relational (Cribb, 2014).

Figure 4: Ethical considerations



There can be ethical issues when mental health patients participate in research and these must be addressed, including issues with capacity, consent and potential causation of distress (Health Research Authority, 2021b; Hem, Pedersen, Norvoll, & Molewijk, 2015; Rodriguez, 2012; Usher & Holmes, 1997). There are unique ethical considerations in secure services (Austin et al., 2009), including issues such as containment and restrictions (Adshead, 2000; Hörberg & Dahlberg, 2015), in addition to the patient group, considered as vulnerable (Rodriguez, 2012; Siriwardhana, Adikari, Jayaweera, & Sumathipala, 2013; Usher & Holmes, 1997). It was therefore vital that it was the patient's choice to participate (Armstrong, 2007), hence ensuring they had the time to consider participation. It was important to note that students could also be seen as a vulnerable group and should not be overlooked (Bowers et al., 2007), due to the complexity of the patient's participation.

While there are benefits to talking about lived experiences, there is still the potential for risk (Dibley et al., 2020). To ensure such issues were appropriately considered I approached the care teams of the secure unit, with regards to the suitability of patient participants, and requested their input. A handover to the care team was considered as required if a patient became distressed and needed support following the interview, as included in the risk assessment[60]. All participants were able to fully consider their participation prior to consenting.

Interviews are widely used research methods, especially in phenomenology, yet little attention focuses on ethical issues (Marshall & Rossman, 2011). In conducting phenomenological research, the researcher must develop some level of trust and a relationship in order for the participant to feel comfortable sharing their experiences and their time. However this can leave a lasting effect on a person with a mental health problem in that trusting another person, and disclosing private thoughts can create vulnerability, which might also be true for the researcher

[60] See appendix 20.

(Usher & Holmes, 1997). I utilised supervision and reflexivity, in addition to ensuring the patient was supported after where required. Ethical issues may be more apparent in qualitative than quantitative research, especially in phenomenological research due to the in-depth exploration of a person's lived experience (Moule et al., 2017). By *being-with*[61] the participants and being open to their experiences I was practicing ethically by valuing and respecting their experiences they shared with me (Dibley et al., 2020).

Due to such in-depth exploration there was the potential for over-disclosure, which could cause participant distress (Robson, 2011). It was important that I was aware of the participants' emotional state when leaving the interview, and that I informed staff if I had any concerns (Smith, 1995), about patients or students. In order to reduce any risk of harm, the interviews were completed in a safe environment on site at the unit, and where there was a mechanism for calling for help, if it were needed, following the unit's safety and security processes.

I particularly considered whether to inform the participants I was a nurse. Transparency is important to me as a nurse, however according to Bell et al. (2015) my dual identity could have implications on the soundness of my study. Hence the importance of reflexivity to enable sound ethical decisions to be made regarding identity revealing in research (Dibley et al., 2020). I introduced myself as a researcher, and informed the participants that I was a nurse if they asked, to be authentic, but acknowledging to the participants that during my time with them my role was a researcher and interested in their views. This only occurred with Bella, who asked if I was a nurse when she was describing what reflection meant to her, to which I replied '*yes'*, and she continued with the interview.

[61] See chapter 4.

In addition to the above, there was a possibility that I may have been informed of poor practice which could have presented ethical dilemmas (Smith, 1995). Any such concerns would have been discussed with my supervisor and formally dealt with and reported in the appropriate forums as necessary. If there was a need to report an illegal act, or a disclosure which rendered others at risk this would have overridden the confidentiality agreement, and the participants were informed of this (Robson, 2011). As a nurse I abide by the Nursing and Midwifery Council code of conduct (Nursing and Midwifery Council, 2018a) and have a duty to report such incidents. Through using information sheets, the participants were fully informed of these issues, of the purpose of the study, their commitment and risks involved (Marshall & Rossman, 2011).

By considering possible ethical dilemmas, such as facilitation and identity, it enabled me to adapt and improve my study (Morgan, Ataie, Carder, & Hoffman, 2013; Oliver, 2010), for example, ensuring reflexivity was embedded throughout, a core element of hermeneutic phenomenology (Dibley et al., 2020).

5.2.1 Ethical theory and codes of conduct

Beauchamp and Childress' principles are a well-known ethical framework, including non-maleficence, beneficence, autonomy and justice (Beauchamp & Childress, 2009). Their principles have become heavily influential in western ethical decision making and education (Wright & Armstrong, 2018). However it was important to be aware of other theories and models of ethics to ensure the challenges are fully explored as some have argued that Beauchamp and Childress' model is restrictive (Armstrong, 2007). As stated by Austin et al. (2009) application of the four principles is inadequate within secure service studies and there appears to be tensions between the range of theories that researchers can draw on to explore the demands of such research (Edwards & Mauthner, 2002).

Armstrong (2007) also highlights, that Beauchamp and Childress did not consider virtue ethics until their 5th edition. Virtue ethics is broader as it considers the morality of character, although there are challenges to define and measure this (Morgan et al., 2015). Aristotle's philosophy focused on morality of character and what it means to be a good human (Morgan et al., 2015), which could create some debate researching those who carry a diagnosis of antisocial personality disorder[62] as they are defined as not conforming to such societal norms (American Psychiatric Association, 2013). Some aspects of virtue ethics conflict with my area, as patients carrying a diagnosis of antisocial personality disorder may be depicted as not being virtuous (Black, 2015). Virtue ethics suggests there needs to be an agreement with what the good society will look like and how to be good member. However if not everyone has the same view of a good society, this could potentially cause conflict (Ellis, 2015). Certainly, people labelled with the associated term psychopathy, are thought to have severe impairment in capacity for moral understanding (Ayob & Thornton, 2014).

Consequentialism also considers what is moral, and reminds me to take account of the possible consequences of the study for the students and the patients, so it was important to ask if the benefit participating outweighed the risk, for the greater good? (Ellis, 2015). There was the potential risk of psychological distress (Ellis, 2015), which was managed by my approach and gaining support from the ward team if needed. However, I was enabling participants voices to be heard which was of benefit to them (Dibley et al., 2020).

Relational ethics is a further contemporary theory aligned well with phenomenology and the research area (Austin et al., 2009). It considers what is the best thing for this person, at this time, and in these circumstances. Its emphasis is on interconnections of people and the environment of secure units, important areas of consideration in this particular study.

[62] Generally considered more common in secure services for men, as discussed in chapter 2.

Relational ethics is informative in guiding consideration of the complexities in everyday moments that occur between people in their space, though there is criticism it can be unstructured (Deschenes & Kunyk, 2020), hence the importance of reflexivity to return to the focus of the study.

Although Taylor and de Vocht (2011) argues that Heidegger stated ethical guidelines cannot guarantee ethical behaviour, similarly to Austin et al. (2009), it was essential as a researcher that I complied with codes of conduct and guidance. Two pieces of guidance I was bound by were the University code of conduct for research and, as a nurse, I was also bound by the Nursing and Midwifery Council [NMC] Code of Conduct (Nursing and Midwifery Council, 2018a). These ensure the protection of the participants (Armstrong, 2007; Health Research Authority, 2021b), though could have impacted how comfortable the participants felt and how honest they would have been if they thought that I could not maintain complete confidentiality (Jones, 1996; Robson, 2011). This was clear in the information sheets[63] and discussed with the participants.

5.2.2 Balance of risk and benefit

The balance between risk and benefit for the participants is a fine line (Beauchamp & Childress, 2009). I had a duty to ensure participants were protected from any unnecessary harm, which included psychological distress (Smith, 1995). However, there was a minor potential for harm and minimal benefit for the participants (Keogh & Daly, 2009). There is always some level of risk when completing research and it is not possible to completely eliminate this risk (Armstrong, 2007; Cribb, 2014) as studies are needed to advance the evidence base to enhance and improve care (Israel & Hay, 2006). Therefore, despite the

[63] Appendix 15.

ethical concerns raised, as researchers, our role is to consider such ethical concerns and propose resolutions in order to complete essential research (Dibley et al., 2020).

5.3 Reflexivity

The primary resolution of ethical challenges, was reflexivity; which ensures hermeneutic research is trustworthy, rigorous and ethical (Crowther & Thomson, 2020; Dibley et al., 2020; Peoples, 2021). It is not something done at specific points, it is a constant process, '*a hermeneutic circle in itself*' (Dibley et al., 2020, p. 145). Researcher reflexivity has become increasingly significant for qualitative (Darawsheh, 2014; Finlay, 2003; Walsh & Downe, 2006), phenomenological (Murray & Holmes, 2013), hermeneutic (Crowther & Thomson, 2020) and nursing researchers (Benner, 1984/2001, 1994). Reflexivity in hermeneutic studies must be *fore-grounded* because of *Dasein's* embeddedness in the world, in not doing so fails to acknowledge how *Dasein* is *being-in-the-world* (Crowther & Thomson, 2020). From preparation, through to interview, analysis and write up, reflexivity was a key component to ensure the soundness and credibility of my study (Darawsheh, 2014). In order to make sense of the data a reflexive diary is essential to help demonstrate the unfolding journey of reflective thinking[64] (Crowther & Thomson, 2020).

Reflexivity is the process of continually reflecting on interpretations and the phenomena being studied; to move beyond previous understandings and positively evaluate experiences (Finlay, 2003). Reflexivity was used as a method of raising my self-awareness and thus, enhancing the quality of my research (Murray & Holmes, 2013). Completing a diary (journal) was an effective way of demonstrating openness and awareness of my journey (Hwang et al., 2018; Lambert, Jomeen, & McSherry, 2010). However, it is important to be mindful that reflexivity is

[64] Hence the important of including excepts from my diary in appendix 30.

also limited dependant on how it is implemented (Finlay, 2003). Reflexivity is more than reflection, it is not only about exploring ourselves and experiences to gain insight, it is our capacity to dynamically and continually reflect on all other things and how they influence our research (Crowther & Thomson, 2020; Dibley et al., 2020). Thus, my reflexive positioning in relation to the subject matter needs to be declared and needed to be utilised as a resource in the course of data analysis in particular, guarding against preconceived conclusions, being open to disconfirming information and capitalising where possible upon knowledge of the research context. Hence the importance of beginning and ending the study with my reflections and providing excepts from my reflective diary[65]. Reflexivity ensures rigorous research; further elements of rigour demonstrating ethical practice in research are discussed later.

Within research, all interpretations are based on previous experiences of the participants and the researcher (Diekelmann & Ironside, 1998). Heidegger wrote about the three parts to the *fore-structure* as referred to in the methodology chapter[66]. In reference to my fore-structures of the study specifically, my *fore-having* is the background and familiarity with the phenomenon, the past. I worked as a nurse in a secure unit, experienced environmental and relational challenges in practice, supported patients with personality disorder diagnoses, supported students in their learning and vice versa. Through completing the study my understanding developed and hence gave me further *fore-having*.

Fore-sight is our present interpretive lens, informed from past experiences. The lens I was viewing my experiences through on my research journey continued to develop and impact on my *fore-conception,* highlighting the interlinking nature*. Fore-conception* is our anticipation of what our interpretations will reveal, our possibilities (Diekelmann & Ironside, 1998). From my past experiences I found humour a valuable element for supporting people, hence expected

[65] Appendix 30.
[66] Chapter 4.

this may be discussed by the participants. In addition to my awareness of the experience of negative attitudes towards the term personality disorder, this came from my experience in practice and subsequent reading during the study in completing the background and integrative review. I needed to be open that I expected such aspects to be discussed and therefore ensure my analysis was directed by the participants. Before undertaking the study I was located as a researcher with previous experience of nursing practice in secure environments and as a nurse lecturer with responsibility for relevant student nurse learning. I consider myself to hold a critical/progressive view of diagnostic categories such as personality disorder and understand the challenges of working therapeutically but safely in secure environments. I broadly support relational and trauma informed practices whilst acknowledging these can be in tension with the necessary desirability of minimising risk.

5.4 Interviewing

In considering the nature of the study and grounding stance[67], a qualitative approach utilising interviews was the most appropriate method. The time people share together is unique, thus in order to illuminate the experiences of this time, interviews were ideal and aligned with the methodological approach (Crotty, 1998; Walker, 2011).

Interviews were the chosen method as they bring raw and meaningful qualitative data (Jones, 1996; Soss, 2014). They enable the participants to voice their experiences, which may be limited if utilising other methods of research (Dibley et al., 2020; Jones, 1996) . Interviews can pursue questions that are difficult and intricate to explore (Soss, 2014). They are effective in collecting opinions and exploring experiences (Marshall & Rossman, 2011), particularly around experiences of social milieus in which people exist (Ryan, Coughlan, & Cronin, 2009),

[67] As explored in chapter 4.

like secure settings. According to Ryan et al. (2009), the interviews were unstructured/ unstandardised interviews; they were free flowing with one main open question yet with some prompt questions included in a topic guide[68]. Full interview schedules do not fit hermeneutically (Moules & Taylor, 2021), however some guiding questions can facilitate a loose agenda, which may change once the interview is underway and not restrict unexpected turns that can provide valuable learning (Dibley et al., 2020).

Interviews are a way of eliciting information on a set topic area by engaging in a conversation about experiences, with the goal of developing an understanding of that experience (Marshall & Rossman, 2011). Interviews provide the participants with time and space to discuss and explore experiences which they may rarely encounter with someone attentive, encouraging and patient (Soss, 2014). Nevertheless, it was important to consider other methods that may have been appropriate, as undertaking interviews with people who may be vulnerable can be a challenge for the researcher and participants (Ryan et al., 2009). In addition to this, interviews can be time consuming (Ryan et al., 2009).

People and their worlds are co-constructed; people make sense of their world from within it, not detached from it (Taylor & de Vocht, 2011). As Heidegger (1927/2019) wrote we are *being-in-the-world* and always *being-with* others. It was therefore a consideration to conduct joint interviews with patients and students. In Heideggarian studies this has been written about minimally. The presence of another in a joint interview can influence the experience of participants, and influence the descriptions they provide (Taylor & de Vocht, 2011). Due to confidentiality issues (Peoples, 2021) and also concern with potential damage to relationships and ultimately risks emotionally from such damage, it was deemed as inappropriate for this study aim. As Taylor and de Vocht (2011) state, joint interviews can be problematic, cause

[68] Appendix 17.

harm and create difficulties in relationships, therefore ethical consideration is needed (Rayner, 2010). It is impossible to predict or plan for in advance what effect another person's presence will have on data collection and the narrative obtained. The timing of interviews was particularly problematic due to student placement time and allocation, and identification of which student/ patient diad to interview. The researcher needs to be very clear about the study aims and make a deliberate choice of method considering methodological, ethical and practical considerations (Taylor & de Vocht, 2011). Heidegger's philosophy would not support one method in preference to the other, but helps clarity with regards to the strengths and limitations of each approach (Taylor & de Vocht, 2011).

5.4.1 Research rigour

Research rigour is often demonstrated by assessment of the reliability and validity of research. Although quantitively focused terms; they are essential in qualitative research due to the criticisms that its results are merely anecdotal (Lacey & Luff, 2007; Paley, 2005, 2016). Muller and Poggenpoel (1996) argue that qualitative studies are particularly valid in that data are consistently analysed. Often in qualitative studies rigour is demonstrated by trustworthiness, auditability, confirmability, credibility and transferability (de Witt, 2006). The examination of trustworthiness is crucial to ensure reliability and validity in qualitative research (Jayasekara, 2012). In doing hermeneutic research I am not aiming for generalisability in the sense that the experiences I interpret are the same for everyone, I am saying the participants experiences were shared with me at a certain moment, I interpret their meaning and invite you to share in this understanding (Dibley et al., 2020).

As demonstrated in the adapted McAllister and McCrae (2017) table below (table 4) the study demonstrated research rigour. In addition, further markers of quality were met as proposed by Tracy (2010). These include; worthy topic, rich rigour, sincerity, credibility, resonance,

significant contribution, ethics and meaningful coherence. This study meets these markers, along with the principles outlined by Yardley (2000); sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. However, as de Witt (2006) argue the '*use of a generic set of qualitative criteria of rigour for interpretive phenomenological studies is problematic because it is philosophically inconsistent with the methodology and creates obstacles to full expression of rigour in such studies'* (p. 215), in agreement with Rolfe (2006). Nevertheless, de Witt (2006) also advise that decisions around the research process need to be accounted for in a systematic way, I will therefore consider how rigour was ensured alongside reflexivity.

A key action made, to ensure rigour, was the consistent use of supervision throughout the study, including during the analysis, discussed later. Supervision enhanced the credibility of the findings as a result of exploration of decision making and interpretation (Crowther & Thomson, 2020). It encouraged reflexivity at all points of the research process, especially data analysis.

Trustworthiness of results is enhanced through extensive documentation of decisions throughout analysis (Asbury, 1995; Diekelmann & Ironside, 1998; McConnell-Henry et al., 2009). Reflexivity and supervision documentation promoted sound decision making and thus credibility of the study. Dependability (Lincoln & Guba, 1985) was demonstrated by such a decision trail documented in supervision notes and my reflective diary[69].

Additionally, the study met the requirements discussed above through the use of interviews as the ideal method for gaining the data needed, ensuring the reliability of the project (van Manen, 1990). Reliability is an important issue in qualitative research as it is dependent on

[69] Please refer to appendix 30.

the methods used (Lacey & Luff, 2007). Interviews are methodologically aligned with phenomenology and therefore the aim of the study. Furthermore, there was in-depth engagement with the topic; from initial exploration of the topic, to completion of the integrative review, to data collection and analysis, and through to interpretation and forming of conclusions (Yardley, 2000).

The data (experiences) were collected fairly and accurately ensuring the data was valid (Lacey & Luff, 2007), and ethical considerations were fully explored (section 5.2). Lincoln and Guba (1985) suggest prolonged engagement in the research area to demonstrate credibility[70], the research area has been an interest and developed since completing my Master's dissertation. In addition to the above, in undertaking phenomenology with a clear underpinning philosophy ensures integrity (Dowling, 2011), as evidenced in the philosophical thread throughout the thesis.

[70] As explored in chapter 1.

Table 4: Trustworthiness of the study

Quality criterion	Actions
Credibility	Patient and student participants Regular supervisory meetings and comprehensive notes Reflexive diary (see appendix 30 for excerpts) Methodological alignment
Transferability	Description of service (chapter 6) Reflexive diary and completion of theme development (see appendices 26, 27, 30)
Dependability	In-depth description of the study methodology and methods (chapters 4 and 5) Clear and in-depth exploration of analysis (section 5.8)
Confirmability	Regular supervisory meetings; independent review of transcripts, subsequent discussions, and development of themes Publication of integrative review chapter (appendix 23) Feedback on study from patients, the public, students, healthcare staff and academics Presentation of findings at conferences and specialist hermeneutic phenomenology courses (see appendices 22, 24 and 25)

Adapted from McAllister and McCrae (2017).

The power and beauty of hermeneutic phenomenological exploration is its uncovering of what lies below the everyday and its capacity to resonate and speak to those who read it, which is the true measure of rigour (Crowther & Thomson, 2020).

5.4.2 Feedback on the study

In preparation for completing the study I gained feedback from various sources. I presented at a University post graduate forum, a patient champion meeting and a joint University and NHS trust research development group. In addition to this, I gained feedback from presenting at conferences and through publication.

Public involvement in research promotes the involvement of people with relevant lived experience in research design and development, improving its quality and relevance (Health Research Authority, 2017). Discussing my study, in the early stages, at a patient champion meeting at a local secure hospital was extremely helpful and an essential element of conducting research (Health Research Authority, 2021a). I gave an overview of the study and the attendees asked questions and gave me feedback and shared their ideas. The group were positive about the study. They discussed getting family and carers involved, I discussed this as a possibility in the future. They asked if I could go for a walk with the participants, I discussed that due to security procedures this would unfortunately not be possible, though encouraged me to reflect on the importance of an informal approach to negate any issues with the environment. They said that doing the study may be therapeutic for the participants, which was heartening to hear and provided a further view of ethical implications of the study.

Some further elements of feedback I received was gained from a poster presentation of my integrative review findings and early findings at a specialist personality disorder conference[71]. In addition to presenting my study in the early stages and in later stages at a specialist hermeneutic phenomenology course, which opened invaluable questions from international peers across many disciplines. I also gained feedback from social media following the

[71] See appendices 22 and 24 for the posters, my early findings poster won most qualitative prize; appendix 25.

publication of my integrative review in the Nurse Education Today journal[72]. This feedback particularly helped my development of understanding from a patient perspective on my dissemination of the research and highlighted the importance of varying viewpoints, which I took forward in my writing. As stated by Dibley et al. (2020) such feedback can be considered as contributory to ongoing analysis, as the findings resonate with the everyday lives of people who have a stake in the area (particularly the social media community offering viewpoints on the term and diagnosis of personality disorder and its impact from a personal and lived perspective). Returning to such communities to share findings is aligned with the philosophy of hermeneutic research (Dibley et al., 2020). I was also able to gain feedback from students in a small pilot exploration[73].

5.4.3 Participant sample for the study

A purposive sample of patients and student mental health nurses from two medium secure personality disorder units (three wards) were invited to participate in the research. Sampling in hermeneutics is always purposive as it is essential the participants have had the experience of interest (Dibley et al., 2020). The students were second or third year/ final year mental health nursing students who were on placement at the time of interviewing, their placement length was variable. The patients were inpatients on one of the three personality disorder wards for men, across the two medium secure units, one NHS and one independent.

The size of the sample is considered adequate when interpretations are clear and visible (Crist, 2003). Guest (2006) states that data saturation provides little practical guidance for estimating sample sizes for robust research and is particularly inappropriate in phenomenological studies. Dibley et al. (2020) argues that data situation is impossible

[72] Appendix 23.
[73] Please refer to appendix 12.

because there is always something new lying beyond the reach of the particular study. Participant size in phenomenological studies have been as low as only one person (Dukes, 1984) and as high as 325 (Polkinghorne, 1988). Interviews with up to ten people is considered optimal (Creswell, 2017; Dukes, 1984), with Englander (2012) suggesting no less than three. One seeks to honour each participant by working intensively with the data, and very large samples negate this (Smythe, 2011). Giorgi (2009) proposes that the depth and quality of the findings should be the focus rather than the number of participants, and although Morse (2001) concurs with insurance of the quality of the data also suggests the researcher accounts for the scope of the study, the design and the nature of the topic when considering sample size. Though hermeneutic research does not seek to demonstrate representativeness, the larger the sample may reveal shared experiences and also differences and uniqueness that add depth to the understandings (Dibley et al., 2020). Often the number depends on the time available in addition to knowing that it feels enough (Smythe, 2011). I reached a point where it *felt* enough, and I was able to make interpretations in the time I had for the study.

5.5 Recruitment of participants

There were two medium secure units approached for recruitment; one NHS unit and one independent unit. The independent unit had two wards and the NHS unit had one ward. I found access to the units took time, which can be a common obstacle. Although, it is important to see their perspective, as research can make work for them (Dibley et al., 2020). Once, I was able to access the units, letters were disseminated to the appropriate people via email initially then printed versions were provided on visitation to the units[74]. Recruitment can be a difficult task and non-attendance can be an issue, therefore it is important to ensure agreed dates in advance (Rabiee, 2004). I visited the units prior to conducting the interviews, as per the

[74] See appendix 14.

proposal flowchart[75], to meet the staff, any students and patients. I put a folder on the units with all the information about the research in. On visiting, it enabled any interested participants (patients that were identified as able to participate by the staff team) the time to ask any questions, get all the information[76] and gain initial contact with me. Students contacted me by email to arrange times for their interviews. The patients were identified by the ward team as able to participate and then asked if they were interested. Once it was determined by the team that the patients were able to participate and were interested in participating in the study, they were given the information sheets, and I met them to introduce myself. Interviews were organised following this, ensuring they had time to read the information sheets and consider their participation in the study. I returned to the ward and conducted the interviews in either a quiet room on the ward or in the unit.

As highlighted in the information sheets, the participants were informed about the limits of confidentiality. They were advised their names would not appear anywhere in the research write up and pseudonyms would be used for any quotes, which is important to ensure participants feel comfortable (Doody, 2013). They were also informed that the transcripts would be wholly anonymised and people that would have view of the data would be the researcher, transcription staff and the research supervisors, and anonymised quotes would be used in the research write up and subsequent publications.

The participants were informed in the information sheets and by myself at the beginning of the interviews that if they revealed any risk to themselves or others, or if they discussed any information that raised concerns about theirs (students) or others' clinical or professional practice, then I would have to inform appropriate persons within or outside the University, in accordance with the University policies and procedures. This was also in accordance with the

[75] Appendix 21.
[76] Appendices 14-17.

ethical application. If there was a need to report an illegal act this overrides the confidentiality agreement (Robson, 2011). As a nurse, I had to abide by the NMC Council Code of Conduct (Nursing and Midwifery Council, 2018a) and had a duty to report such incidents.

The staff team decided which patients were able to participate, as stated in the ethical application, therefore diagnosis was not sought. The patients may have had co-occurring diagnoses of other mental health problems, learning difficulties or disabilities, and thus not excluded. Co-occurrence of types of personality disorders, mental health problems and learning difficulties/ disabilities are common for patients in secure services (HMPPS & NHS, 2020; Weaver et al., 2003), therefore to exclude would have been problematic if not impossible. The wards were specific personality disorder units, therefore the primary diagnosis was of personality disorder. The type of personality disorder was not known, unless referred to by the patient themselves. The experience of one condition is understood by participants in the context of any other, which adds meaning (Dibley et al., 2020).

A further consideration in recruitment was the flawed nature of personality disorder diagnosis itself (Tyrer et al., 2015), by recruiting from specified personality disorder units, it reduced concerns in recruitment around diagnosis. Asking the staff team to identify patients able to participate ensured soundness of the recruitment process. It reduced any potential risks of recruiting patients who may not have had capacity or that may have been unwell and become distressed during the interview. The staff team were best placed to identify patients who were stable, had capacity and who were interested in the study. It was then at this point I met the patients interested and organised participation.

5.6 Data collection

Data collection in hermeneutic research is an art; considering the participants while knowing what to follow up and what to leave and practicing reflexively throughout (Dibley et al., 2020). In addition to accepting that '*there is no right time from which to gain the perfect perspective'* (Smythe, 2011, p. 41). The interviews were held in either a quiet room on the ward or on the units where the patients were inpatients and students were on placement.

In each interview I was able to ask all my questions and the interview ended when it felt '*right'* to both myself and the participant. I noticed they either said "*I think that's everything*", or *"I can't think of anything else".* Or once I had asked all the prompt questions, once the participants came to an end of what they were saying, I always asked if there was anything else, they would like to say or share. To which they said "*no*". Hence, confirmation I did not require further follow up interviews.

The interviews were not aiming to explore the patients' history or gain their reflections on my interpretations (Crist, 2003), therefore repeated interviews were not pursued. I also did not share the transcripts with the participants, as the interpretation of text will always produce a new interpretation or meaning, therefore the participants do not hold particular privilege to confirm insights generated (McConnell-Henry, Chapman, & Francis, 2011). McConnell-Henry et al. (2011) in fact argue that '*member checking'* contradicts Heideggarian phenomenology philosophy and conflicts values of interpretivism. Hermeneutic research is not to demonstrate absolute truth but to reveal understanding at that time (Dibley et al., 2020). The analysis and thus themes identified were of my interpretation.

5.6.1 Transcribing

The interviews were digitally recorded and then the recordings were transcribed. Verbal data from interviews need to be transcribed into written form in order to conduct analysis (Braun & Clarke, 2006). Braun and Clarke (2006) recommend transcripts are reviewed for accuracy, both myself and my research supervisors reviewed the transcripts prior to the analysis and discussions were had. I did some of the transcribing myself to enable me to continue engaging with the participants stories and enhance my interpretation and analysis (Peoples, 2021). Of those I did not transcribe myself I read and re-read the transcriptions and listened and re-listened to the recordings, of which reduced the errors in the text (Halcombe & Davidson, 2006) and ensured I was fully immersed in the data and connected to the participants experiences (Peoples, 2021). I used humour in the interviews where appropriate, to reflect humanness and encourage relaxation (Moules & Taylor, 2021), as did the participants, particularly Leo, which enabled a comfortable atmosphere and maintained an informal feel[77]. It is however important to be aware that humour does not translate well in transcription (Dibley et al., 2020), I therefore added (laugh) at points to signify this to add context.

5.6.2 Data storage

Recordings and typed versions of the interviews and consent forms were stored securely in a locked cabinet at the university and electronic files were password protected (University of Central Lancashire, 2021). The consent forms were stored separately to the transcriptions with another name used. Personal data collected on the consent forms will be stored for five years following completion of the study as per University guidelines. Anonymised transcripts

[77] Explored in section 5.7.

will be open access via the university as identified on the information sheets and consent forms[78].

5.7 The Hermeneutic interview

There is not one way to do a hermeneutic interview, each is individual and special (Moules & Taylor, 2021). I was keen to ensure the participants felt comfortable when I interviewed them[79], as fed back from the pilot exploration, which included ensuring there was privacy and trust. We were able to have our own space during the interviews, which enabled privacy. A comfortable environment can ensure participants are at ease (Ryan et al., 2009), however I was restricted in the space we could use due to the environment. I therefore focused on building rapport to ensure comfort. It felt authentic for me to spend time building rapport with the participants discussing shared interests, for example, veganism with David, holidays and dogs with Oliver, music and television with Steven, television with George and children with Julie. This rapport building time aided in developing a comfortable environment and subsequent fluid conversations. Giving of ourselves and being open with people creates trust in phenomenological research (Dibley et al., 2020). The in-depth aspect of interviews can make them more conversational though they are still different from everyday conversations (Soss, 2014). Although Dibley et al. (2020) proposes that from a Heideggarian perspective the researcher may reveal as much of themselves as the participant, I also needed to be considerate of the potential risks with being in a secure unit. Nevertheless, interviews are a social interaction and the relationship between the researcher and participant is essential for a successful outcome (Moules & Taylor, 2021; Ryan et al., 2009).

[78] See appendices 15 and 16.
[79] See appendix 29 for some interview excerpts demonstrating style of engagement.

In the topic guide, I included '*Tell me about yourself'* as an ice breaker, however it felt more comfortable to just start talking rather than naming it as a specific question or ice breaker, all the participants engaged in a social informal conversation when either walking to the room where the interview was to be held or on entering the room. We chatted informally when looking at the consent forms and talking about the study, which felt authentic rather than staged as an ice breaker formal question. Once we had chatted informally and I had talked about the information sheet and general information, I asked the study question. This was open-ended broad question; '*can you tell me about your time with… (students or patients)?'.* I then used probe questions as I needed to explore their experiences in more depth or to take the participant back to something they had already revealed for deeper meaning (Dibley et al., 2020).

Although I did not conduct an interview using a shared dialogue approach (Sorrell-Dinkins, 2005), I did make connections with the participants to ensure the *time* with them did not *feel* like a formalised interview. Making human connections is a salient element of the interpretive research process (Soss, 2014). Though it is important to consider the impact of developing connections to then not see the participants again. It was therefore essential I was clear on my time with them for that set period.

It is important as a researcher to know your limits and the limits of what you can provide to the participants (Soss, 2014). Although I have the skills of being a mental health nurse, which is useful in conducting interviews (Ryan et al., 2009), I was not there to support either the patients or students with their mental health problems. While it is important to develop trust and connections, boundaries of the role of the interviewer needs to be clear (Ryan et al., 2009).

I also needed to be aware of the emotional impact the interviews may have had on my own mental health, as the researcher role is a human role, particularly in interpretive studies (Soss,

2014). Supervision was crucial in this regard. During my interview with Julie, she disclosed an experience of trauma. It was important for me at that point to use some skills I developed as a mental health nurse to support her during this disclosure and check she was okay following this. For nurses supporting people is second nature to us (Dibley et al., 2020), hence I felt confident to support her during her disclosure. In addition to this, I ensured I was supported with my own mental health. In conducting hermeneutic interviews we find some of the most distinctive and fruitful findings, as they bring emotion to the surface; intended or not, hence the importance of considering ethical implications earlier (Ryan et al., 2009). Emotions advance rather than threaten research, they are crucial to explore and interviews are a sound method for enabling this (Soss, 2014).

The use of silence is important (Ryan et al., 2009), though I was worried about this. I reflected on my feelings towards silence and acknowledged prior to the interviews that there may be silences and that they were helpful for myself and the participants. Silence can provide the researcher and participants time to think about anything else they may have missed or enable time to reflect on what has been said. Silence can often speak louder than words (Sorrell-Dinkins, 2005). van Manen (1990) spoke of epistemological silence in which we face the unspeakable, which may be due to pain or difficulty in choosing the words to express feelings. I experienced fleeting silences during the interviews and sat with these.

I used a dictaphone to record the interviews, which enabled me to be fully present in the interview, as I did not have to take notes, which was immensely liberating; fully investing in the conversation, really listening to the participants and focusing on what they were saying. It allowed me to ensure I was fully present. Conversely, I noticed that although I missed seeing Julie and Molly face to face, interviewing them on the phone due to the pandemic Covid, enabled me to make notes reminding me of questions to ask. In this way they were not a distraction as Walker (2011) warns.

5.8 Data analysis

There is no single correct way to analyse data in hermeneutic research (Diekelmann & Ironside, 1998). As argued by Smythe et al. (2008) every person will take away their own thoughts formed as a result of their past experiences and their '*thisness'* of their own situation (p. 1393). No hermeneutic phenomenological projects are the same, nor should they be. As stated by Crowther and Thomson (2020), they are a *fusion of horizons* (Gadamer, 1967/1976) of the time, people and places. '*Remaining open to the possibilities encourages uniqueness and creativity in research*' (Dibley et al., 2020, p. 48).

Additionally, as acknowledged in other research (Schafer & Peternelj-Taylor, 2003); the experience I have adds further credibility to the study and challenges the view of Lincoln and Guba (1985) of the benefits of being a stranger in a strange land as Husserl proposed (Peoples, 2021).

Smythe et al. (2008) reflects that hermeneutic research is to engage and provoke thinking about the experience of being human, which can only be achieved by recognising the limitations that being human brings; therefore we need to accept and celebrate the mystery in hermeneutic phenomenological research. I therefore took an individual approach to my analysis, to *feel* and dwell in the data with influence from Heidegger and the hermeneutic circle (Dibley et al., 2020; Smythe, 2011). Although this underpinning philosophy was not intended as a guide for research, and I honour that I am not a philosopher, it can encourage questioning and enable understanding of meaning and thus be used as a foundation that informs interpretive decisions (Crowther & Thomson, 2020). In addition to the foundation of Heideggarian philosophy, I was influenced by the approach to analysis of van Manen (2014), principles from Peoples (2021), Crowther and Thomson (2020) and Crist (2003). A simple

thematic analysis is not enough in hermeneutic phenomenological research (Smythe, 2011), hence my individual approach.

Researchers must wait patiently (or dwell) and tolerate the uncertainty and woolly nature of analysis (Dahlberg, 2011). van Manen (2014) refers to this as passive activity. Hermeneutic research gives wonder, openness and is unbounded, hence analysis of research through a Heideggarian lens can feel unnerving, unsettling, uncomfortable, intimidating, messy and unstructured (Crowther & Thomson, 2020; Dibley et al., 2020; Neubauer et al., 2019). It is not recommended for novice researchers (Dibley et al., 2020) and some can struggle with the free-flowing nature of letting the thoughts come (Smythe, 2011). However, I found an instinctual skill in viewing the findings through a Heideggarian lens, perhaps from my experience as a mental health nurse (Holm & Severinsson, 2011) and being drawn to the methodology and research area (Dibley et al., 2020). Perhaps I was attuned to phenomenology (Smythe, 2011) as I found thinking in such a way strongly resonated. As stated by Smythe and Spence (2020a) one must '*trust the process'* (p. 7). As advised by Dibley et al. (2020), once sitting with or relaxing with the data, understanding will come and grow. Running and swimming[80] enabled meaning to show itself and I experienced many phenomenological nods, as conceived by van Manen from Otto Bollnow (Dibley et al., 2020). Or as Peoples (2021) describes aha moments.

I took inspiration from elements of Crowther and Thomson (2020) approach, who propose three levels of analysis in hermeneutic studies; firstly crafting[81], describing and initial interpretation, then deeper interpretation and finally interpretive leap where philosophy draws us deeper in to analysis. The leap enables you to say something more from between the lines,

[80] As explored in chapter 1.
[81] I have included some short crafted stories in appendix 30.

dwelling with the philosophy and resonance coming through at the heart of the study (Smythe, 2011).

Hermeneutic research moves beyond descriptions to uncover meaning (Crowther & Thomson, 2020). Reading individual texts and then considering them all as a whole influences the way you understand the individual texts (Peoples, 2021). Hence, although importance is placed on individual experiences and interpretations of them, it is also influenced by their similarities, differences and themes. This is part of engaging in the Hermeneutic circle (Neubauer et al., 2019). This level involves engaging in Heidegger's texts and other phenomenological texts, which is crucial in hermeneutic studies and distinguishes it from other approaches (Dibley et al., 2020), hence the importance of time and space to dwell and think (Crowther & Thomson, 2020). When a researcher begins to dwell and ponder the data and its meaning, that is when the philosophy comes alive (Smythe, 2011).

I read and re-read the transcripts, and listened again to the recordings, and considered and then reflected upon the themes. Themes can give order to our research and writing and are part of the iterative process (Dibley et al., 2020). However, they are only tools for writing (van Manen, 2017) and there is no one framework to develop and identity themes. The areas of meaning reveal themselves through the analysis, and move a researcher deeper in their understanding, in addition to relating to ontological experiences instead of categorical ideas (Dibley et al., 2020). I was also continuing to read and develop my understanding of hermeneutics and Heidegger. It enriched my development as a researcher and person, and therefore impacted upon further analysis of the transcripts. I would not have achieved the depth of analysis without Heidegger's influence and insights I gained from engaging in hermeneutic phenomenology.

The process of analysis is iterative and not linear, interpretations are complete but never ending, such as the Hermeneutic circle (Crist, 2003; Diekelmann & Ironside, 1998). Hermeneutic phenomenological research is unique in the richness the findings and interpretations offered; integration of philosophical and research concepts and their interpretation do not end with completion of the study/ thesis (de Witt, 2006). '*An unfolding and infolding occurs as the data is read and re-read, considered and re-considered, examined and re-examined. There is no beginning or end, no top or bottom to this circular process'* (Greene, 2009, p. 23). Hermeneutic research never claims to be complete or final (Crowther & Thomson, 2020). I make no attempts to claim any interpretation as right or the truth, they are a representation of the *fusion of horizons* (Gadamer, 1975) between the participants and my pre-understandings and interpretation at that moment in time (Dibley et al., 2020; Smythe, 2011). We are always on our way (Diekelmann, 2005). However, in order to *complete* the thesis, there had to be a point where I was happy it was *enough* at that time within the word count restrictions (Paley, 2016). There was a time when the thesis needed to be completed and disseminated, yet knowing that there was much still unthought and unsaid (Dibley et al., 2020; Smythe, 2011).

> '*The quest is to provide a research report that enables the audience to engage with the experience as lived by others, to ponder afresh the phenomenon in question, and to be taken along on a showing, thinking pathway which invites more questions.*' (Smythe, 2011, p. 37).

My visual analytical process

The process of analysis and interpretation is often not made specific in such methodological studies despite its widespread use (Crist, 2003). I therefore provide my analytical process (table 5) below to ensure rigour and transparency (McConnell-Henry et al., 2009), though not to dimmish or contain the flowing nature of the analysis undertaken, as explored above.

My analytical process was iterative; mirroring the Hermeneutic circle. The below is what this looked like, however I moved from steps forward and back and viewed this process and circular and spiralling, going down towards my understanding.

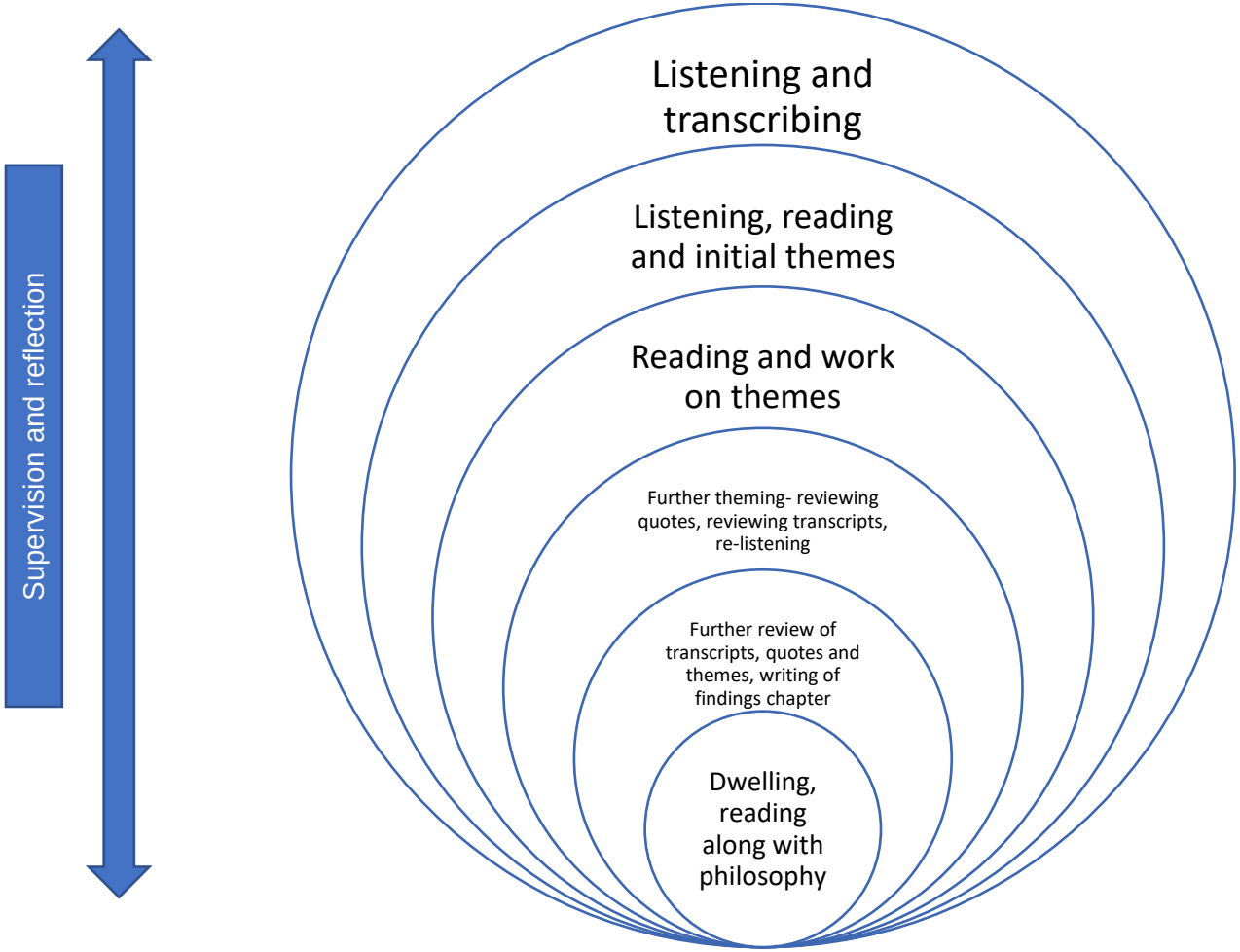
Table 5: My detailed analytical process

- First listen to check timings- make notes, reflections, think about emerging themes
- Second listen and first read- transcribe/ send for transcribing- check transcription- make notes, reflections
- Second read and theming- starting to pick out quotes and themes- make notes, reflections
- Third read and themes- work on themes
- Reviewing quotes, reviewing transcripts, re-listening
- Further analysis, tweaking of themes and sub themes
- Further review of transcripts, dwelling, review of quotes and themes, examining the whole and the parts, back and forth
- Pulling quotes to findings chapter
- Further analytical review of themes and quotes during development of findings chapter
- Further development from working on findings chapter drafts
- In-depth dwelling when working on discussion chapter- reading along with philosophy to develop thinking (this was a substantial step)

*Use of supervision and reflective diary throughout all steps.

Figure 5: Visual representation of analytical process

This diagram shows the circular nature of the analytical process, like the Hermeneutic circle.



5.8.1 Computer software

Computer software was used to support the analysis the data collected (NVivo). Such computer software can be a powerful ally to support the management of data and can be helpful in organisation and demonstration of interpretive progression (Carter, 2004; Dibley et al., 2020). However, I was mindful of how technology could have diminished my interpretation of the data or loss of important details (Peoples, 2021; Ritchie & Lewis, 2003; Smythe et al., 2008). I therefore interpreted the data manually first and then used NVivo to develop my analysis further, returning to manual interpretation as it resonated most.

5.8.2 Supervision

Throughout analysis it was important for me to complete a reflexive account to highlight any issues that may have arisen (Braun & Clarke, 2006). I ensured this was completed and utilised supervision to discuss any issues. The interpretation was my own, I did however utilise supervision to support my analysis and development of themes (Crist, 2003). Although not required for analysis in hermeneutic phenomenology, team involvement, through debate and discussion, adds depth and insight to interpretations (Crist, 2003). Exploration of interpretations during supervision was essential to recognise assumptions where able and interpretations made, an approach to engage in the Hermeneutic circle (Crist, 2003).

5.9 Conclusion

This chapter has explored the ethical considerations relevant to conducting the study, highlighting reflexivity as the key element to ensure full consideration of the ethical complexities and challenges of the research. Interviews were the chosen approach for this study with reasonings outlined. Research rigour followed this before discussing recruitment

and data collection. The hermeneutic interview and my analytic process were outlined and discussed alongside underpinning approaches.

Ethical approval was gained from the Health Research Authority. It was essential to explore the ethical considerations of the study, identifying reflexivity as core in ensuring the trustworthiness of the study. A purposive sample of patients and student mental health nurses from two personality disorder units (three wards) were invited to participate in the research. Unstructured hermeneutic interviews were completed. I conducted an individual approach to analysis, to feel and dwell in the data with influence from Heidegger and the hermeneutic circle.

In the following findings chapter, I outline the participants leading to a narrative of the findings and participant quotes. Themes of the findings from both participant groups; patients and students, are discussed *together*, aligned with the exploration of the participant's time; shared *together*. A conclusion is provided which summarises the key points from the themes discussed.

6 Findings

In the previous chapter I provided an overview of the ethical implications that were considered for this study and how resolutions were decided upon. I also discussed my methodology and approach to interviews and recruitment of participants. The hermeneutic interview and my analytic process were outlined and discussed alongside underpinning approaches. In this chapter I turn to present my findings.

6.1 Introduction to the chapter

I outline the location of the participants in this chapter leading to a narrative of the findings and participant quotes. Themes of the findings from both participant groups; patients and students, are discussed *together*, aligned with the exploration of the participants' time; shared *together*. The time shared between patients and students cannot be understood without reference to each other. This section is organised using the themes and subthemes, as identified in a thematic map, which ensures a logical order to the presentation of the findings. A conclusion is provided which summarises the key points from the presented themes and leads on to an exploration of aligned philosophical, sociological, psychological and pedagogical stances in the discussion chapter.

6.2 Findings in phenomenological studies

This study is underpinned by an interpretive hermeneutic phenomenological approach hence, the findings are constructed according to how I have interpreted the data and organised it into themes. Phenomenology is a way of thinking and being (Crotty, 1996; Crotty, 1998; Dowling, 2007; Moran, 2000), and therefore has influenced my interpretation and understanding of the

participants' experiences (Dibley et al., 2020). It is important to note that using themes to present findings could be restrictive and forcing a linear structure rather than a revealing (Dibley et al., 2020), hence the thematic map (figure 6) and my pictorial representation of the findings (figure 7) demonstrates the inevitable overlap within the themes. Although they are presented as separate themes for clarity and structure of exposition, there is an interlinking nature of the themes, due to the natural and cyclical way they are experienced in everyday life, aligning with the Hermeneutic circle. I was led by the findings illuminated in this research to structure this chapter.

6.3 Context

There were two medium secure wards at the independent unit, ward one was an assessment and treatment ward for patients carrying a primary diagnosis of personality disorder who would then move on to ward two. Ward two was a treatment ward for patients carrying a primary diagnosis of personality disorder who were starting the transition of transferring to other units as part of their care pathway.

In considering the spatiality (van Manen, 2014) of the units and the landscape, the following are some observations. Despite ward two being a pre-discharge unit, ward two felt more '*unsettled*'[82] than ward one, which was commented on by the ward manager at the time. This was apparent in the way the staff appeared busy and stressed (sighing and rolling eyes when discussing how busy it was). In fact, I was delayed visiting ward two as it was '*unsettled'*. The staff on ward one were welcoming and appeared relaxed when speaking with each other. The

[82] Unsettled refers to the feeling of an atmosphere of unpredictability and tension. I observed staff tense in their interactions with each other and patients; to the point, brief and rushed, not relaxed with pleasantries as on other wards.

wards physically mirrored each other, each had a meeting room, a small communal lounge, small kitchen, staff office and then the en-suite bedrooms were down a corridor from the office.

The NHS unit was one ward with two sides, the students were on placement across the whole ward. It supports patients carrying a primary diagnosis of personality disorder. Side one (as ward one at the independent unit) was for assessment and treatment side who would then move on to side two. Side two (as ward two at the independent unit) was a treatment side for patients who were starting the transition to other units as part of their care pathway. When visiting the NHS unit, I felt relaxed and comfortable. The staff had a lovely, welcoming and approachable manner. They were friendly towards the patients with a relaxed, comfortable outlook. There was a courtyard in the middle of the unit, with en-suite bedrooms around this, and a large communal area and activity room, with the manager's office opening on to this. The staff office was situated on the other side of the unit near bedrooms at the bottom end. This unit was more open and appeared brighter than the independent unit because of the windows and larger spaces.

6.4 Participants

Seven patients participated in the study; four were from the NHS unit and three from the independent unit. There were five students; two from the NHS unit and three students from the independent unit where the patients were inpatients (see table 6). I have chosen names for the participants, rather than numbers, to add to the reading and richness of the findings, in addition to emphasise the human situatedness of the research (Dibley et al., 2020). There are some more dominant voices in places, when particular concepts were important to the participants, for example Leo in theme 1.2, however I endeavoured to consider the extent of perspectives through analysis and data presentation.

I firstly interviewed David, Steven, Fred and George at the NHS unit[83]. I then interviewed Hollie who was on placement at the independent unit (ward two). Later in the study I interviewed Oliver (student), Jasper and Mike on ward one of the independent unit. Followed by Leo and Bella on ward two. Following the pandemic Covid-19 I then interviewed Julie and Molly by phone from the NHS unit.

Jasper and Mike spoke about Oliver's time on placement, as does Oliver speak of his time with Jasper and Mike. Bella was on placement where Leo was an inpatient, however they do not refer specifically to each other. The other participants do not refer specifically to each other, as they may not have shared time together.

[83] All names have been changed to ensure anonymity.

Table 6: Participants

Names (pseudonyms)	
Patients (all men)	
David	NHS unit (side one)
Fred	NHS unit (side two)
George	NHS unit (side two)
Steven	NHS unit (side two)
Jasper	Independent hospital unit (ward one)
Leo	Independent hospital unit (ward two)
Mike	Independent hospital unit (ward one)
Student nurses	
Bella (woman)	Independent hospital unit (ward two)
Hollie (woman)	Independent hospital unit (ward two)
Oliver (man)	Independent hospital unit (ward one)
Julie (woman)	NHS unit (both sides)
Molly (woman)	NHS unit (both sides)

6.4.1 Brief biographies of the participants

Patients

David

David had been in mental health services since he was an adolescent and was in the NHS unit when I interviewed him. David was very chatty and the longest interview I did at almost two hours. Prompt questions were not needed as he went in to detail about all his responses. David was vegan and enjoyed talking about that with me as a shared interest to build rapport.

Fred

Fred was involved in teaching students in the NHS unit he was residing in. He had a broad regional accent which was tricky to understand at times. I was mindful of asking for clarification on a few things he said. He had physical health issues which he taught students about.

George

George had been in services for many years and resided in the NHS unit when I interviewed him. He had Autism which he was open in talking about. George liked watching television and referred to it a lot during the interview, we spent time speaking about television building our rapport.

Jasper

Jasper was from the North West and had been in services for 6 years. He felt he was previously misplaced and felt he was now getting the psychological support he needed. Jasper was interested fitness and liked going to the gym. Jasper felt easy to interview as he expanded on all his responses and prompt questions were minimally needed.

Leo

Leo had previously been in prison prior to moving to the secure unit he was residing in when I interviewed him. He was in the independent unit. He had a broad Northern accent. He loved playing cards and spoke about it a lot. Leo was easy to interview as he was chatty throughout.

Mike

Mike had been in services for over 20 years and was residing in the independent unit. He was previously a professional football player. He had Autism which he was writing a book about. Mike was moving to a lower secure unit soon after we met. I needed to ask prompt questions to gain more detail.

Steven

Steven worked with the Care Quality Commission and visited national level meetings. Steven was moving to another lower secure unit in the few weeks following our interview. Steven used to like going to concerts and gigs which we spoke about. I needed to ask prompt questions to gain more detail.

Students

Bella

Bella was in her third year of the BSc in mental health nursing and on her second to last placement. The placement was five weeks, she was on her last week on the placement. Bella liked cooking. Bella was detailed in her answers, despite saying she was not chatty.

Hollie

Hollie was on her last placement of her third year of the BSc in mental health nursing and was finishing her last week on the placement. Hollie enjoyed playing scrabble with patients. A relative of hers had a personality disorder diagnosis which was why she was interested in the study. Hollie was easy to interview; she explained her answers and had an approachable manner.

Julie

Julie was in her third and final year of the BSc in mental health nursing and was on her last placement before becoming a qualified nurse. She was an employed student during the Covid-19 pandemic. Due to Covid-19 I did Julie's interview over the phone. Julie spoke about her children and we built rapport based on this.

Molly

Molly was a third-year student employed as an aspiring nurse during covid, she was on her last placement. She had got a job on the same ward as a qualified nurse. We shared a common interest of having dogs and online shopping. Molly was easy to interview, she expanded on all of her points and I did not have to ask many follow up questions, she gave examples and went into detail about her experiences. Due to Covid-19 I did Molly's interview over the phone.

Oliver

Oliver was a third year student on his second to last placement of the BSc in mental health nursing. The placement was for five weeks, it was his last week on the placement. Oliver was interested in fitness and going to the gym. We spoke about holidays and dogs to build rapport. Oliver was easy to interview; he showed humour and gave detail in his answers.

As Oliver was the only student who was a man, when discussing his experiences, I have put (student) following his name to ensure clarity. Other than this the students were women and the patients were men.

6.5 Findings

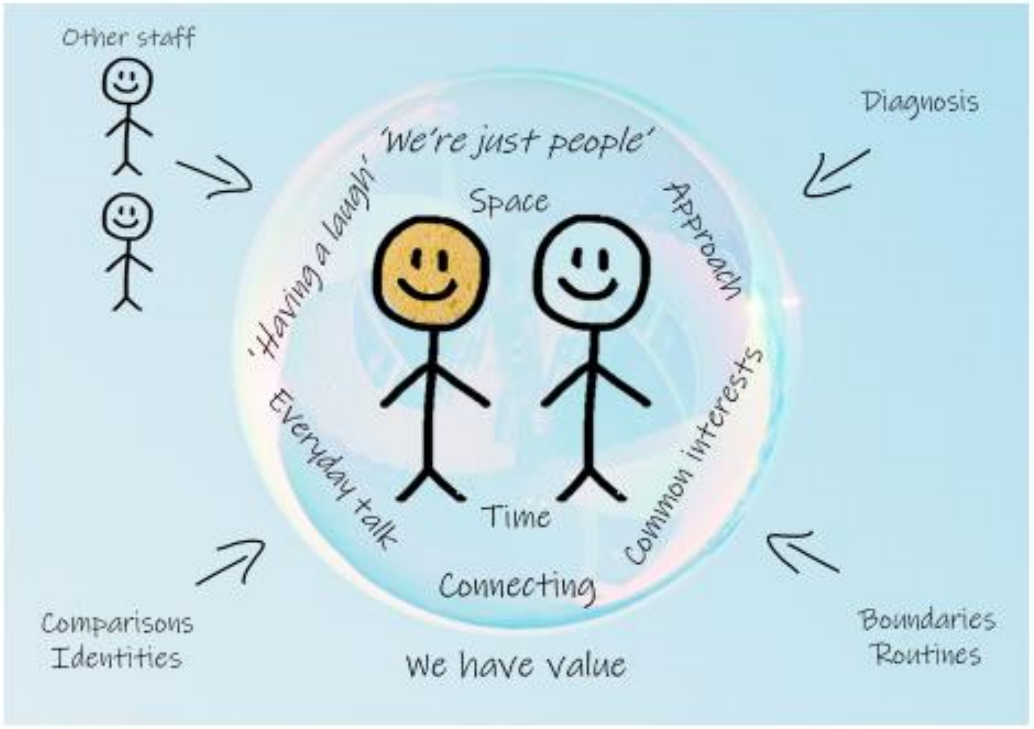
I will now explore the findings of the study by giving a narrative of the experiences of the participants, explored using themes. Naming the themes (or patterns) is an art to use language that conveys understanding and needs to be grasped by the reader (Dibley et al., 2020). I have used quotes from the participants to depict some of the themes to acknowledge their language use and demonstrate understanding of their experiences. In addition to the Thematic Map I have also included a pictorial representation of my findings (below, figure 7) to show the lived nature of the findings and although I discuss them in themes to provide a coherent structure the pictorial representation depicts how I view the findings. I hope this aids the reader in seeing the parts and the whole in a visual way, as I have found essential to my interpretation.

Two key themes and an overarching theme were decided upon, as shown in the Thematic Map below: '*Everyday stuff*' and '*Balance'* with the overarching theme of '*Impact'*. These will now be presented.

Figure 6: Thematic map

Figure 7: Pictorial representation of the findings

In this pictorial representation of the findings you can see how I view the findings visually; the student and the patient are at the centre and their shared time in a *bubble*. Within this they experience '*everyday'* talk, they '*have a laugh'*, and connect over common interests showing they are '*just people'* and have value. Identity, physical time, comparisons and other staff all influence this, in addition to the surrounding landscape of routines, boundaries and diagnosis. These areas are explored in the structure as depicted in the Thematic Map (figure 6).



6.6 Themes

I now present the findings of the study in the themes identified in the above Thematic map (figure 6). I begin by discussing Everyday stuff with the three subthemes; '*Just being around'*; '*Having a laugh';* and *'The way you speak to people is important'*. Balance with three subthemes; Recognition: '*We're just people';* and they're the same as us; Identities: '*More like us';* and Weathering the ride: '*Sponges'* to holder of keys, will then be discussed. This will be followed by the third overarching theme to end the discussion; Impact with three subthemes Time; Having value and feeling valued: '*Damn well not useless now';* and The landscape[84].

I start and end each theme with a quote, going back to the participants' themselves.

6.6.1 Theme 1: Everyday stuff

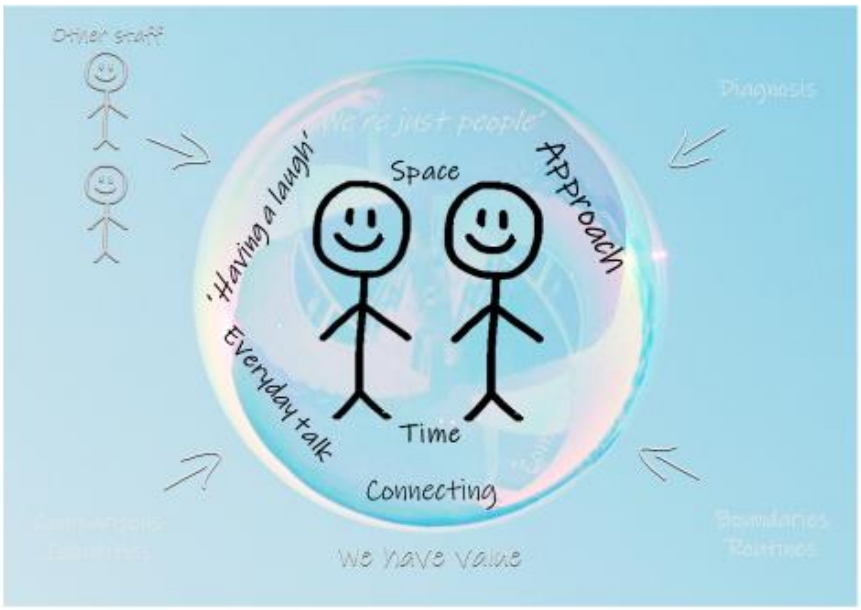
Summary

In the first theme Everyday stuff there are three subthemes; '*Just being around*', '*Having a laugh'* and *'The way you speak to people is important'*. Both patients and students talked about the importance of doing '*normal stuff*' (Steven) which included watching television, engaging

[84] Use of italics in the theme titles signifies quotes from the participants.

in various activities and just talking. By '*just being around'* (George); just being together; being there; doing everyday stuff the students appeared to help the patients to feel human, feel *normal* by escaping reality and coping in a strange and boring place. For the patients it was '*just/ quite nice'* (David, George) being together doing everyday stuff despite being in a secure unit. For the students it was nice to just chat to patients and watch television with them to get to know them. It was something that felt '*normal'* (Hollie, Oliver (student)) for the students, like '*having a laugh'* (David, George, Hollie, Jasper, Julie, Leo, Oliver, Steven) which showed the connections they had as humans together. The time they shared just being together doing '*everyday stuff*' and '*having a laugh'* was a gift and made both patients and students feel valued.

For the patient and student participants in this study, the way you are, the way you speak to and approach people is important. A person's approach to someone can be supporting and positive while also negative which was linked to poor attitudes by the participants. The way students engage with patients and how they approach spending time with them can impact positively, negatively and indifferently on patients.



The landscape

Subtheme 1.1: '*Just being around*'

> *… 'this nursing student came and sat with me and we did the modelling together, so that was nice.'*
> *(George)*

The patients and students referred to the value of simply being together; '*just being around*' (George) whether watching television, playing pool, talking, playing cards or just sat together. This appeared[85] to help them feel human and feel *normal* in what was an abnormal place. By talking about everyday stuff or '*normal stuff*' (Steven) it influenced their mood, helped them feel a connection with others and relieved boredom. Appearing to be due to the environment; watching television was a focal activity that opened conversation between students and patients, and promoted connection with peers, thus encouraging a sense of humanness. As a result of the positive impact of being together, it was noticed and judged if students spent time in the office. All the participants spoke in some way about '*being there'* with each other.

'*Just being around'* together appeared to give the students and the patients a sense of normality, in an abnormal place that was the secure unit they were in. '*Just being around'* involved '*just having a normal chat'* about where people were from and hobbies they do (Leo). Hollie reflected that engaging in conversations gave patients a sense of normality into their lives, she identified this as essential for the patients in helping them feel comfortable. Talking about everyday stuff together had a positive impact on the patients and students' mood. Oliver (student) thought it was nice to interact with people and how it would be '*awful'* not speaking to anyone for a shift on placement. Steven spoke of how having a general chat cheered him up:

> *… 'If you're sat around and you chat with somebody and they mention something about a band or something like that or talking about tour or gig and you can get on about that. And they're talking about normal stuff it's sometime, really cheers you up…*
> *(Steven)*

[85] Spence (2017) encourages the use of words such as 'suggest', 'appear' and 'perhaps' to create a tentativeness consistent with hermeneutic phenomenology.

Patients valued general '*chit chat'* (George, Jasper, Molly) and just talking about *normal* things like politics and music. This links with theme 2.1, where the patients and students made connections by sharing common interests like football (Bella, Hollie, Leo, Oliver (student)). Mike spoke of a good experience when he was sharing time with a student; she was engaged and asking him questions, he said how they were '*flipping from one conversation to another, from politics, history'*, which made him feel the student was interested in what he had to say.

Molly said that although she spoke to patients about *'trivial things',* the patients appreciated it '*because they don't want all of the time to be about medical jargon or things about their mental health or why they're in'* and how it was nice to have a '*break'*. She identified that '*trivial'* conversations helped the patients feel like a '*person rather than a patient'*. For Jasper, chit chats were about '*pretty standard'* stuff and '*nothing super heavy'*, yet they made him feel more positive about his future; highlighting that he could spend time with people who were from outside the unit and have similar interests with them, despite him being an inpatient:

> *… 'It just makes me feel more positive about my future. I'd say with [student], you know what I mean, with similar music tastes, and similar interests, similar sense of humour, so it's just good, it's just a good, positive thing.'*
> *(Jasper)*

Patients discussed the value of students always being there for them '*day after day'* supporting them (George) or always being there to talk to:

> *'The students here, they're open to let you talk… Even if you find it a bit hard at times they're always there…'*
> *(Fred)*

The patients and students described spending time with each other as being similar to being with a mate (Bella, Jasper), partner (Steven) or a friend (Bella, Hollie) and this being a positive thing linking to feeling human and having a sense of normality. Jasper spoke about going on leave with a student which he described as being fun and '*just like being out with a mate'*, listening to music, getting food and going to a museum. For Steven he also spoke fondly of

sharing an enjoyable time with a student, comparing this with being with a partner, while being aware it was different and that he was still an inpatient in a secure setting:

> *'I went to [theme park] with, it was just being, I know it sounds odd, it was just like with your partner or whatever, even though it wasn't. It just felt really good to be able to walk around with them, go on rides with them, and just, I hate using that word normal stuff, but, yeah just like that. Just felt really good I suppose, you could be, I think relaxed, just do things rather then, even though you're in, in like medium secure setting, but you can just, enjoy the student on there, and enjoy your time with them I think is really really good.'*
> *(Steven)*

The students also identified spending time with patients as being the same as if they were with '*anyone else'* (Hollie). Hollie said when she played scrabble with patients it was like playing with her friend, having a chat. Bella spoke of going on leave with a patient and getting to know him to try and '*make this friendship work'* and how she believed patients wanted students to talk to them like a mate or friend. Although the patients and students saw each other as '*friends'* spending time together in an informal relationship, Hollie identified the difference between being friends and being friendly:

> *'It is different than friendship, but it's a very fine line. It's not friendship but you still interact with them the same way that you would with your friends, but maybe a more moderated version of it is the best way to explain it.'*
> *(Hollie)*

There was also the identification of a more formal student role of helping the patients through difficult times. Hollie found that if there were a few people sat chatting or playing games others would join, and patients would ask others to join if they looked sad or upset, which she said was nice to see. George noticed that if he was feeling anxious or sad that students would come and talk to him, which helped him a lot. He found it relaxing and comforting to always be able to talk to them and nice that they would check how he was doing. He also found that normally he did not see staff come into the communal areas but when students were on placement they would *'spend time with you and it's nice'*. He said that the students spent '*quality time'* with him; playing games or watching television which helped him when he was

'*feeling a bit down'* and to cope with his anxieties. Fred spoke of how a student supported him just by sitting and talking after a challenging ward round:

> *… 'talk to them. Whatever I talk to my main nurse about I talk to a student about. If I come out of a ward round a bit wound up and a student nurse is in our TV room or our corridor there and, "How are you?" "A bit wound up after the ward round, but going to learn to settle for a wee bit before I get it right in my head." Then we'll just sit and talk about it. "Is there anything I can help you with?" "Yes, well…talking.".'*
> *(Fred)*

For David, Leo and George the time the students spent with them made them feel valued[86], the time they had was a gift the students gave them which made them feel worth something, which was noticed. Just like it was noticed if students did not spend time with the patients, on the '*shop floor'* (communal areas) and spent their time in the office (Mike), these students were called '*office hiders'* (Oliver (student)). Mike referred to students learning '*nasty habits'* from the nursing staff by '*going into the office and skiving'*. It is interesting that his view was that staff were skiving in the office and not *working*. He said it was brought up at each ward meeting and the patients said the staff should be '*out here'* (in communal areas) with us as they were '*not employed to go in there'*. Oliver and Molly each spoke of this and referred to getting '*stuck in'* by spending time with patients doing activities and supporting leave from the unit, rather than '*spend all the time in the office'* (Molly):

> *'I don't think you should be sat in the office because, at the end of the day, you're providing a service, aren't you? I think you should be out on the shop floor, really…*
> *… I mean, as a student, you're here to observe as much as you are to engage. You know, you've got certain things that need to be completed and what have you, but I like to get stuck in. Like, there are plenty of office hiders…*
> *…Students who hide in a corner in the office.'*
> *(Oliver, student)*

Doing activities helped both the patients and students feel valued as it opened up conversations. Activities were helpful for patients to cope and also students settle into the ward and cope too. Leo spoke of helping students settle into the ward by approaching them to bring them *'out of their shell'* by doing activities like playing Xbox or cards:

[86] Explored in theme 3.2.

> *… 'I'm not going to let them sit there and think, "Fuck, what am I supposed to do?" Just go and approach them, ask them, "Would you like to play Xbox? A game of cards?" or just sit down and have a chat. Instead of making them sit there and just looking like this, that and that, just always approach.'*
> *(Leo)*

Engaging in activities acted as something different to break the day up and relieve boredom. Hollie reflected that patients must get bored and identified that she would as well, so she spoke of sitting in the communal areas chatting to them, aligning with George who stated that *'it'd be pretty boring without students here'*. Steven especially noticed how the ward was boring without students to spend time with:

> *… 'you get bored doing the same old thing. They bring different things, different ideas, even asking you if you want a game of cards or something like that, stuff like that…'*
> *(Steven)*

Activities seemed to act as a distraction for the patients to help them cope with being on the units. Steven spoke of how playing cards would '*lighten the atmosphere'*. Jasper similarly reflected that by getting involved in activities like board games distracted him from his problems:

> *… 'if they've got them out, you come out, and you just get involved, and then all of a sudden, you're distracted from your problems. Then, she took the initiative and started bringing board games out. She was a real presence on the ward.'*
> *(Jasper)*

Various activities were mentioned by both patients and students including; cooking, watching television, playing board games, pool, cards or walking, all ways the patients and students shared time together; just being together. Perhaps because of the environment and access to other activities, these were the most talked about activities. As Hollie said; *'because it's a ward environment, there's not a lot for them to do.'* And Steven referred to students giving patients something to focus on in the environment:

> *'I know it's a lot better for a lot of the lads, cause there's a lot that don't get off the ward. Or they can just go on grounds for an hour. So I think it gives them something to focus on.'*
> *(Steven)*

Several patients and students talked about the importance of just sitting watching television together and chatting. Hollie spoke of it being nice when football match was on and everyone watched it together. For David is was Jeremy Kyle, he reflected how when he was watching it with a student it appeared to help him forget where he was and the routines:

> *'It's little things like that, or even if it's just watching crappy TV. I don't really want this on record but I'm missing Jeremy Kyle (laugh). Actually one of the students actually got me in to watching that… Yeah it's really really nice with the students. When you're sat on your own and your watching rubbish TV by yourself, someone can just hop in and sit down and join you. It's not like a case of checking your watch, "oh I've got to be here in 5 minutes," … There's no rushing about. You miss having a student, when they're not here.'*
> *(David).*

Watching television was important on the wards, Oliver (student) confirming Hollie's thoughts of the nature of the environment and its limiting impact on activities partaken making television a '*big activity'.* The participants talked about the television as being a focal point. It appeared that the television would bring people together. It also appeared that the students brought people together and that students just being in that '*space'* with the patients was positive. David said that students seemed to '*fill out the lounge'*, resulting in patients actually spending time there. Which only usually happened when a patient was on observations[87]. George talked about it feeling homely, sitting in the lounge with the students:

> *… 'talk to sit down have a drink of tea and a chat and talk about what was on the television what's in the newspapers. It's more sort of homely and more sort of friendly.'*
> *(George).*

Although sitting watching television together was a positive thing for the patients and students, David said it was nice when the television changes from being the focal point to a comfortable space with people just spending time together conversing:

> *… 'we've been lucky with two [student] nurses at the same time, which was quite good. Some people would see that as a hindrance, but far from it. When we had those two students, when one of them was in the lounge there would be a lot more patients in there than there would be normally. The room was a lot more nice, the TV wasn't the focal point, it was more turned down, it was a lot quieter… It was really enjoyable.'*
> *(David)*

[87] Being supported by a member of staff.

Spending time together doing activities or watching television with '*just a nice cup of tea'* was an everyday thing that had immense value for both the patients and students. Bella said that for some patients it may be in their care plan to watch a movie with a '*nice cup of tea*' if they were feeling angry as something '*therapeutic'* to help them cope. David spoke of it feeling nice when students *'talk to you and sit down and have a drink of tea… and it's just spending time on the ward…'* It appeared that when students shared time with patients by just being around it had a therapeutic effect. It would help them feel relaxed and comfortable (George), it would cheer them up (Steven), help them during hard times (Fred) and make them feel more positive about their futures (Jasper):

> *'So, I sat there, sitting here with her having a nice cup of tea and we'd just chat.' (Leo)*

'I'm used to spending time with some sort of students. Basically here, the students on the ward, more like sort of general stuff. You talk to them about, not a lot of students that we have on the ward do any sort of really close interactions in one to ones or anything, it's more just being around, checking on us, just general chit chat, taking us to the bank, shops.' (George)

Subtheme 1.2: '*Having a laugh'*

> *'There was a lot of laughing, fun and games. It was a positive experience for everyone* [playing pool], *I think. If it wasn't, I think they were hiding it very well.'*
> *(Oliver, student)*

The students and patients spoke about '*having a laugh'* (David, George, Hollie, Jasper, Julie, Leo, Molly, Oliver (student), Steven), a joke (George, Hollie, Julie, Leo, Molly, Oliver, Steven) and '*having banter'* (George, Julie, Molly) which was of great value. Though there was discussion of this being balanced with students' professionalism as certain elements included '*taking the piss*' (David, Jasper, Leo). This also highlighted the individual nature of humour. In engaging in '*silliness'* (George), the patients felt the students were more relaxed and not as serious as compared to other staff as they were there to learn in addition to them not being seen as the decision makers for patients' care[88]. However, the students were able to engage in more formal and challenging discussions with patients. In being more relaxed and '*having a laugh'* they were more relatable and connected over shared memories.

'*Having a laugh'* helped patients and students feel '*good'* (Jasper). George associated students '*having a laugh'* as being supportive and helping him cope during times when he was struggling with his mental health. Showing the significance of something as simple as '*having a laugh'*:

> [having a laugh] *'just relaxes you and stuff, the tension seemed to go and stuff and then after that we had sort of great sort of relationship and used to laugh and joke…'*
> *(George)*

The impact of having a laugh was related to Jasper feeling *normal*, despite being in a secure unit. It helped him have a connection with the outside world, knowing he was able to have a laugh with students who he saw as '*achieving'*. Hollie also identified that sharing humour linked to a person feeling human and having space to be '*normal'*. She compared having a laugh with patients with sitting in a pub with friends, as Jasper did, with something connecting people

[88] Linked to theme 2.2.

in secure units to the outside world and a sense of normality in an abnormal place (Oliver). Fred found that having a laugh when teaching students helped him feel comfortable sharing his experiences, which he spoke about feeling very nervous about when he first started. More practically, for Steven it made the day '*less boring',* similarly Julie spoke about it making the '*day go quick'*:

> [Having banter] *it's nice. I mean, it's nice, it's really nice. It makes you feel that put a smile on somebody's face, it makes the day go quick.'*
> *(Julie)*

Having '*banter'* was another way the participants described having a laugh together. Banter was described as students being '*one of the lads'* (Leo, Steven) but this was not gender related as Steven described having this with female students. Leo linked having banter to there being a '*warm welcome'* to the environment for students starting a new placement. Although banter appeared to be more about engaging in pranks for Leo or '*boyish silliness'* or '*rudeness'* for George:

> *'It's just basically what, it depends when, you've got to understand, some students I know that I've got a really good sense of humour and joke a bit about them, some you still think no you can't go that far. But it's just gentle sort of er boyish sort of boy sort of banter and stuff, joking and a little bit of rudeness and silliness in there.'*
> *(George)*

Oliver, one of the students, raised the view of whether having a laugh was professional yet spoke of its importance:

> *[a laugh and a joke] 'Yes, I think it's important. A lot of people don't think it's professional, but I think that you can have a laugh and a joke, totally… It's fun, it's what makes everybody happy, I suppose.'*
> *(Oliver, student)*

Molly acknowledged the benefit of humour while also discussing how it was necessary to maintain boundaries and appropriate humour, she spoke of ensuring jokes were sensitive and not offensive. It represented the connection with one another and enabled them to bond. David spoke of bonding with a student when they were '*chuckling'* together noticing '*daft things'* when watching other people interact. He said how it was '*nice to share that with a student'*. Molly

demonstrated that students appreciated sharing humour with patients when reflecting on making porridge with a patient and '*laughing and joking while trying to make the porridge'* as they both did not know how to. Leo and Steven also spoke fondly of sharing funny times with students, for Steven particularly reflecting how both him and a student shared a perspective on something funny:

> *… 'think there was one time which was a bit was funny it did make me laugh. One student said her mum actually when they go camping, which I can't class as camping but she always takes a carpet a proper carpet to put down in the tent. Which I thought was weird, but she thought that was weird as well.'*
> *(Steven)*

Humour stood out as an essential aspect of Leo's experiences. For him, laughing together was an important part of his time with students, it was a way of sharing experiences and he spoke of these as fond memories. Especially sharing humour with others. He reflected on a memory with a student, who was '*running around'* looking for her lost pen, which was easily found. He described himself as howling with laughter and said if I would have been there, I would have been too:

> *'They're laughing and I'm laughing and she's laughing, I'm laughing at them there, I'm laughing at her… Oh, it was funny. But, I miss her… We all miss her because she was a fantastic nurse and fantastic. She had me in stitches. I had her in stitches…'*
> *(Leo)*

Although Leo used humour to help others, some of his jokes also appeared to be at the detriment of others being laughed at. He spoke of a story laughing with a student, at the detriment of another person, a fellow patient:

> *… 'someone said something and I found it funny. I couldn't stop laughing. Me and me mate are just sat at that table there. I'm laughing at him. He's laughing at my laugh. I'm laughing at this kid who's getting terrorised, who's getting socks thrown at him, dirty boxers and everything, and all that. The student nurse was in stitches at the window there, seeing it. I've had a couple of good experiences with a couple of the student nurses up here. It's been great. It's been absolutely fantastic.'*
> *(Leo)*

Jasper and Leo also spoke about '*taking the piss'* out of each other or things they were doing with the students, which appeared to help them feel human. Jasper spoke of taking the piss

out of things on television or when spending time with Oliver (student) talking about exercise, injuries and diet. Leo, though appearing to laugh with students at the detriment of others he did also make jokes about himself too:

> *'Like, we've got a student nurse today. She's a bit wary, but when she saw me and my big beard she just looked at me and said, "What's happening with you?" I said, "I've had a rough day. It's grown overnight." She just started laughing.'*
> *(Leo)*

Although having a laugh with one another was valued, George, Hollie, Jasper, Julie and Molly refer to humour being an individual thing which you may be able to share with some but not all. Hollie and Jasper refer to the type of person, some people may be '*quiet and reserved'* (Jasper) or '*calmer'* (Molly) and like to have a '*serious conversation'* (Hollie), thus Hollie identifies that '*in the end, it's making sure they are happy'*, and Molly said, essentially you support the individual and their needs. George said that sharing humour can depend as some students have a really good sense of humour while others '*you can't go that far'*, highlighting some evidence of boundaries with humour. Similarly, Julie discusses ensuring banter is appropriate, showing that not all banter is appropriate:

> *… 'some of them [patients] you can have a laugh with, you can have jokes with, and all that. And banter, I'll say banter, like appropriate banter with them. Others you cannot. So you've got to know the patient. Because some of them take things personally. No matter the thing you say, they are going to take it so personal. To them, having to explain it in a different way. But others, use banter.'*
> *(Julie)*

Though Leo said it was '*irrelevant'* if they were students, students were seen as '*more fun'* (David, George), '*more free'* (Jasper) '*more relaxed'* and '*not so serious'* (George) as compared to other staff, being seen to be able to have more '*banter'* (George, Julie, Molly) or '*silliness'* (George). This may have been as they had less impact on decisions about the patients care or because students were perceived to have more time to spend with the patients. For George, students were learners and not as '*strict'* as some nurses who had been on the unit a long time. They were more learning the trade rather than seen as formally '*professional'*:

'They seem to, I know it might sound daft, seeing as they've got less responsibility when they're a student, they've got less stress, and they're a bit more fun and a bit more like "yeah yeah I can sort of have a laugh," and enjoy time and things like that.'
(David)

Although students were viewed as more '*relaxed'* as compared with other staff, they did still have a role in challenging patients as discussed by David, Jasper and Molly, showing the complexity of the student nurse identity[89].

… 'the student nurse was crying with laughter. She had to go off to the toilet because she was crying. It was funny. I will remember that day for the rest of my life. It was funny. I was laughing at her, and she couldn't stop crying. Both of them couldn't stop crying with laughter. Every time that I saw them I'd just laugh. It was funny.'
(Leo)

[89] Further explored in theme 2.

Subtheme 1.3: '*The way you speak to people is important'*

> *'Everything you do is important and the way you present yourself, the way you speak to people is important.'*
> *(Oliver, student)*

A student's approach appeared to significantly impact on the patients, both positively and negatively. Approach, in general, related to how the students '*were'* with patients, how they engaged, their general approach, demonstration of respect and attitude to spending time with patients, resulting in the building of relationships. Various terms were used by the participants to describe their encounters together. *Regular* staff/ staff who had been on the unit or worked in mental health services for a long time were often perceived as having a less desirable approach. Balancing use of self, alongside managing appropriate boundaries, was reflected upon. The participants also considered how patients speak to students.

The patients and students referred to various characteristics, attributes, skills, and/ or actions that were important elements for students to display while on placement in the secure units. For Oliver (student), everything students do and the way they behave has an impact when spending time with patients:

> *… 'everything you do is important. You're such a big part of these people's lives. You're not just hotel staff, I think everything you do is important in some way. The way you behave can impact on somebody's life.'*
> *(Oliver, student)*

There were some specific attributes that were highlighted by the patients as being important in students, these included being polite (George), passionate (Jasper), and kind and respectful (Leo). For Leo being kind was displayed by students by asking patients questions and offering patients a cup of tea and biscuits, which was reciprocated by the patients, resulting in them sharing biscuits and chocolate together. George spoke of a student being '*nice'*, when I asked him what made him think she was nice, he spoke of how she was polite in her approach and demonstrated an understanding of his experiences:

> *'Just basically the ways she come across, she was helpful and stuff, and nice and stuff. Just nice, she talks and stuff. And she also came across very sort of polite and sort of yeah so I found her quite reasonable to talk to. She came across really well and she understood about my sort of personality and stuff and some of my sort of quirkiness.'*
> *(George)*

If the students were approachable and supportive the patients respected them back (Fred). For Leo this could be as simple as saying hello. Tone of voice, posture, demonstrating good communication and listening skills were also identified as important. Julie recognised the importance of listening to patients as sometimes they just want to talk, and in listening to them gives them '*peace'* and reassurance there is someone who can help them. Leo spoke of his time with students, clearly highlighting the importance of students listening skills and the impact on his sense of value. For Hollie and Julie in listening to patients they were helping them work towards their recovery:

> *'It's about being open to them, as well. And listening to them, having an open conversation, and just say, "Okay, I'm here for you, I'm here to listen to you and I'm here to help you as much as I can." "You're not going to put me off, I'm going to do this, I'm going to do that" but to give them reassurance that you are going to support them and you are going to help them through that timeframe while you are there, and make sure that they are cared for...'*
> *(Julie)*

As well as listening skills, Bella spoke more specifically about communication skills and being mindful of your body language when sitting with a patient. Tone of voice and body language were particularly important for Leo and were provoking if he perceived them to be associated with a '*bad attitude'*. I asked if he had any examples of what a '*bad attitude'* was, he said:

> *'It's the way she was acting and the way her body language was and the way her voice was, "Meds, meds, anyone meds," like, it's like, "Who the fuck is she talking to?" So, I was there hearing it, "Anyone who wants their meds get here now," and all of us are looking round like, "Who the fuck does she think she is?".'*
> *(Leo)*

Leo further describes a particular student '*geeking us out proper bad, looking us up and down, like we're nothing'*. Showing just as a respectful approach can have far reaching impacts, an approach deemed disrespectful has impact on patients feeling human. Jasper depicted a

disrespectful approach as a student being '*cocky*', which related to students believing they '*knew everything*':

> *'He was just so cocky. He thought he knew everything. There was a lad on here who cut his leg really bad, and he had stitches. He was like, "You know what you want to do before that? You just want to stop and think, stop and think before you do that". I thought, "Really? Really? You really think it's that easy?".'*
> *(Jasper)*

Just as Leo and Jasper reflected on some approaches that impacted on them, Fred said if students were nice to patients and respected them, they would be respected back, however if students were an '*arse'* they were ignored. Similarly, to Mike's thoughts (end quote).

The way patients spoke to students and staff was also important. Leo spoke of the way patients speak to staff as being associated with their progression through services, identifying the importance of how their approach with staff may be viewed with regards to their engagement in care:

> *'If you're going to be a dick they aren't going to come and see you. They aren't going to say to you, "Alright mate?" They're not going to come and sit around with you if you're being a dickhead, they're just going to stay in the office, do what they do in the office and then go straight home.'*
> *(Leo).*

Molly reflected on her experience of a staff member raising their voice with a patient which escalated an already tense situation. Such attributes were generally uncommon in students and appeared to be more common with '*regular'* staff or '*support workers'* (Jasper) who the patients felt had a less desirable approach. However, Jasper also states that students assume a support worker role. Therefore, perhaps because students were perceived as learners (George) this impacted on their approach or their perceived approach, however[90], three of the students were also support workers, showing the complexity in roles and approaches experienced. Nevertheless, students were generally viewed as '*more approachable'* (George) than other staff support workers or nurses. For George, he found students to be more relaxed:

[90] As explored in theme 2.2.

> *… 'because some of the nurses have been here for some time and stuff, although they come across as okay and fine and I can talk to them, but when you get students outside they're a bit more sort of just learning the trade, so, it's a bit more relaxed.'*
> *(George)*

In students being learners, they were viewed more positively[91]. This appeared to be linked to them showing an interest and being actively engaged in conversations (Leo). Mike spoke about the importance of students asking questions to enhance their knowledge, to him this demonstrated that they were interested. Oliver (student) talked about being sociable, while also having meaningful involvement with the patients:

> *'Sometimes I know when certain people might need, maybe, a little bit of help engaging in social situations and stuff like that, I'll fully go out of my way to try to encourage them to join in with something or maybe do an activity or just have a conversation or just a silent walk somewhere or whatever.'*
> *(Oliver, student)*

Just as Molly and David spoke about students' own experiences being valuable, being yourself was important for Julie and Oliver (student) in order to build relationships. Julie spoke of having a '*professional image'* but still being yourself and not being overly conscious, to help the patient be themselves and engage in conversation. This aligns with Oliver's thoughts about being personable and not being a *'robot'*. He spoke about using your personality as a student as you are the tool to help people, which included helping patients feel comfortable:

> *'Part of working in mental health is your sense of self, really, putting yourself into everything that you do. It's, sort of, one of your tools as a mental health nurse, using your own personality to try to help people. It may help people open up. You can be anyone you want if you're going to bake bread or whatever, but you can't not have that human edge. You know, you can't be a robot…'*
> *(Oliver, student)*

Although being a '*person'* was viewed as an essential quality, as Julie made reference to being professional; David, Oliver (student) and Hollie spoke about the importance of having boundaried relationships where a staff or student's home life did not interfere with their engagement with patients. An approach that was perceived as positive and well boundaried

[91] As explored in theme 2.3.

appeared to encourage interaction and engagement and the potential for the development of relationships.

The term *relationship* was referred to by all students but only two of the patients (George and David). David spoke about building rapport and relationships and Julie and Bella reflected on building trust which, for David, helped develop a bond, or a click (Steven). Other terms were used to describe the interactions the patients and students had, such as rapport[92].

Hollie described the relationship about being there for the patients. She said she had completed many essays on the topic, yet it was still difficult to explain, but it was mainly about making sure patients have someone they can talk to if they need. When she said *therapeutic relationship,* I asked her what that meant to her, she said:

> *'Just them being able to come to me if they are agitated, or me being able to tell them there's agitation there. There are a few patients that I can pick up on and then distract them, the one who hears voices, just generally engaging and chatting, and getting him to come out. He notices and appreciates it afterwards, so it's nice…'*
> *(Hollie)*

David spoke about rapport, trust and relationships with students, viewing them as helpful. He said a relationship was a '*nice balance'* of the ups and downs, while a therapeutic relationship could '*eradicate the downs'.* He described them as beneficial:

> *'A rapport is always akin to a friendship, if that makes sense. A friendship that is based on core elements of a friendship. You don't have to have the extra added baggage with the difference between a therapeutic rapport and a normal rapport. Normal rapports are good, but when you want to be able to become more well, and particularly in places like these, the therapeutic ones are so much better because when they do they just keep to that core bit, you share values, you share things, interests, everything that you talk about and do is supposed to be for beneficial reasons. There are no negative reasons, that's the whole rapport of building up a real big level of trust…'*
> *(David)*

David also referred to having professional and boundaried relationships with staff and that this relationship should be therapeutic and different to other relationships, where the staff member

[92] See appendix 28.

maintains the focus on the patient rather than themselves. Oliver (student) spoke about helping the patients and ensuring relationships were beneficial:

> *'So, it's the relationship I've got. I'm in the position of helping that person, with me being a staff member and them being under my care, as well as it's trying to make the best out of the personal relationship between the two of you in order for it to be beneficial to them.'*
> *(Oliver, student)*

'If they're not willing why should you show willing?'
(Mike)

6.6.2 Theme 2: Balance

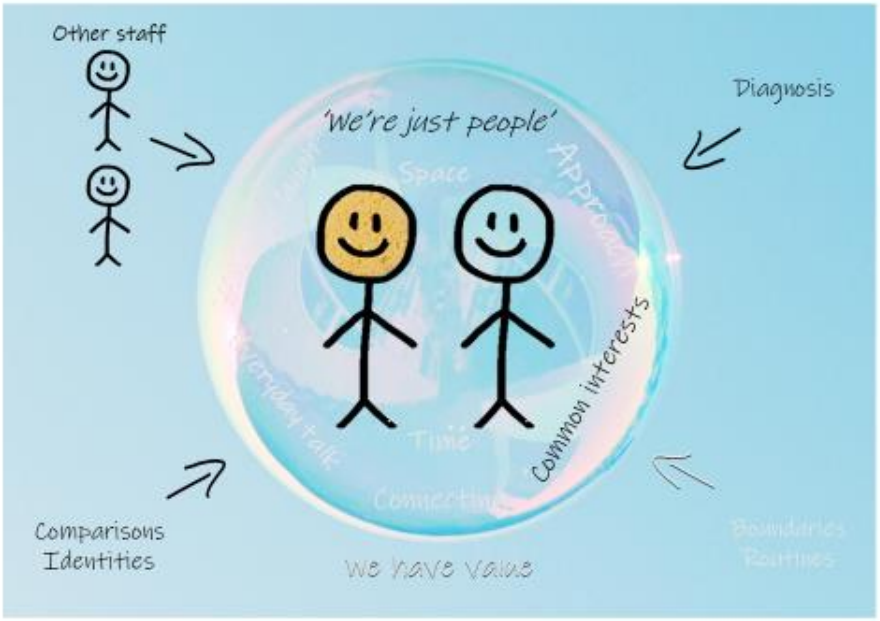
Summary

This theme explores what it means to be a student, what they do and what it is like, and how patients view students and how this is different to other staff. There are three subthemes; Recognition: '*We're just people'* and they're the same as us; Identities: '*More like us*' and Weathering the ride: '*Sponges'* to holder of keys.

The students and patients bonded with each other through connections they made with their common interests and recognised each other as '*just people'* (Fred and Jasper). They related to and identified with each other in an abnormal place. The students saw the patients as people they had common interests with and empathised with their experiences and circumstances. There are strong links between the connections made through doing '*everyday stuff*', '*having a laugh'*, sharing experiences and having value even in a strange place, highlighting the interlinking nature of the themes.

The patients and students talked about comparisons between staff, which was in relation to associated roles, time and boundaries. Patients noticed that students do different things and due to this they have more time and spend less time in the office. They are also '*sponges'* (Fred); soaking up learning and fresh with less ingrained negative attitudes than other '*regular'* staff (David, George, Steven). They are, however, also learning and new to it, showing various

aspects and elements to being '*sponges'*. For students, although they were '*new'* to that placement, they still had other experiences that were important to their experiences and learning.



The landscape

Subtheme 2.1: Recognition: '*We're just people'* and they're the same as us

> *… 'we're not these big, bad mental patients, we're just people…*
> *(Jasper)*

Both the patients and student participants identified with each other by talking about common interests. They recognised each other's experiences, showing empathy. By sharing experiences, they were making memories and connecting with each other. The students had empathy with patients being in hospital and their historical experiences. The patients equally showed empathy with regards to the training the students complete.

A significant statement made by Fred and Jasper, was; '*we're just people'*. This related to the rejection of a label and how they were not defined by this label of '*mental patient'*, '*personality disorder'* or '*PD'*, they were people, individuals who struggled with their emotions but '*normal'* (Hollie) people like anyone else:

> *'I mean, a patient is just a person. We're a people with stickers on our backs, on our fronts that say, 'Personality disorder,' or 'Dangerous and severe personality disorder,' or PDs or mental illness or whatever else, but we're just people…*
> *(Fred)*

> *… Well, for me, when I was in my last hospital, I wanted them to see that people with PD, it's not just one thing with these people who are just malignant, time-wasting people, you know what I mean? We're just people that really suffer with emotions, and feel things a lot more than a lot of other people, and that's not just bad, you know what I mean? You're alright, well, if you're low, feel really low, or if you're happy, or it feels a good passion, we feel it really strongly'…*
> *(Jasper)*

The students demonstrated an awareness of Fred and Jasper's thoughts and spoke about seeing the patients as people, rather than a diagnosis or someone with a criminal history, showing that they viewed each person as individual with their own experiences. They were understanding of their histories and spoke of getting to know the patient as a person rather than a label or offence. Hollie spoke of talking to patients like anyone else and not treating them differently. Julie spoke of finding out *who* they are (as a person) rather than *what* they are (as a diagnosis or criminal offence):

> *'Just forgetting about the mental illness they've got and getting to know who they are. … Knowing them as a person, aside their diagnosis...'*
> *(Julie)*

Hollie, Julie, Molly and Oliver identified that patients in secure services do have evidence of historical risks to others, which was often the reason they were in secure services. They said that although it is important to be aware of risks and assess risks, all the students stressed the importance of seeing the person despite such risks. Showing that although they were aware of the risks present, they aimed to not let it influence their general approach and to see each person as an individual. Molly said that '*not everything revolves about the reason why they're there'*, that '*what they've done doesn't define them'* and that patients deserve to be treated *'just like everybody else and have a normal conversation'.*

This was also true for the patients seeing the students as people (Steven) and '*forgetting the badge is there*' (Fred). Fred and David both spoke about the students being '*inbetweeners'* or the '*gap'* between staff and patients, mirrored by George who defined students as being '*more like us'* showing an identification with them. For George students were '*not different from people'* which was seen as a good thing. David thought of them like volunteers and that they get bored just as patients can, showing some empathy for student experiences while also comparing the likeness:

> *'Sometimes they take the initiative as well because students get bored, it's really quite funny. They get bored more than we do at times. And they're like "come on what do you fancy doing, we'll do something on the ward".'*
> *(David)*

Just as David demonstrated an understanding for student experiences while they were on placement. All the students reflected and were empathetic of patients' experiences in the past and on the impact of being in hospital. Bella said she would put herself '*in their position'* and reflect on what she would do and how reassurance was crucial in supporting patients. She also reflected on patients' '*sad stories'* considering their historical experiences and how they may not have had experiences to be aware of what was '*right or wrong'*, showing an

understanding of how patients may present in services. Molly spoke of understanding patients' frustrations when not able to do '*simple things'* and how she wanted to help them. Oliver (student) considered the environment and how he supported patients to cope:

> *'It'd be my idea of hell, you're not allowed to go outside, you can't do this, you can't do that, I don't really like telly. I don't know, I do empathise a little bit and try to help people get through, find them something to do. Just talking to them.'*
> *(Oliver, student)*

Such empathy was particularly noticeable for Julie who had her own experiences of trauma and Hollie whose close family member had a diagnosis of a personality disorder. Hollie reflected that her experiences made her able to manage difficult situations and why she was interested in participating in my study. I was privileged that Julie chose to disclose her personal experiences with me and spoke of how they enabled her to support patients:

> *'Just listen to how they got into mental health services, their childhood experience or what they've been through. When you do that- I think the times that I've done that, the patient is able to have that confidence in me – "This person listens and this is what I want" – and you build that relationship from there, that communication.'*
> *(Julie)*

Molly said that relating your experiences to patients can help the patients see you as '*human'* as well. David similarly spoke about students' own experiences being a valuable thing as made the students relatable and more likely to have essential qualities to be a nurse. He appeared to respect their choice in career:

> *… 'it's not like something when they go round career day at school and people say, "Oh, I want to be a doctor" or, "I want be a police officer" or, "I want to be a fireman" or, "I want to fly fighter planes" and all that kind of stuff, or be an astronaut. And it's like, yes, someone people say they'd like to be a nurse, but no-one ever says, "Oh, yes, I'd like to look after people who are mentally unwell" no-one ever says that. So there normally has to be a bit of a kick behind somebody going for it and it's nice to find out the different reasons as to why, because it gives you something to be able to relate to if you're struggling with mental problems. They sometimes normally have some impact on themselves, whether it be through family or friends or something and they'll say, "Oh, I had a friend that I saw fall apart with their life and things when I was younger," and all the relatives suffering with dementia and things like that and you just wanted to help them. And that's motivated them so much just to study it. And I love it when people say things like that, because no matter what you do, you're not going to make a crap nurse because you've got that motivation that kick start at the beginning of the day and it's really quite nice.'*
> *(David)*

The patients also demonstrated an understanding of what the students must experience when doing their nurse training, including being assaulted (Jasper, Mike), showing empathy for their experiences:

> *… 'people don't come here to get spoken to like dirt. I wouldn't want to come to work where patients are assaulting staff and things like that. I wouldn't want that.'*
> *(Mike)*

Both the patients and students spoke about making connections with each other over talking about everyday stuff and highlighted the positive impact of identifying and sharing common interests with each other to build rapport. Oliver (student) said that there was always something to talk about as everyone is different. For Bella it was cooking, Jasper and Oliver- health and fitness, Hollie- scrabble, Julie- being a mum, Leo- cards and chocolate, Steven- hobbies and music, David and Fred- education, Molly- dogs and tattoos, George- television, and Mike- politics:

> *… 'one time when there was a couple of female students and we went to [theme park]. And a lot of the normal staff wouldn't go on the big scary rides with me they don't like it. But yet, oh I'll go on it, so it was great, so we went on just about everything, about 5/6 years ago, I always go on everything. I like being scared if you know what I mean. And that was good, they were just, I like that, I like that. It was really good… I think what surprised me about this girl in particular, she had done bungy jumps and I've done one of them years ago, I did a parashoot jump as well and she was actually going to, that was her next plan.'*
> *(Steven)*

Having such shared interests helped the connections between patients and students. Steven spoke about '*clicking'* with students (ending quote), where you talk to a student and realise you have common interests and despite not sharing time for long, getting on '*really well, having a laugh and a joke'.* Such connections occurred despite differences in age and gender. George and Steven, although believing it would be hard knowing what to speak about with young female students, each spoke of fond memories connecting with them.

Hollie, Julie, Oliver (student) and Leo, were on different wards and at different times and each spoke about using football to engage in conversations as a common discussion point on the

wards. For the students this was even if they were not interested or did not have the knowledge about it. Julie said she had little knowledge about football but the patients liked talking about it and thus she always tried to make conversation about it. She described football as a topic to use to build rapport with patients to engage their interest. Similarly, to Leo, who used football as a topic to have a laugh with people, often joking with others about their choice in teams. Oliver identified that there would often be people from all over the country in the unit and they would compare teams they supported as a basis for conversation. Hollie also reflected on the time when it was the World cup and how it seemed to give people a connection to others:

> *… 'Yes, everyone came together for all that* [World cup] *quite a lot, so that was nice to see. everyone just forgot about their problems even just for the game, or a bit of the game, so yes, it was nice.'*
> *(Hollie)*

In sharing memories and bonding over humour there was recognition of each other. Leo often spoke of cards in his stories about sharing time with students and this particular story highlighted to me how the interactions between people were about the card game and not whether they were patients or students, they were people sharing time together. A few patients and students were playing cards for sweets:

> *'This amount was, what, £30/£40 worth of sweets. Yes, chocolate biscuits, crisps, I mean everything was on the table. So, we put it in the bag and I put the bag on the table like a shopping bag… There was all of us, everyone was out, and there were only two of us playing, this student and me. This student thought she had a run, I had a royal flush and I won the full lot. But I still gave her some.'*
> *(Leo)*

David also spoke about sharing difficult experiences with students and how he was then able to talk about them after as compared to other staff who may not have experienced them. He reflected that students were able to help him as they saw as much as he did on the ward, so could understand if a situation was difficult for him or if he needed to be challenged on something if he took something '*a bit too personally'*, which he appreciated.

Steven: 'I don't like most people anywhere I've ever been. But there's certain staff I click with and certain ones I don't. Yet I always seem to get on, I don't know why, with students.
Emma: And that click with, how do you explain it? If you can.
Steven: How do I explain it, I don't know. You just get talking to them and you realise, even though you don't think you would have, that you've got lots of things in common, just the same, like similar music, like you might like doing similar things, it's that sort of thing, I suppose because you patients spend a lot of time by themselves in their rooms and or doing things by themselves, and when you come out and talking to the student, get interacting with a student. It just feels as though, once you get talking, that you've know them a long time even though you might have only known them a couple of hours.'
(Steven)

Subtheme 2.2: Identities: '*More like us'*

> *'Nursing students are sort of more sort of general, they do, they come and sit down, they talk to you, play board games, or watch TV and just sort of more like us.'*
> *(George)*

The students were not able to do the same things as other staff members, their responsibilities were different which was both positive and negative. They were not able to do certain tasks which could be frustrating yet also a good thing as they were not doing some of the '*annoying things'* (David) other staff do. The students and patients made comparisons between students and other staffs' roles. Many of the participants spoke of how students have '*more time'* as compared to other staff whether nurses or support workers. However, three of the students also worked as support workers which added another element to the comparisons made between roles.

For Julie and Oliver (student) there were some difficulties with being a health care support worker and a student. Julie found it problematic to change between identities. This related to differential roles as a support worker or a student. She also referred to previously working as a support worker on a ward then starting placement on the same ward as a student and how the patients struggled with her change in role and associated confusion. Although there was such complexity with regards to role differences, Julie reflected on how it was helpful having transferable skills:

> *'I think, for me as a student, for me being a healthcare assistant, it helps, that transition. You've got that experience and it helps you in being a student. The experience helps you in building that professional relationship with clients, and knowing your work environment and knowing what to do and what not to do.'*
> *(Julie)*

Oliver (student) felt powerless when in situations requiring restraint, as a student he was not able to undertake this role, yet as a health care support worker he was. He spoke about needing to protect other staff but due to his role as a student was restricted in difficult situations where there was the potential for restraint.

Julie, like Oliver (student), also reflected on difficulties managing her role during restraint situations, being able to be involved in restraint as a support worker but not able to as a student:

> *'It's something that you always have to remember. For example, when it comes to this training, when I'm a healthcare I'm able to restrain but, when I go on placement, I can't. So sometimes it's- Maybe I'm doing a placement on a ward where I've been able to restrain someone as a healthcare, but I'm on that ward as a placement and I cannot restrain. And it's always being alert that, "I can't do this, because I'm in a different role…'*
> *(Julie)*

Hollie also spoke of not being able to do certain things in her role as a student, such as supporting patients with leave off the unit. Though in being unable to do some tasks she focused on doing activities on the ward which were valued by patients. For patients, it was frustrating when students had to check things out with staff (Jasper). This seemed to prevent them getting '*stuck in'* which Jasper, Oliver (student) and Molly referred to. Jasper said that students should not be afraid to get '*stuck in'* by helping patients to solve problems or taking the lead in situations. Although Jasper wanted students to spend as much time as possible with patients and found it frustrating that students had to check things out first which prevented them getting stuck in, he did show understanding that sometimes students do need to spend some time in the office as part of their learning.

When I asked Oliver (student) and Molly what getting '*stuck in'* looks like practically they said it was being autonomous, asking staff if they needed anything doing, getting activities out to do with the patients or just sitting with them watching television. Molly describes learning more this way:

> *'It's really good because it keeps you busy, it keeps your skills up you learn so much more getting stuck in and being like on the floor than sitting in an office and just staring at the computer all day. And but I've learned so much more going out and like getting stuck in with the patient. And it's just like going down and assisting at meal time and helping out, grabbing things and bits of bobs for them so… I enjoy it because I feel like I learn a lot more doing things then I do learning about just like having them spoke at me.'*
> *(Molly)*

Students were restricted in some ways, as identified by Hollie and Jasper, but consequently were not restricted in other ways. Students were not able to do certain tasks like escorting patients on their own or completing observations, which both students and patients found frustrating, yet David identified this as a good thing:

> *'It's good that they can't escort if that makes sense? Because that's all they would be made to do. They wouldn't learn anything on their placements. They'd just say 'oh would you mind covering here, would you mind covering there, would you mind doing this'. But in turn it massively limits the type of activities you can do.'*
> *(David)*

Julie spoke about engaging in other roles when she was unable to complete certain tasks due to being a student. Also speaking as Hollie did about doing other things like sitting with patients.

In not being able to carry out certain tasks, for David, the students did not do '*all the annoying things'* that *regular* staff did and they would not be able to gain a relationship, which appeared to be related to spending time with patients and learning from them:

> *'Would you like them to be able to do more activities? Ideally, yes, but with that I think people would abuse that, as in terms of members of staff would say, "Oh, as soon as you can escort, you can do obs" and then the next thing you know, they're effectively a healthcare, they're not learning anything, the special relationship you have with them as a patient evaporates, because next thing you know they're doing all the annoying things like checking you on obs and all that kind of stuff and you end up having a go at them and you don't want to have a go because they're new and they're learning.'*
> *(David)*

The patients found students to be '*more fun'*, like '*inbetweeners'* and '*volunteers*'[93], potentially as they were seen to have different responsibilities as compared to the nursing staff, who make decisions on the patients' care.

Molly said that patients were understanding of decisions made about their care and that often it was not *them* (the staff on the wards) but management decisions that they disagreed with.

[93] As referred to in theme 2.1.

Molly spoke of being on placement during Covid-19[94] when patients were not able to go on leave due to lockdown[95]. She spoke with empathy of what that must have been like for the patients and demonstrated understanding for when they became frustrated. She said '*sometimes they just see you almost as a bad guy'*:

> *… 'putting a stop on what they want to do when you restricting them and you're just making up these, almost silly rules for them to follow, and it's really difficult for us because it's not something we want. We have to just put in place because it's the rules of the service. And we're trying to keep them safe. Trying to minimize risk. It's really difficult to communicate we're just doing what we have to do. We want to keep you safe…'*
> *(Molly)*

For Oliver (student), although the consultant or management made the decisions, he reflected that the students agreed to and followed such care decisions:

> *… 'you're looking after someone for a long time and you're the rule maker, you're the baddie and the goodie and you get to say what happens. Whether it's you who actually… You don't, really, it's the management that does and the consultant and whatever, but you're the person who's got to put it forward and agree with it.'*
> *(Oliver, student)*

There were comparisons made between health care support workers and students. Generally, support workers were seen as '*annoying'* (David) and more negative than students, who were generally positively spoken of by all the patients. This is interesting, considering that Oliver, Bella and Julie worked as health care support workers as well as being students. Of course, there was the individual nature of the way staff approach patients that was referred to[96], but this varied judgment between the two groups seemed to be specific to their roles, and view of their roles. For example, David reflected that if students came to work as a support worker for a shift '*you'd see them just as a healthcare again… because they'd be running around like a blue-arse fly'*. Similarly, to nurses being referred to as '*busy'.* This perhaps reflects the notion of perceived time staff have with patients. David said he would get an '*instant closer bond'*

[94] Worldwide pandemic in 2020.
[95] Measures put in place by the UK government to manage the spread of the virus Covid-19.
[96] As referred to in theme 1.3.

with a student as compared to a health care support worker. I asked him why he thought that was, he said:

> *'Attachment with you, effort, they're not doing something. Very rarely does a student annoy you. (Laughter) It's a fair point. How often are you sat in your room and you just want some time to chill and you've got somebody lifting up the spy hole really noisily and it's like staring at you almost, and you're like, "What are you looking at?".'*
> *(David)*

It appeared that David perceived the support workers to be invading his privacy as part of their role. Although David spoke of the specific roles he deemed *annoying* that support workers did, he also reflected that he had achieved a good rapport with *some* support workers, signifying the complexity in role perception and general view of support worker and student nurse. In addition, David refers to certain approaches that challenge set perceptions, including having a '*genuine attitude'*, '*nice personality'* and good listening skills. He reflected on the difference in how patients treat support workers as compared to students, perhaps showing an already formed view of each group:

> *… 'we still treat her like the student nurse and we still talk to her like a student nurse and things like that. It keeps the relationship the same because it's like, 'Hang on a second, she's technically a healthcare today, but we're still treating her like she's a student nurse in a good way.' It's kind of like, 'Yes, this is strange.'.'*
> *(David)*

As compared to nurses, possibly due to perceived roles, students were seen by the participants as having more time to spend with patients. Bella, David, George, Hollie, Julie and Oliver (student) each identified that students had more time than nurses who were seen as being '*busy'* doing '*paperwork'*. David said that having third year students on placement was a good balance, they could complete similar roles to a nurse while also not being '*tied down by a load of menial tasks'* like paperwork. He referred to nurses having to spend time in the office writing reports, coordinating the ward or sometimes the hospital, which he felt was '*ridiculous'*. George felt that students were '*more friendly'*, which seemed to refer to accessibility, stating that nurses were '*always busy doing stuff'* rather than spending time with the patients like students do:

… 'the majority of the nurses spend more time in the office and we notice that more students spend time with the patients on the floor than in the office and stuff so, and that's nice. We like that spending a bit more time with us and stuff...'
(George)

A possible reason for the perception of students having more time than nurses or other staff, as speculated by Bella, Hollie and Molly, was that students are '*not in the numbers*', they are not included in the staffing numbers of the ward, they are '*supernumerary'* and Hollie believed this made them flexible and Molly and Bella said gave them time with patients:

'So, as a student, I try to put myself in their place, like, "If you need anything, just come to me and I can always create time, because I'm a student. It's not like I'm in numbers, so I can always create time for you." I do that every day and it's been quite helpful… … It feels good… I have time to talk to them. I have time to do activities with them.'
(Bella)

Hollie, Julie and Bella each independently said that they would miss the time they can spend with patients once they qualify, highlighting the view that as students they have time to spend with patients and once they are qualified nurses will not be able to spend that time with patients as they will have to spend more time in the office completing paper work:

'I think that is the thing I'll miss when I qualify. (Laughter)… at the moment, everything is all about paperwork, documentation, and all. Because, in my placements, I spend a lot of time with patients. And sometimes I feel that, if I qualify, I might not be able to do as much as that… Because obviously I'll take a different role and I'll be doing the paperwork… a lot of nurses now spend time in the office and less time on the wards with the patients...'
(Julie)

David reflected on an experience that exemplifies the view from a patient perspective on the time that nursing staff and students have when asking for some milk. It also highlights some of the potential consequences for agitation due to unclear/ poor time setting:

… 'with regular staff it's like, "Give me a minute, just let me make sure I'm not doing anything." And you're a bit fed up at that first and then you're stood there because it's 20 minutes later and you're still waiting, so you politely remind them and they go, "Oh, two minutes." Next thing you know they're just finishing off typing something and you're just like, 2 minutes become another 20 minutes, next thing you know it's an hour until you've got a cup of tea and they wonder why you're annoyed. Then when a member of staff comes out the office and it's like, "Are you all right? You look a little bit upset since last time I saw you," and you look at them and go, "Yes, I wonder why." Yes, you've got to sit down, don't you, and being with a student it can be just like, "Would

you mind just getting me that milk out, would you mind just sitting down watching this with us," and they'll go, "Yes, sure.".'
(David)

The students had various roles which were identified by the student and patient participants. A key role for students was to help the patients by spending time with them doing everyday stuff to build rapport and make connections, as explored in other themes. A further key role, Fred and Jasper spoke of, was the role of a learner[97]. Mike highlighted the importance of placements for students' learning, not just theoretical learning at university:

'Well, it's new for them, they're learning, aren't they? So, as the saying goes, you can study as much as you like, but experience you can't beat.'
(Mike)

As part of students' learning on their placements they had to complete certain competencies, such as medication administration (Bella, Leo, Oliver (student)). However, these competencies appeared to take students away from spending time with patients, as Oliver and Molly talked about. They also created anxieties for the students when there were specific competencies that they were not able to meet on certain placements. Molly gave examples like supporting patients with specific medication or percutaneous endoscopic gastrostomy (PEG) feeding tube and other physical health competencies. Both Oliver and Molly referred to their competencies as being targets to be met and that in getting them completed they would then have time to spend time with the patients and also explore other experiences:

'So, well, you're on placement and you've usually got competencies and stuff to fill out, but I've had them all done on my first placement. So, I've just spent time with the patients, really, get to know them…
… I've got more time to explore the service and experience it a little bit more, rather than just having targets all the time.'
(Oliver, student)

Molly insightfully said about making the most of opportunities while balancing completing outcomes. Other such competencies the students were required to achieve included care planning (Bella, Hollie, Julie), assessing risk (Julie), supporting patient safety during incidents

[97] As explored in theme 2.3.

(Julie), attending and presenting at ward round (Oliver (student)), and completing documentation/ paperwork (Bella, Julie). Despite Molly and Oliver reflecting on some issues with set competencies they also provided opportunities for the students to support patients, for example, Hollie found that doing care plans with patients was a valuable experience for her learning but she also appeared to feel pride to have supported the needs of a patient.

A further role the students had while on placement, Bella and Julie spoke of, was reflection. They said how reflecting on situations with a practice assessor can help students cope:

> *'So I think, for me, after that I had a reflection with my mentor* [practice assessor], *just to talk about it. I said, "This is emotional, this sort of thing." I think the reflection is what saw me through, yes.'*
> *(Julie)*

… 'when we do have students, they spend more time with us than some of the nursing staff…'
(George)

Subtheme 2.3: Weathering the ride: '*Sponges'* to holder of keys

> *'I just felt good that there was someone coming into the job who's not had his head filled full of shit about what we're about…'*
> *(Jasper)*

Students were viewed positively as being '*sponges'* (Fred) and having a '*fresh perspective'* (Jasper) as they were generally '*new'* (Bella, Jasper, Steven) to the units and new to nursing. The patients enjoyed learning about the students and building new relationships. Both patients and students felt nervous upon their first encounters. The patients believed that students did not have ingrained or '*jaded'* (Jasper) views as present in other staff. There were positive and negative aspects identified to being new. Students may have had limited experience to manage challenging or difficult situations which was balanced with reduced risk of having potentially negative ingrained views. The participants were opposing in their views of students reading notes about the patients.

Patients identified students by various terms depicting that they were new, these were all used in a positive manner. Students were designated as '*baby lambs'* (David), '*sponges'*, '*baby-os'/ 'baby fish'*, '*fresh and open'* (Fred), and *'bright eyed and bushy tailed'* (Jasper):

> *'They're more like sponges… they want soak up more information…*
> *(Fred)*

Jasper said how it was '*nice to have a fresh face on the ward'.* Fred said how they were '*willing to learn*'. Steven similarly referred to the impact the students had on the environment by being new, that they '*brighten the place up'* and enabled various conversations:

> *'If they're* [patients] *a bit down in the dumps and then a student comes on and they working with that student or whatever you just seem to be, you know because you get different perspective from different people, different than normal so when you're seeing regular staff all the time. So when a student comes on they're just new and more knowledge and they're wanting more knowledge so you can chat to them about different stuff.'*
> *(Steven)*

A key element to students being new was around learning, they were thought of as '*sponges'*; soaking up all their experiences on placement. Learning not only referred to the students, but the patients also. For patients, having students gave them experience of connecting with someone new and potentially building new relationships. For Jasper, students being new was a '*good thing'.* He spoke not only of the students' learning but how it was nice for the patients to learn about them, as someone different to talk to. He reflected that often bank or agency staff do not engage as much as they may never return to the unit, while also saying that it can get '*samey'* with *regular* staff. Highlighting the need for a balance, that students appeared to give:

> *… 'it's a fresh face, I want to make a good impression with them, or just learning about them, what they like. Just, like say your job, for instance, or your course, if someone new came on your course, and you were just bored with everybody, not bored but you knew them, knew what it was about, just in the same way someone might come into your workplace, or if you lived in a shared house or something, and someone new came along, it's just interesting to find out about them, and what music are they into? What films do they like? Just the same way really… It's just interesting to meet new people.'*
> *(Jasper)*

A further element of students being '*sponges'* was the role teaching gave the patients. Particularly Fred, David and Jasper, who each enjoyed teaching the students, viewing them as open to learning and as a result made the patients feel valued. Jasper felt like he was part of students' learning, which make him feel like he was helping them, and David spoke of it feeling good that the students can learn new things to help them in the future and reduce any prejudice. For Fred he liked that they were willing to learn:

> *'Willing to pick up new stuff, talk to patients they're just newbies learning to do the job to move on and things. They come fresh and open, so they leave all that stuff behind. Come into work happy as hell.'*
> *(Fred)*

Another role the patients enjoyed, was helping the students settle in. All the patients acknowledged that students must feel '*nervous'* (Steven), '*anxious'* (Jasper), '*awkward'* (David, Jasper), get '*butterflies'* (Leo) or feel like a '*spare part'* (David, Jasper) starting placement on '*new territory'* (Mike):

… 'when they come in they're a little bit nervous and that. Like, they don't really, they just look at you and then as soon as you look at them they're like… Like look at you proper weird and that, and then when everyone starts putting their hand out they'll look at you like "Ah, nice to meet ya…" So, I put my hand out first and then everyone joins in, "I'm this, I'm this, I'm this." "Right, what you doing here?" "I'm doing this. I'm doing that. I'm doing studenting."'
(Leo)

Fred reflected on being '*nervous as hell'* too when meeting new students and George found it difficult to know what to speak about with students:

'So the first time I met a student and stuff, at first I found it quite hard because I didn't know what to talk to her about…'
(George)

The patients and students equally experience nervousness when meeting each other for the first time. Bella reflected on feeling scared and how it was important to be aware of any risks. Gaining support from practice assessors (mentors) and the wider staff team was useful for helping the students feel comfortable in their placement areas.

Bella spoke about a difficult incident where a patient would not return to the ward after something she said. She found her practice assessor supportive by offering her space to reflect back on the incident and reassurance that it could have happened to another member of staff not just her:

'He didn't go back. He didn't go back on the ward. I was really sad. I wasn't happy. But what I did was I just spoke to my mentor, like, "I'm really sad." And she was, "Oh, no. Don't worry, it could be anyone." But she gave me directions and I was so happy that they didn't say, "Oh, it was because of you, that patient didn't come back." She just said, "It could be anyone."'
(Bella)

Although it was a positive thing that the students were '*sponges'*, on the other hand was being '*new'*, which potentially meant less experience and knowledge. Jasper found it difficult when students had a lack of knowledge or were ignorant to his experiences:

'When I used to self-harm a lot, and she was like, she wanted to help, but she just didn't have a fucking clue what she was on about. She went, "Why are you doing it? Is it because you're bored?" I said, "No, no," I said, it's not because I'm bored." I just laughed it off, and then I spoke with a nurse later because it wound me up a bit, but I

just said to him, "Why, why is she asking me?" He said, "Oh, just, she didn't mean anything by it," but I just laughed it off really, because some people just don't get it.' (Jasper)

Although David thought it was helpful for students to have a bit of understanding when they first start placements, he also said it was important for them to not have prior knowledge despite the risk that they would be scared, then at least they would not have poor attitudes:

'I'm kind of almost glad in a way these students don't get that predisposition, before they come to these placement. I'd rather they be a little bit scared and come to these placement and not know what personality disorder is than know the wrong things and have to try and change that.'
(David)

A further example of a negative aspect of students being inexperienced, that Leo referred to, was students making errors, for example with medication. Bella shared her understanding of how patients may feel about students doing medication. She recognised they may feel students are not as knowledgeable as qualified nurses:

'So many times, there are patients, they'll go, "Oh, I don't want Bella to do my meds." It's not because of anything, but it's because I'm a student. They might be like, "Oh, a student." Everyone has different perspectives about students. Some might be like, "Oh, she doesn't know what she's doing," or, "She's not qualified, so I don't want her."'
(Bella)

Reading care plans was discussed as important by Bella; possibly as a way of building knowledge, reducing errors and coping with nervousness.

'As a first-year student, you get to know things and you want to know everything in one go. No. Yes, so I think it's because I'm new, I didn't know much. Now I know what to do and when not, or what not to say, you know what I mean? I know now that before I get in contact with a patient, I need to read about them and know what triggers their actions.' (Bella)

However, Molly instead spoke of the importance of focusing on the person and learning about them by speaking to them, as also stated by Fred and Jasper. She spoke of not reading patients' notes before meeting them, to get to '*know them for them not what you found on the computer*'. Similarly, to Jasper, Molly spoke of presumptions that get made from reading about a person rather than talking to them:

'It does feel good talking to patients because then you get to know them. You get to know them and because sometimes you just kind of read up about the person. And you think ooo, and you start to make presumptions, not intentionally. It's just kind of, I think, human nature. Just you don't intend to make any judgments or anything beforehand, so I think. Talking to them… talking to them getting to know them for them, not what you found on the computer.'
(Molly)

Hollie and Fred also referred to staying away from reading files, unlike Bella. Hollie said she did not want to know any patients' histories as believed they would want her to '*see them as they are now'* and share in positive experiences. Fred spoke about the importance of getting to know the patients to understand things from their point of view:

'They only get what's written down on paper, they only get the black and white, they don't get colour. To actually come out and talk to patients, understand it from a patient's point of view.'
(Fred)

Finding out about the person from the person was also mentioned by Jasper. He said it was important for students to come to placement willing to learn from patients, not to tell patients '*how it is'* as '*who else can tell you how it is for you better than yourself*'. Fred referred to students' development using an analogy of learning to run:

'The kid's not going to be born and just jump down and run away, "Woo-hoo, I'm going, see you later. See you in 40 years' time when I'm" or whatever. That will never happen. The kid has got to come out and start learning, everywhere he looks, "Doing my bottle, you beauty, I'll just cry because they come running." Then they'll learn to start moving their legs and their feet, "Ah, look at that person moving about with his legs, what do I do? I'll try it. Oops, I fell down. I'll get back up and try it again. Yes… Oh, no, I fell on my face this time." Students, they've already came here, they've already learned the walking part. I mean, they're already at the running stage, but if they go through the computer stuff, just listen to all the other staff, they might as well take themselves back to the crawling stage. You can only learn about patients from patients.'
(Fred)

For patients, an important aspect of students being learners was that they were seen as '*not regular'* (George), which was linked to them having '*no preconceptions*' (Jasper), and not being '*jaded'*, (Jasper). The patients believed that students had a *'fresh perspective'* (Jasper) as compared to '*regular'* staff. For George he said how it was '*nice'* to have someone new with

a '*difference perspective'* (Steven). Jasper spoke of students coming to placement '*without anybody else's opinions in their heads'*:

> *… 'they're not jaded. They come in with no preconceptions. They're just coming in to learn, and they just always seem to be interested in what you've got to say, and what's your story…'*
> *(Jasper)*

David reflected on students not appearing to have the same ingrained views that some *regular* staff can have:

> *'I found teaching people that have been nurses for a while about borderline things is a completely different experience to teaching people that don't know much about it, because you'd have to deal with the prejudice.'*
> *(David)*

David and Jasper both talked about the importance of reducing the potential for development of negative attitudes by engaging with students early on in their placements and training ('*get in there early*' David). This was linked to the length of time staff work in services, where '*old school'* (Jasper) staff (staff who had been on the units for a long time) were seen to have poorer attitudes ('*more prejudice'* David) towards patients, particularly those carrying a personality disorder diagnosis, as compared to people who had '*nursed'* (David) for less time. Jasper spoke of helping students have awareness of becoming '*jaded'*:

> *'We're nice people, just struggle with our emotions, and so I just wanted to make them see that they might remember, as they go through career, and they start meeting the old school, or ignorant people who are trying to jade them, they'll think, "Well, no, because I remember this lad. He was this way,"...'*
> *(Jasper)*

David highlighted that staff can influence the students' perceptions of patients in a negative way:

> *'All that stems from people when they go on some placements and other nurses and things and go "So what is personality disorder about?" and they've gone, "Stay away from it like the plague," because they're a sceptic and whatever. And then that student, their only impression is of that and so on, and it's a bit of a pain.'*
> *(David)*

He spoke of students as '*baby lambs'*, without prejudice, but as they are exposed to the prejudice of others, become '*sheep'*:

> *'So I like it where students haven't had that prejudice. It's like a baby lamb. It's like, "Yes, you're ready, you can grow up and whatever else and you can just prance around and enjoy everything and then you let in prejudices when you become a sheep".'*
> *(David)*

Molly highlighted that students can also influence other students' views of placements or patients, as well as other staff. Molly told me of another student who had been on her placement before her describing the patients as '*childlike'* and how they demanded attention. Molly challenged this and said it was not the '*right attitude to go in'* with. She said:

> *'I found it completely different to how they'd described it to how a lot of people described it. Yeah, you are very busy because they are, some days can be a lot more challenging than others. It's about going in and talking to patients themselves and like learning about the unit from yourself rather than taking what other people say as the truth.'*
> *(Molly)*

Molly also reflected on how it was useful to observe how other staff, and indeed other students, work and pick up on their approach if she thought it was good or deciding not to mirror their approach if not.

Despite the participants talking about some experiences of students with negative views of those carrying a personality disorder diagnosis, this was minimal, and the patients viewed students as less likely to have ingrained views. It appeared that being open to learning rather than being '*new'* was an indicator of a more positive approach and less negative perspective, as some of the students also worked as healthcare support workers, so were not specifically new to the environment. David appeared to show some underlying consideration that perhaps it was on an individual basis, as some staff were seen as not '*weather[ing] the ride'* and their judgments were clouded by others, indicating that some could '*weather the ride'* and not have their judgments clouded:

> *'I've bumped into some bad nurses, but I've never bumped into a bad student. And it's like, 'I guess you all start the same, just some of you don't last very well. Some of you*

don't weather the ride, some of you are just like 20 years down the line and you're bitter and cold and harsh…'
(David)

Hollie and Julie do refer to a common negative term associated with patients who carry a diagnosis of personality disorder; manipulation, which is a view David associated with longer term staff, identifying the often-poor attitudes towards patients carrying a personality disorder diagnosis. However, Hollie shares her dislike of the term and although Julie uses it, normalises the associated behaviours, showing understanding. Demonstrating that although the students knew of such judgements, they focused on seeing the person.

David shared Julie's view that '*manipulation'* is a human behaviour, and not just something patients carrying a personality disorder diagnosis do. Hollie spoke about the impact of the diagnosis and associated stigma and how the term '*personality disorder*' which '*sounds like there is something wrong with their personality',* which she disagrees with and believes there should be another name:

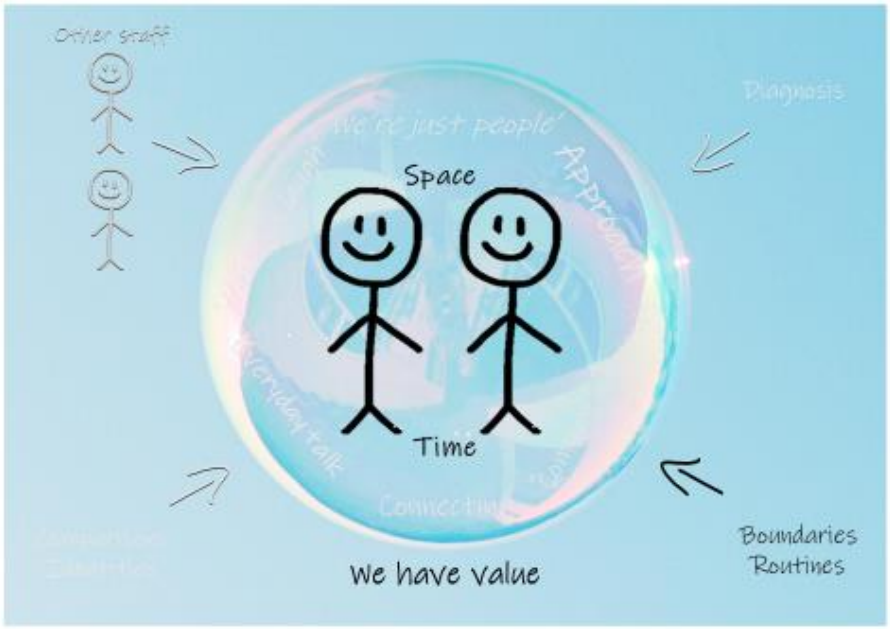
… 'It's always been a bit of an opinion of mine, I don't really agree with many diagnosis, and I don't think people can fit into one box, personally, I think they display a lot of different symptoms. I understand where the need for diagnosis does help patients quite a lot of the time to understand what they have and what they're going through, and even to relate to other people about what they're going through. Yes, I don't, personally, agree, but then they can be stigmatised into that box and it does cause a lot of stigma, particularly personality disorders. It's a summary of my thoughts.'
(Hollie)

… [students] *'seem to brighten the place up, and cause you with other staff you know most of the time so when you get a new face different perspective on things, and so yeah I think it changes peoples atmosphere.'*
(Steven)

6.6.3 Overarching theme 3: Impact

Summary

This theme has three subthemes; Time; Having value and feeling valued: '*Damn well not useless now';* and The landscape. The students are on placement for a set duration, which can impact on the effort put in by the patients in engaging with students, and thus both the patients and students were mindful of attachment when considering the length of time students have on their placements. Despite this, the students and patients had a significant impact on each other, learning from each other and supporting each other in a reciprocal way. This was through sharing time together, doing everyday stuff; '*Just being around*', '*Having a laugh'* and connecting over common interests. When students spent time with patients, the patients felt valued, felt human, felt that they mattered even though they were in an inside world. The patients felt they had value because they could teach the students giving them a role and worth. The students also felt they had value because they could support people and make a difference. They also learned from the patients. The students and patients observed the routines and boundaries physically and relationally of the environment.



The landscape

Subtheme 3.1: Time

'It's like you've got a mission, but it's not actually finished completely' (Julie)

The allocated physical placement time the students had on the units had various elements. Students were seen as new, open to learning and '*sponges'* which attracted a positive view. Conversely, patients reflected on the intensity of their engagement depending on the longevity of the students' placements. Students and patients were aware of the potential for implications with attachment, for example building relationships for them to end shortly after. However, the time students had was viewed as precious and there were discussions of deeper relationships even in short timeframes. The students spoke of missing seeing outcomes for patients, balanced with being ready to leave placement.

For David, the time went slowly on the ward, particularly if you were unwell, and that students can help you cope with this as they are there '*all the time'*. Hollie said that days can '*blur into one*' due to experiencing the same things and same routines. It was interesting to hear David and Hollie reflect on their experiences of time in the environment. For David he said if the ward was busy it meant the students got more time with patients, as the staff did not have the time to ask them to do tasks. George spoke of how the staff seemed to spend more time on one side of the ward which was for assessment rather than the side he was on which was for treatment. He said '*we're a bit more sort of responsible than they are on this side, so they don't check on us every 15 to 20 minutes'*. Showing how perceptions of how well patients were, was measured by time. Similarly to George, Bella referred to the experience of timed routine, for example patients would …*'wake up at 10 o'clock, mealtime or TV time. 12 o'clock, go to bed, switch the TV off.'*

A further element of time David, Julie and Bella each highlighted, was that students seemed to have a short amount of time on their placements and that this had an impact on the '*time'*

to build relationships with patients. For Julie she felt that once she had developed relationships with the patients she was coming to the end of her placement, which she found difficult:

> *'I'm able to build up a relationship but it takes a bit longer. Most of my placements have been like a six-week or seven-week placement. So sometimes, by the time that you are able to build a relationship, you've got to move on from that place and go back to uni for the theory aspect of it. So I think that's where I struggle and that's the part I don't like, when you've built that relationship, where the patient builds their trust with you, that trust relationship with you, and you've got to move on. It's a bit difficult.'*
> *(Julie)*

Just as Julie talks about building trust, Hollie and David reflected on building attachments and how it can be dependent on the time students have on their placements. They reflected that if a student is perceived to not be on placement for long it affects how open the patient may be to sharing time with them. For David he associated such experiences with having a personality disorder, and being mindful of difficulties in ending good relationships:

> *… 'worst thing about students is the placement are always so short… Not just myself but a lot of people with, this is a personality disorder ward, I've got borderline, one of the biggest thing with borderline is fear of abandonment thing. And you try to put that, anybody that manages to speak to students, puts that to one side. And speaks to them. Mainly because sometimes there can be no one to speak to. And next thing you know you've really got to know them really well, I don't know whether it's good, or really awful or it's good practice for people with borderline to get used to appropriately closing down relationships. If that makes sense? Rather than this sort of like breaking them apart the day before or not creating a relationship in the first place, which a lot of people do know with some students, they'll just keep them at arm's length, because they know like "you'll be gone in a few months" sort of thing.'*
> *(David)*

For David it was a balance between having someone to engage with and managing the effects of ending a relationship once the students finish placement. Molly demonstrated an understanding of this and acknowledged that perhaps '*some patients don't really like students. Because we're flitting in and out really quickly out of placements. We're there for 6 weeks then we're gone and they never see us again'*. Hollie and Julie spoke of being mindful of this and thus managing patients' expectations by giving clarity of the period of time they have in that area on commencement of their placements. Hollie said she understood that patients may not want to get '*attached'* knowing that students will be leaving. I asked her how those conversations come up, she said:

> *'They always ask me, "Oh, when are you leaving?" There will always be a little boundary there. I know quite a lot of personality disorders come from attachment issues, and are stemmed from attachment issues, which is unfortunate. I think, because they are relatively well in comparison to some of the patients around the hospital, they know that I'm leaving, so they might put boundary in place.'*
> *(Hollie)*

Hollie reflected on the importance of managing boundaries in relation to her length of time on placement, while being mindful of patients' attachment and transition to other units or services. She identified that their relationship would have to end, and the patients needed to be aware of this. She reflected how it was understandable why patients get attached to staff when they have '*helped them so much'*.

As well as being mindful of patients' knowledge of the students' length of placement, Bella, although highlighting that the placements are short, spoke of the importance of making the most of the time she had with services users. Showing how the students positively managed the perceived short placement length:

> *'Actually, the time I spend with service users, it's been really good, to be honest, because our placement is just like a short placement, so you value every time you spend with them.'*
> *(Bella)*

Just as Bella valued her time with patients, Julie focused on making a difference for the patients she did share time with, despite the short length of her placements:

> *'For me as a student, it gives me- I'm happy, if I'm able to help someone. Even in the short space of time that I'm there, if I'm able to help someone, it gives me- I'm happy that I've made a difference in somebody's life. Sometimes I think, as I said earlier, because of how short our placements are, sometimes there is little that you can do in order to see to the end. But then you know that you've made a contribution to somebody's life and made somebody's life better.'*
> *(Julie)*

Julie believed that the longer duration a student had on placement the more likely the patients would feel comfortable with them, as you cannot put a timeframe on when someone will feel comfortable with you. On the other hand, David spoke about gaining deeper relationships with students who had limited time on the ward as compared to staff who were there longer:

'Maybe my standards are a bit too high. But then when you meet a student again, sometimes more often than not after a month you're sat there and you've got a brilliant rapport, better than half the healthcares who have worked with you for a year or longer.' (David)

For Jasper, although he was sad for the students to finish placement, he was also happy for them in progressing in their training and becoming nurses:

… 'because if you get to know people and you get on with them, and stuff like that, and then they go, but you know that from the get go, you know what I mean, that they're going to be leaving, got a few months and stuff, so it's sad, but obviously I'm happy for them.'
(Jasper)

Jasper also highlighted that although the patients can experience difficulties managing the short time period the students have with them, the time they do have is precious and beneficial. David highlighted that despite seeing so many students and not remembering their names, he could still picture their faces. The time students shared with patients was also precious for the student nurses who spoke of feeling sad that their placements were finishing. Julie particularly spoke of feeling like she missed the transition between services when placements were for a short duration. She wanted to see the patients move on positively in their care pathway towards recovery. She wanted to know what happened to the patients after she finished placement; to see how they managed in the new environment. Similarly, Molly spoke of not being able to see the end of work:

… 'you don't get to see all things through. So you'll start a piece of work with the person or you'll start to process their like a discharge process. Or a care planning process and then you have to leave before you get to see it all the way through'.
(Molly)

David equally said; *'like anything good, I know it's a bit cliché but anything good, it always comes to an end'.* Leo spoke of feeling '*wounded'* and that it was '*heart breaking'*; powerful words to describe his feelings when students leave. Despite this he appeared to feel hopeful about the future and seeing them again. Showing that although short placements can impact patients negatively in the short term, they speak fondly of their time with students:

> *… 'wounded means it's like sad that she's leaving and I'm never going to see her again. But, one day, touch wood, I'll see her somewhere in XXX, bump into her and say, "What's happening?".'*
> *(Leo)*

Jasper demonstrated understanding of what it can be like for students on placements, and that, although he and other patients valued their time, some may be ready to finish:

> *'The last girl, XX, she was really nice, and she just seemed to get it. She was alright. I think towards the end, I think she was ready to go, think she'd had enough.'*
> *(Jasper).*

Julie and Molly also discussed that there may be some placements you are happy to leave. Molly discussed aspects of length of time on placement and the *pro et contra* (pros and cons), demonstrating the complexity in the concept of time on placement:

> *'It is good in the sense that you get to go like experience different places and it's like short time bursts. I know some people in my group haven't had brilliant experiences on placement so it. For that maybe if it's somewhere that you don't particularly want to work. It's not a long term thing where you have to kind of stick it out. You get your experience done and you move on. But sometimes if it's a placement that you really enjoy, like I've been really lucky at all of mine. I've enjoyed all of mine. You feel like you're just settling in, you just get into the routine. You'll learn about the patients, learned about the staff. Then you get kind of shunted somewhere else or you have to leave.'*
> *(Molly)*

'Then I found out that she was leaving and I was a bit wounded, but it's one of them, isn't it?'
(Leo)

Subtheme 3.2: Having value and feeling valued: '*Damn well not useless now'*

> *'It's nice like that, because you know that every moment that that student is spending time with you, they're not doing it because they have to. They're not doing it because they have to write a note about you, they're not doing it because they have to do this, they don't have to do that, they have to do this. The only reason that they're spending time with you is because they want to. And that feels nice, that really does feel nice.'*
> *(David)*

For the patients and students, helping each other and learning from each other made them feel valued. When students spent time with patients, they felt they had helped them and made a difference. The patients felt like they had value by teaching the students, which impacted on them feeling they had a role, purpose and worth. For the patients and students, having value and feeling valued appeared to make them feel human in an often dehumanising place. Value could be associated with physical time and was a measure placed on the value a person felt they had. Yet the gravity of how the students impacted on the patients was immeasurable.

The students all referred to helping patients and feeling like they had '*made a difference in somebody's life*' (Julie) by supporting them, helping them '*open up'* (Oliver (student)) and '*move on and get better'* (Hollie) or just being there for them to talk to. These were the main reasons for them starting their nursing courses. Julie spoke about helping patients feel at '*peace'* by sharing time with them talking, which then helped them approach her if they needed:

> *'If you are a person they can come to when they are troubled and you are listening to them, then they find a peace. They are more relaxed in your presence, they are more relaxed with you. And they can come to you and say, "This person is someone I can go to and say anything, and I know that when I'm talking to the person, the person is going to support me.".'*
> *(Julie)*

Bella also spoke of supporting a patient to feel relaxed when they felt like harming themselves, and how talking to them would help. Julie reflected proudly on an experience when a patient refused to have his physical observations completed with staff for several days yet agreed to

have them completed with Julie. She also spoke of an especially difficult experience when a patient had attempted to hang themselves, and because she trusted her instincts to check on him earlier than when the observations were due, the staff were able to save his life.

Oliver (student) spoke of an experience where a patient he had supported while in seclusion used to call him '*Shrek'*, when seeing him later in his placement called him Oliver, a '*nice little thing'* which made him feel like he had done '*something positive'*. Molly told me about a patient who had asked her to just sit and chat with him because he was struggling with his mental health, she felt proud that he trusted her to have a conversation with rather than other members of staff who had been on the unit a while. She also reflected on sharing time with another patient who wanted to read her a poem he had written, and how she felt privileged that he had opened up to her about something personal:

> *'It feels really good because it's something like it was a difficult topic he was talking about. He'd written a poem about his friend, who had taken an overdose of drugs and had passed away. I felt really fortunate to have him say "can you come listen to this" because it was about a very sensitive subject close to home with him. So it was nice to have that interaction. "I'm really glad you read this to me". It does mean more when a service user does that, it means it's good for your professional relationship as well. And because you're building up that trust and you were able to have that trust between yourselves.'*
> *(Molly)*

After being on placement for a few weeks, Molly said that the patients had started to ask her for things rather than looking past her to other staff when they had approached the office:

> *'They knock on the door for something and they'd speak past me to somebody else in the office. Someone that they knew. Whereas now if I open the door, they'll actually ask me to help them. So they know me enough to be able to ask me to help them out with what they need…'*
> *(Molly)*

Such positive outcomes helped the students cope with challenging experiences and made them feel '*happy'* (Bella) to come back the next day. For Oliver (student), spending time with patients made it worth coming to placement. George and Jasper spoke about giving feedback to students, either as part of a questionnaire (George) or writing testimonials (Jasper), which

they were pleased to do. Julie and Bella reflected on it feeling '*nice'* to be '*wanted'*, to get recognition and to be able to build trust with patients, which developed their confidence. Bella, although jokingly said she was avoiding a patient who said was getting her a card, she spoke how gaining recognition with cakes and cards on finishing her placements made her '*feel good'* and '*makes you want to do more'*:

> *'As a student, like I say, it feels good, people coming to you and you are able to intervene in their situation whenever anything is going on their head, or maybe they are feeling self-harm or anything. It's quite good. And it makes me feel good that I'm impacting in someone's life and I'm not just coming here every day just because I want to get my competences. Whenever I come here, I make sure I do something and I just want to do something that, when I leave people will say, "Oh, we miss Bella."'*
> *(Bella)*

Just as the students helped and supported the patients, Fred spoke of helping the students as they develop during their training. He spoke of the amusement when students he had supported became nurses:

> *'I mean, to know that you've actually given them that help all the way through. To actually even have one of them in your healthcare, to actually becoming your main nurse, that's even funnier.'*
> *(Fred)*

The impact the students had on patients was significant for all the patients in my study. Jasper even said how he had never met anyone who did not value having students on the units they resided on. For Leo when students spent time with him, he felt like they were interested in him, and were putting him before doing '*work'* which seemed to refer to such things as paperwork:

> *'Then I'd sit there with her, and I'd sit here for nearly an hour-and-a-half chatting to her. She just sits there and listens and listens and listens. She might have work to do, but she doesn't give a fuck about the work. She's more interested in us.'*
> *(Leo)*

George spoke of finding it '*nice'* having some '*one to one'* time when a student was focused on him and not the other patients on the ward. For David it also appeared that being put first, not '*being at the bottom of the list'* and not '*playing second fiddle'* to something else made him feel appreciated and valued. He also reflected that he felt at the bottom of the list with other

staff as there were often interruptions which reminded him he was in hospital and that reality check was a '*dampener'* on things. Yet time with students acted as an escape:

> *… 'you feel appreciated. Like I said, when you've got other nurses, if nurses ever get to do activities now, other health care, there always seems to be doing something, 10 minutes on, I've got to check its half an hour, you were enjoying something, there and then and the next thing you know someone's checking the time, or has to go in the office and check something. It proper puts a dampener on it a reality check of "oh yeah we're in hospital." But when it's with a student, it's kind of like, next thing you know "oh dam, I've been here while." It's kind of nice like that.'*
> *(David)*

The patients missed the students when they left, because they had felt valued when students spent time with them. It was clear for Leo that students' dedication to helping patients meant he would approach them for support:

> *'I miss her… Because she was absolutely one of the best student nurses that I've ever seen. She did things for you. If you needed to see her she'd be there straight away. If you asked her to do something she'd be there straight away. Even if you were in crisis or if you couldn't get hold of your mum or anything, I'd say to her, "Excuse me, it's alright if we could speak to you?" and she'll say, "Come on Leo, let's go for this chat.".'*
> *(Leo)*

Mike felt valued when the students knew about his diagnosis and were inquisitive, he also valued being able to teach them:

> *'It was interesting that she took the time to ask me about me, you know? So, I felt easy to respond to her questions. She was very good. She learnt a few things from me.'*
> *(Mike)*

David reflected that the students did not have to spend time with the patients so when they did it was really appreciated. He also said that the students spent time with patients because they wanted to, not because they were obliged to or were paid to be which seemed to make their time valued. He said, '*there is something more about them than it's just a job*'. David said, '*you bring up a conversation with a student and you never normally get shut down*'. Mirroring a statement by Leo about a student who '*would drop anything for a chat'*. Highlighting how they considered them as reliable. David compares this with other staff who, he seemed to think, only talk to patients because they had to, which appeared to be a barrier to engagement and thus meaning he was more likely to engage with students.

A further example of the significant impact students had on patients, that George discussed, was how a student made him feel safe to discuss personal topics. He said a student could tell he was struggling, and she reassured him. When I asked if he could tell me a bit more about feeling safe, he said:

> *'I felt safe to talk about the things she observed and stuff and like I said I'm pretty honest and open. So she noticed something and I was honest and open about it and she came across don't worry, she knows about my problem and didn't have a problem with it and that was quite nice.'*
> *(George).*

Steven spoke of how if he was struggling, he would do something with a student which would improve his mood and make him '*feel better'*. When the students spent time with Jasper, it made him feel like he was '*okay'* despite questioning himself a lot and residing in a secure unit with a personality disorder diagnosis, he was '*getting on with them'*. It appeared to give him hope for the future. This appeared to be an anchor or a connection for him to the *normal* world, connecting with '*normal people'*, while he was '*locked up so long'* in an institution. It made him think '*I'm not that bad'*:

> *… 'because they're going on, and they're achieving, and they're part of the normal world out there, and they're coming into here, and I'm having a laugh with them and feeling good.'*
> *(Jasper).*

David felt hopeful about the students' becoming new nurses, taking forward a more measured opinion of patients from doing teaching sessions with him. He used an example from a Doctor Who episode to explain his drive for teaching students. He explained that when the Daleks or Cybermen ask Doctor Who "*why do you have a love for humans, they're pathetic and barbaric*" and Doctor Who says, "*because they're a species of hope*". He described how he has hope and can make a difference by teaching students about personality disorder in a compassionate way to reduce negative attitudes.

Teaching students was a key element for David, Jasper and Fred in them feeling valued. This appeared to give them a purpose and a role. They taught the students about their diagnosis

of personality disorder and felt this made a difference to the students' perceptions of patients with the diagnosis and patients they may spend time with, in the future:

> *'It's one thing where I like talking to students because I feel like I can make more of a difference. Aside learning that, I can't really make too much of a difference of what has happened to me, but I can try and make a difference of what happens. So whether that's myself or someone else or whatever else. It's the one thing that motivates me, particularly at times of difficulty, because it's that little bit of hope'.*
> *(David)*

Regardless of whether some patients were '*scheming'*, as Jasper spoke of, he was focused on students not prejudging patients because of the diagnosis:

> *'I know there is a lot of stigma around PD and stuff, until I came to a PD place and you get it, because there is a lot of manipulation. There's a lot of stuff like that, and I never got it. I think I want to be the one that shows them we're not all like that, we're not bad people. Some others here are a risk to ourselves, and we're not all just scheming and up to something. I feel like, for the couple of students that I've met here, they've got it…'*
> *(Jasper)*

As well as teaching students about their diagnosis, Bella spoke about the patients teaching her about medication:

> *'So, as a student, I learn from patient medication wise. I don't even learn from my mentors* [practice assessors]. *I'll be like, for example, "Tom, what's this medication for?" Because sometimes I don't know the medication round I'm giving out. So even before you ask me, I'm like, "Please, do you know what that medication is for?" And believe me, they know. Patients know better.'*
> *(Bella)*

Steven enjoyed teaching the students to play pool, just as Hollie spoke of teaching the patients to play scrabble, showing the reciprocal nature of teaching and learning between patients and students. Due to this reciprocal relationship, connections were built, which became lasting memories, for Leo especially. He seemed to really enjoy teaching students to play cards, even though he spoke about being fed up with repeatedly teaching them; he spoke to me with pride about being a role model by helping students settle in:

> *'"We'll have a nice game of cards and we can chat." They just go, "Oh right, sweet. But I don't know how to I play." I think, "For fuck's sake. I'm not doing this now." So, I sit next to him and I show him what to do. It's got 10, 9, 8, 7, 6, he can put all them down at the same time, he's like, "How do you know this?" I said, "Listen, don't worry about me." But yes, everyone comes to me about the students and that, it's just me, and then*

I sit down with them and have a chat. Then they go in the office and then they'll go, "That guy over there… Leo…".'
(Leo)

Equally, David told me staff and students came to him as he was '*the go to person to learn about personality disorder'*, which he joked that they had not even said hello before asking but sounded proud of himself. For Leo, having a role of supporting students, also appeared to help him feel proud of himself. He reflected on his journey while an inpatient, and how helping students settle in, was a key element of his growth. Again, showing how students made a positive difference for patients. He said he had been called the role model on the ward, and that he was the person for students to go to. When I asked what that was like, he said:

'I absolutely can't believe it. After two-and-a-half months of absolutely fighting with staff left, right and centre, doing all sorts of shit, smashing doors through. From the way I was acting a month ago until now, I'm absolutely proud of myself because I've worked so hard to get where I'm at. It's two-and-a-half months, but now it's nearly two months now that I've done absolutely no damages, no nothing. So, all the doctors have given me my leave.'
(Leo)

Fred said that teaching students increased his confidence and helped him feel worth something, he spoke of himself as a person rather than a patient. It appeared that sharing time with students supported Fred to reflect on his traumatic experiences and feel more positive about his future (end quote). This mirrored David's experiences, where before taking on a teaching role with students he described experiencing severe anxiety where he would sit in a corner, and how a student would be the one to sit with him, which he said he would remember as she helped him a lot when he was '*really struggling'*:

… 'it got quite extreme where I'd sitting in a corner and I couldn't feel like I could move my head anywhere, so I'd feel really anxious and stuff and I couldn't breathe anywhere else, so I just sort of sat facing a corner almost it looked. Some of the patients would affectionately say, 'Oh, he's like naughty boy in the corner,' and I laugh at it now. But then this student nurse, [***], would actually be the one that would sit down next to me and see how I was doing, even when it was just little things.'
(David)

‘I don’t think there’s a patient here that’s never ever been told in their life as a youngster, “You’re useless.” I mean, “You can't do anything.” We wouldn’t be here, we wouldn’t have personality disorders if we never got all the wee things happen or done to us as kids. To actually step back and actually, “You know what, you might have been useless but you’re damn well not useless now.”.’ [teaching students]
(Fred)

Subtheme 3.3: The landscape

> *… 'this is a draining ward. There's a lot of shit that goes on, so it's not all sweetness and light…'*
> *(Jasper)*

The landscape, the students and patients shared time together in, included the physical environment, routines and structures, risk and boundaries, and the feel and atmosphere of the environment. The patients and students talked about the units being an inside world that is separated from outside, where patients are '*warehoused'* (Jasper) and unable to go outside, while aware that students can leave. Other aspects of power were reflected on in relation to routines. The patients and students seemed to be aware of the importance of managing risk, boundaries and safety, while also having a positive and therapeutic landscape with space and time to develop rapport and trust, through activities, sharing common interests and '*having a laugh'*, as discussed in other themes. In order to have a therapeutic landscape, the atmosphere on the ward appeared to be a key element. There were varying opinions of positive aspects in addition to challenges of the environments. The units were described as boring as well as stressful, showing the diversity of the landscape and associated experiences within it.

Jasper and Julie referred to the wards being draining and having certain '*dynamics'* (Jasper). Leo described the environment as scary, particularly for new students who may find the environment unpredictable:

> *'It's one of them isn't it, it's just to get them into the environment because it's like coming in to a hospital, they're not going to expect what's going to happen because you don't know what you're going to expect. But, they can walk through that door and someone could be kicking off. They're coming into an environment where they've never worked before, and it could be scary for them …'*
> *(Leo)*

However, Hollie said that acute wards were scary, while longer term placements, like secure services, were more relaxed. This appeared to be in relation to how long the patients had been

inpatients and how the units were more focused on specialist care. She stated how patients who had been inpatients for 10 years knew the ward processes and were more '*settled'* as compared to acute services which may be '*very mixed'* and fluctuate more as she had experienced on other placements. Hollie continued to speak about how there were risks present on secure units but that it did not feel risky but '*comfortable'* and '*nice'*.

Julie however spoke of a time when the secure ward where she was on placement was described as high risk with many incidents of aggression, self-harm and suicide attempts. This resulted in high levels of staff sickness which exacerbated the unpredictability, resonating with Leo's experiences. Julie said that the staff did not know the team they would be working with or if they would be short staffed when starting their shifts. She said how staff were coming to work with their adrenaline high due to such unpredictability. Molly also spoke of some days being '*more challenging than others'*. Molly demonstrated empathy for the staff and patients when students start placement and '*come in and kind of almost disrupt'* things. She said how the staff team would have to take in to account the student, their learning and competencies and how they would '*fit in to things'*.

With regards to managing boundaries and risk, although being aware of patients' risks did not affect the students' perception or general approach to patients. Bella, Hollie, Molly and Oliver (student) did speak about self-disclosure. Hollie said, '*I don't give away too many personal details about myself'* and Molly spoke of maintaining appropriate conversations. This included not sharing where she lived, as Oliver also referred to, or if she had children due to being on placement in a secure unit, and the risk histories of the patients. Hollie and Molly also spoke about some practical aspects of managing risks in a secure unit, such as being mindful of where they sat and their surroundings, and Hollie discussed accepting gifts and what this could mean to the patients; balancing managing risk with individualised care:

> *'Yes, it's because it's forensic. I mean, not in every place, but, for example, like accepting gifts from patients is something I would never do, personally. I wouldn't want*

them to think that they're getting preferential treatment over a different patient, even though I do believe in individualising characters, just maintaining that you're all treated the same way and cared for in the same way.'
(Hollie)

In a practical sense, Oliver (student) and David, despite their experiences from different units, spoke about the stressful routines, noise and medication times. Similarly, Molly, who was at the same unit as David, said the ward could be an '*intimidating'* place. Oliver noted '*daunting'* ward round rooms full of people, showing empathy for the patients and what it must be like for them in such environments and not being able to leave:

'It can be really noisy. You know, everyone's got a different illness, they're in hospital, it can manifest in different ways. Sometimes noisy ways and disruptive ways. So, yes, it can be a stressful place to be.'
(Oliver, student)

Leo said it was important how you treated the staff because in '*being a dick'* may result in patients being an inpatient longer or being '*stuck'* there. He reflected that the staff can leave but patients cannot:

'If you're being a dick you're going to stay here for a lot longer, they've got a home to go to. You're stuck here for the rest of your life.'
(Leo)

Although this appeared that he was referring to patients having control in the way they treat staff, there also felt a sense of powerlessness and highlighted a feeling of being contained in the environment of the secure unit. This was also reflected by David who reflected on a routine experience in a secure unit; being observed and thus feeling he had a lack of privacy:

… 'when someone's staring you while you're just trying to relax in your room and you're watching a film or you just want to chill and lay with just a bit of music on and all you're hearing here is a shutter going up. I wish I didn't have that feeling that where, you know when you feel like someone's looking at you? You can always tell. You don't even know the hatch is open, but you just look up and you just see someone's eyes on you and you're just like… (sighing)'
(David)

David spoke of a story where he would wait to the next time he was being observed and threw a ball at the shutter at the perfect time, making the staff member jump. He laughed about this

memory but to me it demonstrated the damaging effect of the landscape of a secure unit for patients, particularly on their sense of privacy.

Oliver (student) spoke powerfully of what it must be like for patients in such a stressful environment, especially when patients may struggle with their emotions and may not realise the impact of such environments themselves. He referred to seclusion as the patients being like animals in cages at the zoo, but the animals have bigger cages:

> *'Well, realistic terms, it's not normal to live in a hospital, is it? Like, it's probably one of the most stressful places on Earth that you could live. I was speaking to one service user the other day and he was talking about not sleeping very well. He said his neck hurts and mine does that when I'm stressed. I said, "You might be a bit stressed." He said, "What do you mean stressed?" He used the words, "I'm on the umbilical cord, I've got nothing to be stressed about." I said, "Are you kidding me? This environment is the most stressful place you can live in, you've got people knocking on your door all the time to get you to take your tablets, everyone shouting in the middle of the night and stuff." It is stressful. It's probably the worst place on Earth you could put someone who is having trouble with anxiety or anything like that, a hospital. They're awful places, really, you try to make it as good as you can.'*
> *(Oliver, student)*

I asked Oliver (student) what he did to '*make it as good as you can'*, and he said '*well, I don't know, I don't really do anything on purpose'*. Perhaps linking to his statement about using yourself as the tool to support patients and Bella saying to be yourself[98]. Despite Oliver thinking he did not really do anything; it was clear from Jasper and Mike that he helped support them and they both spoke positively about Oliver and his approach. An example of his approach which highlighted the impact of the landscape was when he spent time with Jasper and Mike outside of the wards. They appeared more comfortable and open to deeper conversations. Oliver went with Mike to view another hospital Mike was transferring to, they travelled there in a van together. I asked Oliver what it was like being in the van:

> *'Just got to know him, because he's quite a… He doesn't really come looking for interaction, I think he's got a diagnosis of autism. When he was held hostage with us for 10 hours, we're had a lovely time. Every landmark we drove past, he was telling us all about it and we learned quite a lot about him...'*
> *(Oliver, student)*

[98] Theme 1.3.

Mike spoke of enjoying his time with Oliver (student) during their visit, interestingly he spoke of the differences in the environments of each unit and how the patients on the unit would not be able to manage in the other unit, due to risks of damage:

> *'So, the guy here now, he came down south to the hospital with me and it was really nice. I mean, this ward's Beirut… I mean, gee-whiz, because they keep smashing things up. But, at the next hospital you couldn't have these patients there. Like in here, for instance, it's got Sofology sofas, it's really nice. Microwaves, football pitches… It's really, really nice. And we spoke about that on our return. He was quite interested and showed a keen interest in me moving as well...'*
> *(Mike)*

Perhaps due to the type of units; medium secure, the students and patients noticed a difference in engagement when they were outside the units.

Although patients and students refer to the units being stressful. Participants in both groups spoke about the issue of boredom, signifying the complexity of their environments (David, Bella, Hollie, Steven, George). Steven and George said how it was boring without students as well as how they '*brighten the place up*' (Steven):

> *… 'well I suppose at these places it's very boring, very same, you just do the same old thing, when you can just chat to people have a laugh and a joke, watch tele with them. It just changes, your mood changes, cause you're used to doing the same old things day in day out. Basically in places like medium secure and high secure places like that. I think it just breaks your day up a lot. It makes you feel a lot better, a lot happier. And you're waiting for the next one [student] to come... Because you haven't been with anyone for a few hours and you're wanting to know when the next ones coming…'*
> *(Steven)*

Hollie spoke of needing to keep the patients' busy, as a way of reducing boredom and offering distraction if they were struggling:

> *'A lot of the time we play cards, we play Scrabble, and we chat and watch TV. Because it's a ward environment, there's not a lot for them to do, so it's keeping them entertained and away from their own thoughts, quite a lot of distraction methods. especially the ones that are hearing voices, and things like that, always try and get them engaged in Scrabble, they love a good game of Scrabble.'*
> *(Hollie)*

Jasper reflected that it was positive to see people from the '*outside world'*, although in referring to the outside world identifies that he felt the ward was a separate, inside world. Molly told me

about a patient she supported who said he sabotaged his discharge plans because he was worried that the '*world had changed'* since he was admitted, highlighting the institutional nature of secure services and potential impact on patient discharge. In a similar vein Jasper spoke of feeling '*warehoused'* and how he had not got the support he needed in previous units. Mike also stated he '*shouldn't be'* in the unit a number of times during the interview.

With regards to the physical environment, students and patients refer to the office as a pivotal point on the ward like the television[99]. The office was a place where staff spent time which negatively affected patients' moods (Jasper). David, George, Julie, Mike identified that nurses spend more time in the office than students. Jasper and Molly also highlighted that the office is a place where patients have to go to ask for things. Just as David spoke about[100], Jasper also told me about having to ask for milk from the office:

> *'I don't know why, but when we sat at that table, and I was feeling a bit downhearted, and she was like, "What's the matter?" I said, "Well, it just pisses me off. It's like, not you," but I said, "It's like you're treating it like a youth club, you know what I mean? You just come in, sit in the office, we come and knock on to get some milk, or a coffee, or a tea...".'*
> *(Jasper)*

Oliver (student) also discussed how there was an '*invisible line'* present to the ward office for patients that they were not able to cross. A further aspect of the environment noticed by Hollie was that if the patients spent time in their rooms it could identify what their mental state may have been like. She gave the example of noticing if '*louder people'* started spending more time in their rooms then something was '*probably wrong'*. Julie found from her experience on night shifts that patients stay in their rooms. Conversely, during the daytime Oliver found patients spent time together in communal areas such as the lounge, which was important to observe how they interacted with each other. He was however mindful that such interactions, although important, should be considered within the context of the landscape:

[99] As explored in theme 1.1.
[100] See quote in theme 3.2.

‘I think we put too much stock in when patients are having a go at each other, they're not allowed to be separate from each other. If I don't like somebody, I never have to see them ever again if I don't want. He has to live next door. I don't share a kitchen and a toilet. So, I think they've put a bit too much into the social dynamics, because it's not a natural environment.’
(Oliver, student)

‘Well, the way I view it, I'm done at the door, I can go home and do what I want. Like, you're literally part of these people's lives. It's almost like a parenting role sometimes, isn't it? Especially in a setting like this, because people can be here for years and years and years, because of the nature of a forensic service.’
(Oliver, student)

6.7 Conclusion

I outlined the location of the participants in this chapter leading to a narrative of the findings and participant quotes. Themes of the findings from both participant groups; patients and students, were discussed *together*, aligned with the exploration of the participants' time; shared *together*.

When together the patients and students connected over common interests, they had a laugh and talked about everyday stuff. The time they shared together '*just being around'* was a gift and made both the patients and students feel valued. There was a shared recognition of humanness and reciprocal teaching and learning that gave them identities and worth. Students were new, open to learning and '*sponges'* which attracted a positive view. In addition to being available and having a positive approach. The landscape of the secure unit impacted on everyday stuff, including the physical space, boundaries, and routines.

In my interpretation of the findings, a key quote stands out; '*we're all people'* (Jasper and Fred) and we have value, the core '*phenomena'*; we are all people existing, we are human beings despite roles, identities and the environment. The participants were all people; sharing time, connecting and laughing over common interests and everyday stuff which made them feel human and of value in often dehumanising places.

I will now explore the findings, synthesised alongside philosophical, sociological and pedological concepts, in addition to key papers explored in the integrative review chapter[101] and other research to come to an understanding of the experiences of patients and students' time shared together on secure personality disorder units.

[101] Chapter 3.

7 Discussion

In the previous chapter I outlined the participant location and the findings of this study, which included *Everyday stuff*, and *Balance* with the overarching theme of *Impact*. Themes of the findings from both participant groups; patients and students, were discussed *together*, aligned with the exploration of participants' time; shared *together*.

7.1 Introduction to the chapter

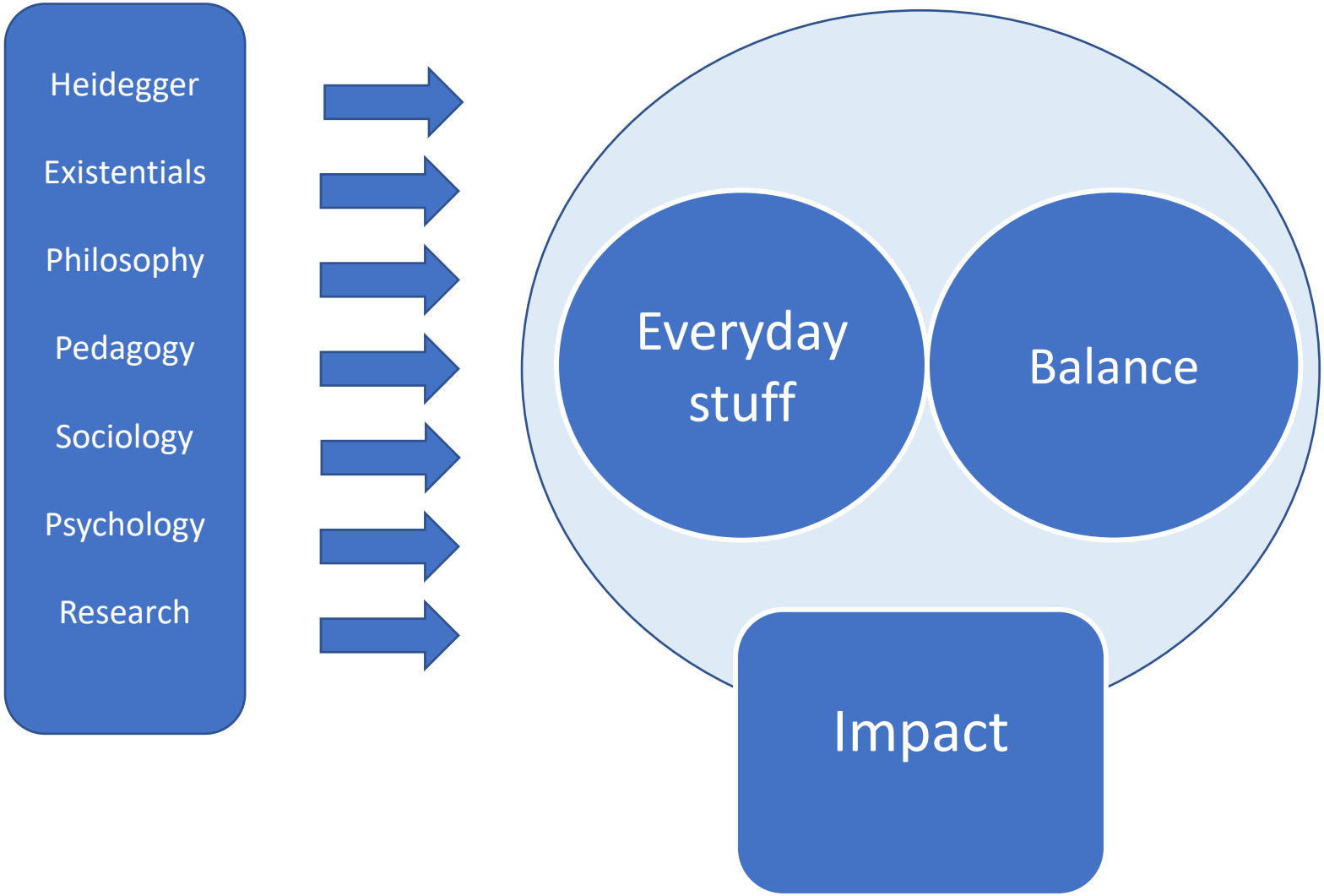
This chapter weaves together the experiences of the participants, key studies explored in the integrative review among other research, Heideggerian and other concepts. I share a synthesis and weaving together of these, shared like the shared time together of the participants.

I demonstrate relevance and transferability with wider academic literature (Dibley et al., 2020), in addition to a '*walking along with the philosophy'* (p. 126), where my interpretation ponders what the story is saying, weaving in other texts and philosophical notions to promote thinking. This distinguishes hermeneutic research from other approaches, adding value and fidelity (Dibley et al., 2020). It can open up new meanings, some of which may have been in front of us all along (Peoples, 2021). Returning to underpinning philosophy enriches and reveals meaning in the experiences of the participants, enhancing the quality of the study (Dibley et al., 2020), and enabling reconsideration of practice.

As Heidegger, following Husserl, proposes, we must go back *'To the things themselves'* (Heidegger, 1927/2019, p. 34/58); the participants voices and experiences. It is important to balance philosophical concepts with the voices of the participants (Dibley et al., 2020) so the data leads hermeneutic studies (Smythe, 2011). With this in mind, the discussion chapter is

structured by the three identified themes *Everyday stuff, Balance* and *Impact*, comprising the participants experiences as interpreted and understood by weaving and exploring influencing concepts and evidence, as depicted in the discussion chapter thematic map below (figure 8). I use subheadings for clarity and to support a structured discussion.

Figure 8: Discussion chapter thematic map



7.2 Returning to hermeneutic phenomenology

The underpinning methodological approach for this study is an interpretive hermeneutic phenomenology. It is therefore crucial to return to this approach explicitly to view the parts and the whole of the findings as aligned with Heideggarian concepts and the Hermeneutic circle (Gadamer, 1975; Heidegger, 1927/2019). The integrity of a thesis is shown by the connection to underpinning philosophy (Dibley et al., 2020; Smythe et al., 2008). I felt it essential to start the discussions with an initial acknowledgement to such alignments (as a whole) before exploring the themes in depth (the parts) as considered alongside these concepts in addition to other theorists and research (Peoples, 2021). All of which is viewed and interpreted through my lens; influenced by my *fore-structures* (Heidegger, 1927/2019) and *prejudices* (Gadamer, 1967/1976). The discussions here explore the applied nature of concepts discussed in the methodology chapter[102]. As stated by Crowther and Thomson (2020) other notions or concepts could have been used because '*multiple notions can surface the overflowing meaning that dwells within*' (p. 8). I maintain my thinking following Heidegger, beyond the methodology chapter, evidencing links throughout (Dibley et al., 2020).

It is important to refer to my earlier note that Heidegger was a philosopher and his concepts were not *made* specifically for research (Crowther & Thomson, 2020; McConnell-Henry et al., 2009). I am not a philosopher, I am a nurse illuminating resonating elements of Heideggerian and other concepts alongside my findings and other research in order to inform practice. In this way I am staying true to the participants' experiences and my interpretation of them.

The time shared is the focus; the connection between students and patients experienced by *being-with,* creating their *bubble* (their time and space together) is where they find '*we're just*

[102] Chapter 4.

people' (Fred and Jasper) and have value; the phenomenon (deeper than the connection and the impact of the connection), everything surrounds this phenomenon[103]. Within the *bubble* the students and patients share, they connect over common interests (to feel a sense of togetherness); they have a laugh; they talk about everyday things. They experience this temporally in their *bubble*. This lived space, in lived time gives them value, makes them feel human. They are *Dasein*; *being-there*; *being-with*; interconnecting and *being-in-the-world*. Students are seen as being available to patients as compared to other staff due to set roles. Influencing the *bubble* are the identities of students and other staff, their approach, and the actual physical time they have on placement. The students are '*sponges'* who are influenced by others. They can experience *fallenness* to become enculturated into *the one* of the landscape when they become *holder of keys* (not learners, paid, '*busy*'). The students balance their sense of self and *therapeuticness* (*leaping-ahead*) with professionalism, identity and risk (*leaping-in*)[104]. All this occurs within the landscape of the secure unit, which includes the physical space, diagnosis (as a result of *thrownness* into the world), boundaries and routines, and doing paperwork in the panoptical eye of the office.

I will now explore the parts (themes), returning to the whole at the end of the chapter.

[103] '*To name the phenomenon risks stripping it of its fullness, however it can also safeguard its possibility'* (Crowther et al., 2015, p. 456).
[104] Figure 9.

7.2.1 Theme 1: Everyday stuff

The bubble

The students and patients spoke of *being-with*[105] each other in their own time and space, where they shared an experience of togetherness, enabling them to feel they were '*just people'* and had value, which had a lasting impact. They connected to each other creating a *bubble,* despite their experience of *thrownness* into the world, the landscape and assessment.

In their *bubble* there was a meeting of two lifeworlds (Rask & Brunt, 2007; van Manen, 2014). Welch (2001) described such bringing together of lifeworlds as presence, embodying past experiences. Rask and Brunt (2007) describe the encounter of two lifeworlds as two people meeting in a '*common sphere'* that they both experience (p. 170), which resonates with my *bubble* metaphor. This shared '*sphere'* or *bubble* aligns with Merleau-Ponty's (1945) description of the '*between'* in interpersonal relationships, or as Gendlin (1995) describes a '*crossing'* or '*dipping'* (p. 547). Or '*presence*[106]*'* (Stockmann, 2018). Such metaphors[107] can be used to explore therapeutic encounters, providing rich imagery for making sense of experiences and informing educational tools (Turner, 2011, 2014). The Tidal Model, for example is commonly used in mental health nursing and works with metaphor to describe relationship building (Barker & Buchanan-Barker, 2005). They are often used in psychotherapy (Turner, 2011, 2014; Turner & Ralley, 2019a, 2019b) and are indebted to the phenomenological tradition (Lakoff & Johnson, 2008).

[105] *Being-with* and *thrownness* are explored in chapter 4 and included in the glossary in appendix 1.
[106] Presence is described as an '*interpersonal experience involving being with the whole of one self for another who is in need*' (Stockmann, 2018, p. 49).
[107] '*Metaphor is for most people a device of the poetic imagination and the rhetorical flourish - a matter of extraordinary rather than ordinary language'* (Lakoff & Johnson, 2008, p. 3).

The students' created an atmosphere[108] with their presence '*just being around'* (George) and through *being-with* (Heidegger, 1927/2019) the patients enabled them to connect and thus created their *bubble.* This *bubble* was a space they experienced together from making connections. Böhme (2006, 2018), suggests a person can radiate an atmosphere and students have the potential for this (Suikkala, Koskinen, & Leino-Kilpi, 2018), as was experienced by participants in this study. Anderson (2009) particularly speaks of how you can enhance or transform an atmosphere, and these can be contagious. The atmosphere, feel of a place, can be described as cosy, safe or tense among others, it is something you feel (Moreno-Poyato et al., 2016; Pink et al., 2015), and something that can enhance the establishment of relationships (Moreno-Poyato et al., 2016), as the participants found. There is complexity as atmospheres fluctuate and are sensed by individuals, and collectively (Anderson, 2009; Schroer & Schmitt, 2017). Stewart (2012) succinctly indicates this complexity, describing atmospheres as:

> *… 'palpable and sensory yet imaginary and uncontained, material yet abstract. They have rhythms, valences, moods, sensations, tempos, and lifespans. They can pull the senses into alert or incite distraction or denial.' (p. 445).*

Despite such semantic and conceptual complexity, an atmosphere was clearly felt and durable for the participants, was a fundamental aspect of their experiences and provided defining moments for them both (Bille et al., 2015). It was a feeling in the air and resulted in powerful human interaction (Pink et al., 2015). Ingold (2014) claims that atmospheres hold the key to the way we embrace and are embraced by the world.

[108] The term '*atmosphere'* appears in everyday language yet its meaning can be vague, defying definition (Anderson, 2009; Bille, Bjerregaard, & Sørensen, 2015; Pink et al., 2015). Marx (1856/1978) used the term metaphorically to describe a revolutionary atmosphere of a society (Anderson, 2009). Pink et al. (2015) questions if our language for representing and communicating atmosphere is limited and methodological explorations inadequate. Anderson (2009) equally refers to atmosphere in addition to other terms used in everyday speech; ambience, aura, feeling or tone. He goes on to suggest that the term atmosphere expresses something vague and ill-defined, though nevertheless felt.

The patients and students referred to the value of being together; '*just being around*' each other whether that was watching television together, playing pool, talking, playing cards or sat together. There was something for them in just sitting together (Salzmann-Erikson et al., 2016), being present, experiencing things together, *being-in-the-world*, *being-with* (Taylor, 2010). In the time shared, they appeared to experience the *bubble* temporally and spatially. The *bubble* appeared to help them feel human and feel *normal,* within the abnormal place of the secure unit (Reavey et al., 2019). They experienced this temporally and spatially in that it was their own time and space, not in the physical or measurable sense[109]. Similarly Dufrenne (1953/1973) describe a collective atmosphere as being experienced outside of time and space. Atmosphere, though objectively difficult to define, is a powerful phenomenon, as found in this study, and temporally interconnects with people, places and objects (Bille et al., 2015), as too does *Dasein*.

Being-with

Heidegger's notion of *Dasein*[110] is crucial to understanding aspects of the time patients and students share. The world is an interconnected context of involvements that gives meaning to everything encountered (Molloy et al., 2020). Our experience with others gives meaning to us. *Dasein (being-there*) is always with others, to exist is to exist-*with*. We are always *being-with* (Heidegger, 1927/2019):

> *… 'the world is always the one that I share with others. The world of Dasein is a with-world. Being-in is being-with others.'* (Heidegger, 1927/2019, p. 119/155)

Students and patients share time and space on the secure unit, socialising about and in the everyday. On the ontological level, just as *Dasein* is never without a world so too it is never without others (Heidegger, 1927/2019).

[109] Explored in theme 3.
[110] Explored in depth in chapter 4. *Dasein*, is Heidegger (1927/2019) term for *being-there* or existing. *Dasein* is always *being-in-the-world.*

Arguably, nursing aligns with Heidegger's phenomenology, *being-with* is thus a crucial phenomenon which lies at the very core of relational elements of nursing and caring (Horgan et al., 2020; O'Reilly & Cara, 2010). Though Deacon, Warne, and McAndrew (2006) argue it is difficult to articulate the *being-with* process in nursing and the skills involved. The role of *'being-with'* has been overlooked in previous mental health research, despite mental illness representing a fundamental disturbance of *being-with* (Schmid, 2018), particularly for patients with a diagnosis of personality disorder, who may find difficulties in connecting with others (Sagan, 2017).

In hospital settings being with, in a physical sense, and sitting with patients have been identified as important to build relationships (Bowers, Brennan, Winship, & Theodoridou, 2010; Davis, 2005). Resonating with my findings, Lloyd (2007) study found that nurses felt their purpose was to *'generate a sense of 'being-with' the patients'* (pg. 489), to make a connection. In sharing time together, patients and students made connections to create their *bubble.* The student's presence establishes the importance of relationality, in addition to corporeality (van Manen, 2014). Corporeality refers to the idea we are always bodily in the world, rather than in a merely physical sense (Wright, 2013). Though Merleau-Ponty (1945) describes this as individual rather than societal, Schutz (1962) described lived corporeality of bodies sharing the same space and the growth of those within it. The body is a fundamental medium through which the world is experienced (Brown & Reavey, 2019). Fuchs (2007) speaks of the bodily sensations involved in connections, for example feelings of warmth, sinking, or tension. Delaney and Ferguson (2014) point to perspectives in interpersonal neurobiology of patterns of brain activation during shared emotional states, bringing the links between the physical and the lived body closer, for example when George felt relaxed in a student's presence.

Being there with patients is referred to by Reed and Hall (2018) as a key aspect of engagement to ensure the best quality of care for patients. Being there is also referred to by nurses in

Cleary (2003) study and patients in Cleary and Edwards (1999). Cleary and Edwards (1999) patient participants expressed how nurses were always there, whereas it was the students who were '*always there'* (Fred) in this study, the nurses seen as occupying the office[111]. For Delaney and Johnson (2006) the expression '*being there for patients'* (p. 201) meant being there when patients needed them, as well getting to know patients.

Being with was an element in Walsh's (1999) research exploring nurse and patient encounters. Seven nurses were interviewed based on an encounter with a patient. Although Walsh's study was phenomenological, the lived experience of the other half of the relationship, the patient, was missing, limiting full understanding of the encounter (Taylor & de Vocht, 2011). The main theme Walsh (1999) discussed was '*shared humanity'*; where '*just being with people*', '*sharing common ground'* and '*being human'* should be central to any nurse and patient encounter. This study reinforced those findings, but goes further by including both parties to the encounter. They are reciprocal encounters. Nevertheless, similarly, to Walsh's (1999) study, in their *bubble* the students and patients shared they were '*just being there'* as people together.

As stated by Morgan (2011) and Bax (2017), Levinas disputed Heidegger's concept of *Mitsein* (*being-with*) and argued that we are first and foremost alone, and we experience isolation. Cavell also called the idea of *being-with* an afterthought (Morgan, 2011) and Nancy (2008) argued there is limited analysis in Being and Time or in his later works. However, Heidegger (1927/2019) maintained we are always *being-with* others, others are always present in our *fore-structures*: our past, present and future. We are always entwined with others and that is from any encounter (Heidegger, 1927/2019), which Derrida points out that Levinas overlooked (Morgan, 2011). Though, as Taggart (2018) and Morck (2016) write, Levinas did argue for

[111] Explored further in theme 3.

having a responsibility for others. Nevertheless, Morgan (2011) reflects, equal viewpoints have value; isolation or connectedness, and perhaps our perspectival alignment with each is subjective. He refers to the '*tender-minded'* (p. 442) likely to choose connectedness. On reflection perhaps the standpoint I take is influenced by my *fore-structures* and hence choice of a caring profession.

People, atmosphere, and things all come together in the mundane everyday lifeworld (Pink et al., 2015). Hercelinskyj, Cruickshank, Brown, and Phillips (2014) found that when staff spent time with a patient and engaging in practical activities in an everyday way this helped normalise situations and was valued by patients, as found in this study.

Mundanity

'Normal stuff' (Steven) or *everyday stuff* patients and students talked about in their *bubble*, resonates with Buse, Martin, and Nettleton (2018) writings on mundane materialities. Materialities are related to places, buildings and objects but are also part of how relationships are constituted (Anderson, Brownlie, & Milne, 2015; Friesinger, Topor, Boe, & Larsen, 2020). Mundane materialities can produce relationships that are necessary for care; *everyday stuff*. The term *mundane* can, however, be seen as both a positive and pejorative term. Such concepts as ordinary talk and the seemingly mundane are taken for granted elements of the environment (Maller, 2015; Nettleton, Buse, & Martin, 2018), especially in nursing (Buse et al., 2018), yet for participants in this study, the time they shared together doing *everyday stuff* helped them feel *normal* and human in a dehumanising place, which is far from a pejorative notion of mundane.

Acts of mundane care, although being an everyday occurrence, are powerful, despite being unnoticed and rarely reflected upon (Brownlie & Spandler, 2018). Ordinary practices and interactions create and maintain connections between people which renders life liveable (Fine

& Glendinning, 2005). Cheetham et al. (2018) describe some moments experienced in a mental health setting as precious because of their ordinariness. Like Molly making porridge with a patient, an everyday and ordinary occurrence, but for her and the patient, a valued moment together. Such attention to the mundane can ensure visibility of the ordinary and promote thinking beyond conventional practice, bringing to light acts of care (Puig de la Bellacasa, 2011) or solicitude (Heidegger, 1927/2019). The implications concerning interconnections between human experience and materiality are not well understood, despite their significance for how we approach and understand important issues regarding mental health (Malafouris, 2019).

Everyday talk, or '*chit chats'* (George, Jasper, Molly) were more than *basic*, they were also precious and fundamental. Despite concerns this is something we have lost (Brownlie, 2014), such ordinary talk is valued by patients (Cheetham et al., 2018; McKeown et al., 2016). It should also not be the only thing nurses do, nurses can deliver specialist therapy as well, they can do both. On the other hand, if we only view the nurse-patient relationship or time spent with patients conducting interventions or therapy as valuable, then this risks dismissal of all other extremely important elements of communication (Cleary, Hunt, et al., 2012). Ordinary communication was a theme of Cleary and colleagues' literature review of nurse-patient interaction in acute services. This included showing an interest and listening, which Mike particularly valued in my study. The human characteristic of listening has been highly valued by patients, as are shared experiences between nurses and patients as key factors in supporting relationships (Gilburt, Rose, & Slade, 2008; McKeown et al., 2016). The mundane can be imbued with shared experiences and memories (Buse et al., 2018). For Leo, his pack of cards was filled with memories of his time with students, which he appeared to enjoy sharing with me. Stories told about materialities, like playing cards, make care and relationships possible (Brownlie & Spandler, 2018).

'*Idle talk',* a term coined by Heidegger (1927/2019), referring to a '*positive phenomenon which constitutes the kind of being of everyday'* (p.168/211), where people make conversations or engage in chatting, was essential for students and patients to enable their *bubble.* In Shattell et al. (2007) study participants wanted straight talk and did not value talk that was false or too nice. Heidegger (1927/2019) did speak of concern for derivative talk, curiosity or anticipation, that leads to trivialisation or gossip. *Idle curiosity,* for example, can cover up what really matters, becoming a distraction because we do not want to think about something (Heidegger, 1927/2019), perhaps affecting recovery through discovery of self for mental health patients. However, as the participants reflected, although some conversations may be '*trivial'* (Molly), they were valuable.

Psychosocial skills

A student's approach impacted on the patients, both positively and negatively. Approach, in general, related to how the students '*were'* with patients, how they engaged, their demeanour, demonstration of respect and attitude to spending time with patients, resulting in the building of '*relationships'*[112]. The students' approach to patients had a noteworthy impact on how positively patients viewed them and therefore how readily they would engage and spend time with them; ultimately creating their *bubble*. Approachability has been minimally researched in mental health nursing, despite its importance (Wright, 2021).

Patients describe humane nurses as respectful, empathic, friendly and available (Sheridan Rains et al., 2021; Ratcliffe & Stenfert Kroese, 2021; Stevenson & Taylor, 2020) , which can influence their sense of empowerment and hope (Cleary, Hunt, et al., 2012; Delaney, Shattell, & Johnson, 2017; Mirhaghi et al., 2017). Patients need to feel listened to (Romeu-Labayen et al., 2020; Sheridan Rains et al., 2021) which according to Browning and Waite (2010) is the

[112] Explored later.

oldest and most influential tool of healing (Benner, 1984/2001). Hence psychosocial skills are vital for student nurses (Jones et al., 2020), and are referred to in Nursing and Midwifery Council (2018b) proficiencies for nurses, specifically Annex A.

Ineffective communication can be a barrier to positive relationships (Gilburt et al., 2008) and thus development of the *bubble.* Such communication as everyday talk, 'small talk' (Gildberg, Bradley, Fristed, & Hounsgaard, 2012, p. 105) or *idle talk* (Heidegger, 1927/2019) is something not everyone is skilled at (Kingston & Greenwood, 2020). Sørensen, Tingleff, and Gildberg (2018) highlight that secure patients may have had limited opportunities for developing social skills due to restricting environments and *normal* social life, which needs to be considered. With regards to students, Geanellos (2002) and Bullington et al. (2019) recommended that nursing education should teach psychosocial skills that are not complex. However, Cheetham et al. (2018) warns that training can make staff worse at relating to patients, focusing on professionalism over authenticity[113]. Goffman (1956) wrote that everyday talk is relaxed, spontaneous and informal. It has a certain rhythm and pace, developed through experience rather than education. Suikkala et al. (2018) contest if such skills can be taught, mirroring the pivotal paper by Menzies (1960) statement '*nurses are born not made'* (p. 107). Similarly Mirhaghi et al. (2017) propose nurses should have life experience in order to develop psychosocial skills and Cleary, Hunt, et al. (2012) posit that, as personal attributes are part of a person before they become nurses this should inform consideration of how students are recruited, to ensure humane qualities are developed and retained. This has implications for selection of staff working in secure services (Bennett & Hanna, 2021) and with patients carrying a personality disorder diagnosis (Benefield & Haigh, 2020; Ratcliffe & Stenfert Kroese, 2021; Royal College of Psychiatrists, 2020).

[113] As explored in theme 2.

Activities

In addition to good psychosocial skills, participation in activities enabled the development of the *bubble*. Activities positively influence the psychosocial atmosphere on wards (Marshall & Adams, 2018; McKeown et al., 2020) and are recommended in NICE guidance for positive patient experience (National Institute for Health and Care Excellence, 2019). Talking about everyday stuff and engaging in activities influenced the patients' mental state, helping them feel a connection with others, as found in other studies (Gildberg et al., 2012). This also offered a distraction or opened conversations (Hallett & Dickens, 2017; Marshall, McIntosh, Sohrabi, & Amir, 2020; National Institute for Health and Care Excellence, 2019). Despite the clinical setting (Reavey et al., 2019), doing activities helped patients cope and enabled students settle in. Cheetham et al. (2018) found sharing purposeful activities supported the development of understanding one another. Similarly Cutler, Halcomb, Sim, Stephens, and Moxham (2021) states meaningful activities promote connection to self and others, giving patients a sense of hope and identity beyond the ward.

Activities can maintain engagement and provide a platform for social interactions (Marshall & Adams, 2018) and are an important way to reduce boredom (Marshall et al., 2020; Muir-Cochrane et al., 2013; Tomlin et al., 2019), a common experience in mental health settings (Cutler, Halcomb, et al., 2021; McKeown et al., 2020). Boredom can trigger aggression (Pulsford et al., 2013), trigger feelings of powerlessness and negatively impact on patients' recovery and mental health (Marshall et al., 2020), reinforcing the importance of meaningful activities (Hallett & Dickens, 2021; Scholes et al., 2021).

However, such engagement in activities is often limited (Brown & Reavey, 2019; Cutler, Halcomb, et al., 2021) due to resource issues and risk aversion, or reliance on specific individuals (McKeown et al., 2020; Tomlin et al., 2019). In this study, the students were the

instigators of activities, engendering a calming atmosphere. As students are supernumerary (Nursing and Midwifery Council, 2018a), there is less pressure on resources. However, due to Covid 19 Nursing and Midwifery Council (2020) emergency standards, students became employed rather than supernumerary, though in my study this did not appear to affect students time with patients[114].

Watching television was a particular activity which brought patients and students together into a shared space even though it is an ordinary and untaxing activity (Masters & Forrest, 2010). George spoke about watching television with the students as '*feeling homely'*. Which is particularly moving considering that people with a personality disorder diagnosis can feel alienated and experience inability to feel at home in the world (Sagan, 2017). Similarly Marshall and Adams (2018) identified feelings of homeliness positively influenced the environment. In my study it was particularly valuable if activities were accompanied with '*a nice cup of tea'* (David, Leo, Bella), another mundane activity (Buse et al., 2018). A cup of tea can be a symbol of ordinary humanness through its familiarity (Bennett & Hanna, 2021; Jackson & Stevenson, 2008; McAllister, Matarasso, Dixon, & Shepperd, 2004). A cup of tea and the television are mundane objects or artefacts (Buse et al., 2018) that can powerfully bring people together, although rarely professionally acknowledged because of their ordinariness (Buse et al., 2018).

Brownlie and Spandler (2018) reflect on the assumption that relationships already must be established for materialities to be shared, however, as shown in my study, the television or activities like cards (as mundane materialities) brought the patients and students together to build their *bubble* and relationships. This appeared to give the patients and students a sense of togetherness. Togetherness infers that we, as *Dasein*, are always situated and experiencing

[114] Julie and Molly were employed during this period.

human connectedness[115] (Morgan, 2011). *Being-with* is Heidegger's analysis of connectedness, it is *Dasein's* openness to fellow humans (Morgan, 2011).

Friendly/ friends

Engaging in activities and connecting gave students and patients a sense of normality and escapism from their environment. Friendliness is facilitated by such social experiences, and a sense of friendship and being together are significant for the development of relationships (Hawamdeh & Fakhry, 2014; Mirhaghi et al., 2017). Aristotle was the first philosopher to write of friendship as sharing life, associating it with well-being (Dibley et al., 2020). He saw ideal friendship as a partnership of equals (Prescott & Robillard, 2021). The patients and students regarded each other as similar to friends. Such experiences can relieve tension, give comfort, enable a sense of togetherness and reduce feelings of isolation (Berggren & Gunnarsson, 2010; Geanellos, 2002). Although such terms are controversial (Geanellos, 2002), participants were referring to relational aspects of connecting and talking, while also considering importance of boundaries. This highlights the need to consider often strong reactions to using terms such as '*friend'* in mental health services. Friendships do not interfere with nursing work (Geanellos, 2002) and in fact, are recommended to enhance mutual understanding and equality (Berggren & Gunnarsson, 2010; Oeye, Bjelland, Skorpen, & Anderssen, 2009). Patients feel value in the nurses being like friends (Hopkins & Niemiec, 2007; Ratcliffe & Stenfert Kroese, 2021). Friendship results in wholehearted engagement which adds meaning and beauty to relationships between staff and patients (Geanellos, 2002), reflected by the participants in this study.

Although friendship between nurses and patients can be described as different to other friendships (Jackson & Stevenson, 2008), as reflected by Hollie, it is nevertheless spoken of

[115] Connectedness defined as '*the ability to experience relatedness',* as part of belonging and feeling connected, it is an essential element of recovery for patients (Aga et al., 2021, p. 306).

as friendship and has qualities of friendship. Friendliness and friendship are different, and not static concepts, they are individual (Geanellos, 2002). Friendliness can be described as an everyday superficial encounter though beneficial, which includes warmth, interest and joking, while friendship is a deeper experience of reciprocity (Geanellos, 2002). Patients and students had apparent experiences akin to friendship, described as feelings of recognition[116]. Marshall and Adams (2018) found using humour and genuine friendliness enabled connections and broke through any barriers.

'*Having a laugh'*, a joke or '*banter'* was of great value to participants, helping them feel *normal* in the abnormal place of the secure unit. Interest in humour and such related interventions was starting to increase in mental health settings a decade ago (Gelkopf, 2011), although there is a paucity of rigorous contemporary studies (McCreaddie & Nasser, 2020; van der Wal & Kok, 2019). The use of humour for students has been explored in America with adult learners (Stein & Reeder, 2009), in the UK with adult nurses (Flynn, 2020), community mental health nurses (Korean study Seo and Na (2015)), and with students in a dated UK study (Struthers, 1999). According to Griffin (1969) Florence Nightingale originally documented the need for laughter in nursing and spoke of it as fundamental in nursing education. Interestingly, Husserl was reportedly lacking in humour (Moran, 2000) and Heidegger was found to be humourless (von Klemperer, 1994).

For patients in this study, humour had many relational benefits for both them and the students. It helped them '*settle in'* to the environment, feel comfortable, build connections and memories, and reduce boredom (Sarris, 2018). Such relational aspects of the participants time together also supported them making connections with each other and encouraged the *bubble* they experienced temporally and spatially (van Manen, 2014), a hermeneutic encounter (Moules &

[116] Further explored in theme 2.

Taylor, 2021). Wider research has highlighted humour's role in connecting people human-to-human (Dean & Major, 2008; Flynn, 2020; Gildberg, Bradley, Paaske, & Hounsgaard, 2014; Gildberg et al., 2016; Sarris, 2018). Humour is fundamentally a social phenomenon (Buxman, 2008). It gives a sense of togetherness (Gildberg et al., 2014; Tremayne, 2014) and shared laughter can nurture a sense of community, camaraderie and belongingness between people (Old, 2012; Pryor, 2010).

Humour encourages a relaxed atmosphere (Emmerson, 2017; Pryor, 2010). This may be especially helpful for those patients new to the environment. Emmerson (2017) and Gildberg et al. (2014) state, despite a capacity for uniting people, laughter can lead to feelings of exclusion and isolation for people not attuned to the atmosphere. Humour appears to be freeing by breaking down barriers and tensions of institutional life. In previous studies in secure institutions, humour has been noted as a frequent occurrence (Gildberg et al., 2014; Gildberg et al., 2016; HMPPS & NHS, 2020) that enables a relaxed atmosphere (Inglis, 2010). In Gildberg et al. (2016) literature review exploring secure services, they found that humour was a personal quality linked to establishment of relationships, trust and of positive significance, mirroring the findings in my study and findings in wider nursing literature (Tremayne, 2014).

Despite the many benefits of the experience of humour, there are some important considerations, particularly in mental health care settings (Gildberg et al., 2014; McCreaddie & Wiggins, 2008; Sousa et al., 2019). On one hand, use of humour to maintain superficial relationships can protect patients from building attachments to only have the students soon finish placement and thus avoid difficulties in ending relationships (Peplau, 1988)[117]. On the other hand, it could prevent connections and diminish the sense of value accruing from such connections. The study participants described a huge sense of value when helping others,

[117] As explored in theme 3.

aligning with Dean and Major (2008) reflections: seeing a smile or laugh makes you feel you have done something good. Haydon and Riet (2014) and Seo and Na (2015) found complications if nurses are '*too busy*' to be humorous due to time constraints, highlighting a further temporal aspect to humour. Perhaps, as in this study, students were seen as '*more funny'* because they had '*more time'* with patients[118].

By its very nature, humour can be on the edge of going too far, and the challenge is to express humour in a socially respectful manner, not causing harm to others (Gildberg et al., 2014; Sayre, 2001). The student participants voiced that humour needed balancing with their professionalism, a vital element of the Nursing and Midwifery Council (2018a) code, particularly as certain humorous elements patients discussed included '*taking the piss*' (David, Jasper, Leo). Such experiences were described as students being '*one of the lads'* (Leo, Steven), however this was not gender related in my study, as they reflected on having this with female students. As discussed by Sousa et al. (2019) there are differences in the way men and women use humour. Men use jokes and banter more frequently which may edge on '*derogative'* (Haydon & Riet, 2014, p.204). Or as George called it '*rudeness'*. Oliver (student), certainly questioned the appropriateness of humour in relation to professionalism (cf. Jones & Tanay, 2016; Lee & Jang, 2019). However, humour can enhance professionalism and, may often wrongly be considered unprofessional or at odds with the NMC Code (Dean & Major, 2008; Tremayne, 2014). As questioned by Flynn (2019), are *we* professionalising humour out of students? Due to the focus on professionalism in nursing as a result of the Francis (2013) and Darzi (2018)[119] investigations, Flynn (2019) essentially writes of the balance between use of self and professionalism, as a '*tug-of-war'* (p. 276).

[118] Explored in theme 3.
[119] The Darzi report was to examine the state of quality in health and care services on the NHS's 70th birthday and make recommendations for future funding and reform of the system.

Importantly, despite these issues and a tendency to take it for granted or view as trivial (Dean & Major, 2008; Tremayne, 2014), everyday humour can be essential for a person's sense of self (Amici, 2019). Humour is a normalising behaviour (Lord et al., 2016). Having a laugh enabled students and patients to connect and bond in their *bubble* and create memories together. Such memories were cherished, and gave hope, particularly to Leo and Jasper. This also enabled a connection to the world and sense of humanness (Benjamin, 2003). This sense of humanness is a common theme across the literature on use of humour in healthcare (de Sousa et al., 2018). Minden (2002) study in a secure service, found humour acknowledged patients' humanity and encouraged them to relate to their surroundings in a positive way. Similarly, humour can be used by patients to reduce feelings of dehumanisation (Dean & Major, 2008) and support them in expressing their emotions (Haydon & Riet, 2014). Humour humanises nurses and creates a bond between patients and nurses (Haydon & Riet, 2014; Olver & Eliott, 2014; Maria Romeu-Labayen, Tort-Nasarre, Rigol Cuadra, Giralt Palou, & Galbany-Estragués, 2021; Tremayne, 2014), as reflected strongly in my study.

Such powerful effects of humour, alongside the low cost of any humour related intervention (Gelkopf, 2011) and potential to change the hospital experience for patients (Haydon & Riet, 2014) makes it surprising that it has not been widely researched or applied in mental health settings or secure services (Gildberg et al., 2016; van der Wal & Kok, 2019). The humanising dimension of humour is too valuable to be overlooked (Dean & Major, 2008) and '*a risk worth taking'* (McCreaddie & Payne, 2014, p. 332).

Seo and Na (2015) recommend education about humour, however, Cleary, Hunt, et al. (2012) argues that humour and willingness to laugh as characteristics were likely as a result of personality rather than from nurse education, and humour may be difficult to teach, just as psychosocial skills. Similarly, Dean and Major (2008) reflect that use of humour is an intuitive

skill gained through experience in practice rather than education, highlighting the importance of student nurse placements.

> … *'humour can lift the spirits, make the heart sing, and the soul soar.'* (Qasim, McKeown, Kunda, Wainwright, & Khan, 2020, p. 13)

The students and patients, particularly David, Hollie, Molly and Oliver (student) spoke of a balancing being friendly and having a laugh whilst maintaining appropriate boundaries. Maintaining boundaries is widely written about regarding supporting people carrying a personality disorder diagnosis (Bowen & Mason, 2012; Kurtz & Turner, 2007). However as stated by Geanellos (2002) there can be such issues as over-involvement in the absence of friendship, hence friendship does not always account for issues in maintaining boundaries. Nevertheless, nurses can experience a constant dilemma concerning the appropriateness of closeness associated with being friendly (Hawamdeh & Fakhry, 2014).

Use of self

Balancing use of self (Rogers, 1951; Travelbee, 1969) alongside managing appropriate boundaries was reflected upon. There was a balance of use of self, including having a laugh and self-disclosure alongside being professional. I will specifically explore use of self and self-disclosure here, while the balance of such approaches alongside managing professionalism is explored in depth in the Balance of *therapeuticness*[120].

Just as Molly and David spoke about students' own experiences being valuable, being yourself was important for Julie and Oliver (student) in order to build relationships. Julie spoke of having a '*professional image'* but still being yourself and not being overly conscious, to help patients feel comfortable and engage in conversation. Nurses can be viewed as detached if not sharing personal experiences (Adnøy Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2014;

[120] Figure 9 in theme 2.

Warrender, 2020). However, there are associated risks with sharing personal experiences. Exposing oneself as vulnerable may be discouraged as being over involved and unprofessional (Hem & Heggen, 2003; Warrender, 2020). Peplau (1988) even stated that self-disclosure specifically, as an element of use of self, was generally inappropriate. However, vulnerability is an authentic showing of self and can consolidate the mutual value of relationships (Angel & Vatne, 2017; Daniel, 1998).

Johansson and Martensson (2019) argue that although there can be a limit to how much students can or choose to reveal about themselves; it is important to offer something to create affiliation and demonstrate genuineness. Oliver spoke about not being a '*robot',* using your personality as a student, as you are the '*tool'* to help people, which included helping patients feel comfortable. This aligns with Rogers' (1951) concept of use of self and Jackson and Stevenson (2008) study where student nurses used their personalities as the tool to support patients. Similarly, Turner (2011) and Warrender (2020) state it is important to have a range of tools in a therapeutic toolbox.

The students' own experiences were valuable, made them relatable and more likely to have essential qualities to be a nurse. Though there are tensions and implications of self-disclosure like stigma, or associated risks, particularly in secure services (Adnøy Eriksen et al., 2014; Warrender, 2020), it's use in mental health care is invaluable (Warrender, 2020). There are positive impacts on relationships where shared experiences can be a point of connection (Oates, Drey, & Jones, 2017), which can enable the *bubble*. For patients in Shattell et al. (2007) study, self-disclosure facilitated connections and demonstrated nurses coming to the patients as a person rather than a nurse.

Formal helping

Although everyday talk in their *bubble,* could be perceived as trivial or *idle*, complex skills are required to manage the mundane (Jackson & Stevenson, 2008). Marshall and Adams (2018) found that in focusing on social interactions there was still the opportunity to obtain necessary information. Though, as David strongly reflected, his valuing of students was precisely because they were not trying to glean information. If nurses simply relate to patients to enable information gathering (Cheetham et al., 2018), they risk being viewed as un-responsive to others feelings (Clarke, 2006).

Nevertheless, students' more formal approach to helping was evident, aligning with the terms often used to describe *therapeutic relationship,* like helping or working relationship or alliance[121]. Various terms were used by the participants to describe their encounters together; interactions, engage, relationship, just being around, and *being-with*[122]. The term *relationship* was referred to by all the students but only two of the patients (George and David). Similarly, in Shattell et al. (2008) study, the nurses hoped for a therapeutic relationship with patients, such terms were however absent in the patient's interviews. In general, for patient and student participants in my study, it was about sharing time together, whether that was doing activities, watching television or just being there together in the same space. Such a focus on normality can build informal and trusting relationships (Vincze et al., 2015). Without trust there can be no relationship (Ratcliffe & Stenfert Kroese, 2021; Stevenson & Taylor, 2020).

The *relationship* was described or experienced in different ways, hence the importance of exploring the time shared rather than being specific about '*relationship'*. Such specific terms as *therapeutic relationship* are difficult to define and research (Delaney & Ferguson, 2014;

[121] As explored in chapter 2.
[122] Refer to appendix 28 for terms used.

McAndrew et al., 2014; Rask & Brunt, 2007) Nevertheless, such language identifies a phenomenon of importance (Chambers et al., 2019).

In secure settings relationships are commonly poor which can hinder recovery (Marshall & Adams, 2018). Patients find that nurses fail to engage with them in inpatient units (Delaney & Ferguson, 2014), reinforced in this study. Relationships require time, personal attributes and skills, shared understanding and partnership (Shattell et al., 2007; Wyder, Bland, Blythe, Matarasso, & Crompton, 2015), which can be complex in secure settings (Jones et al., 2020; Ratcliffe & Stenfert Kroese, 2021). Key barriers include resource issues including staffing, and care versus custody dilemmas, which seriously threaten the heart of nursing (Mirhaghi et al., 2017). Administration and resource issues are corrosive of therapeutic relationships in mental health care (Delaney et al., 2017), as experienced by the participants.

Patients in secure settings have been described as difficult to engage and build relationships with (Clarke, Lumbard, Sambrook, & Kerr, 2016), however, for the student participants this appeared in contrast to their experiences and for the patients who overwhelmingly valued engaging with students. For participants the term used or the environment they were in did not interfere with their development of a connection/ friendship/ relationship.

George noticed that if he was feeling anxious or sad that students would come and talk to him, resulting in him feeling cared for and valued. When students shared time with patients by '*just being around*' it had a deeper therapeutic effect (akin to friendship). It would help them feel relaxed and comfortable, it would cheer them up, help during hard times engender more positivity about the future and ultimately, the time they shared with students helped them feel safe. Feelings of safety can be instilled by social contact (Gilburt et al., 2008). Often an implication from attachment development when younger (Bush, 2018), patients carrying a

personality disorder diagnosis can experience a poor sense of safety. Students '*just being around'* enabled a sense of a safe haven for patients (Feeney, 2004) in their *bubble.*

The students focused on neglected mundane materialities like activities, television, cups of tea, or ordinary talk creating a space on the secure units which enabled the forming of a *bubble,* where the patients and students felt human amidst a potentially dehumanising place (Mollerhoj & Os Stolan, 2018; Thibeault et al., 2010). Such powerful experiences of the mundane are deserving of further exploration (Buse et al., 2018). Focus on informal, social interactions and approaches is warranted in secure settings (Marshall & Adams, 2018) to create a positive landscape[123].

Being-with, having a laugh and connecting over common interests develop friendships which enable a relationship that is therapeutic (Gardner, 2010). The therapeutic relationship, or whatever term is used, is composed of connectedness (Mirhaghi et al., 2017). Though this requires a balance of *therapeuticness* and managing professional boundaries and safety as explored in the next theme.

[123] Further explored in theme 3.

7.2.2 Theme 2: Balance

In the time patients and students shared they were *being-with,* connecting over common interests, forming their *bubble*[124] where they felt a sense of mutual recognition of humanness and togetherness. Such experiences of *therapeuticness* (*leaping-ahead*) can be at times in conflict with focus on professionalism, control and risk aversion (*leaping-in*), hence the development of Balance of *therapeuticness*[125], discussed in this theme.

Students were viewed positively as '***sponges'*** (Fred). Their limited experience to manage challenging situations was weighed against reduced risk of having negative ingrained views or becoming *holder of keys*; part of the workforce (*the one*). Despite complexity in comparisons made, there is hope when students become *holder of keys* as *regular* staff they can *weather the ride* (David) by focusing on the everyday mundane, *being-with* and connecting with patients to create the *bubble*.

Common interests

Common factors or interests were discussed by all the participants as a way they connected with each other, despite differences in age or gender, aligning with other studies who found that common factors are essential in building relationships (Awty et al., 2010; Jones & Wright, 2017; Livesley, 2001b; McCloughen, Gillies, & O'Brien, 2011; Shattell et al., 2007). Mutual interaction about common interests creates a sense of community founded on togetherness and trust (Andersson et al., 2020). Just as watching television and sharing time in activities encouraged a sense togetherness. So did engaging around common interests like football, mirroring other studies where engagement in football talk cemented togetherness and shared

[124] Explored in theme 1.
[125] Figure 9.

recognition (McKeown, Roy, & Spandler, 2015). Hollie reflected on positive experiences when everyone watched football together. Julie described football as a topic for building rapport with patients and engaging their interest. Likewise, Leo used football as a basis for laughing and joking with people, with banter about team allegiances.

Recognition of humanness

Steven described a *click* he experienced with students when talking about such common interests. This click or the connections patients and students made formed their *bubble*. Connecting with patients in mental health settings is something done in *everydayness* and often unnoticed, despite its importance (Delaney & Johnson, 2014). Mental health nursing is embedded in the *everyday world* (Awty et al., 2010); the focus of Heidegger's (1927/2019) Being and Time.

By sharing experiences, participants made memories and connected with each other. By making comparisons to each other, they demonstrated a connection of humanness in a reciprocal exchange (Awty et al., 2010; Mirhaghi et al., 2017). This mutual recognition communicates value vested in the other person, which is essential for patients in mental health services (Rashed, 2019). This recognition establishes a common humanity (Benjamin, 2018; Walsh, 1999), identifying with each other on the same level (Bennett & Hanna, 2021; Cook et al., 2005), not as student and patient but as people liberated from identities, roles and structures. As remarked by Fred and Jasper, inpatients in two different hospitals; '*we're just people'.*

Valuing a person's humanity has been widely written about as essential in mental health nursing (Delaney & Johnson, 2006; Geanellos, 2002; Hopkins & Niemiec, 2007; Sharda, Baker, & Cahill, 2021). However, previous studies have found that staff distantly acknowledge or recognise patient's humanity (Hem & Heggen, 2003) and policies fail to ensure recognition

due to power inequalities in mental health care (Lewis, 2009). Recognition of common humanity is ignited by our connections with others. Such a sense of humanity is validating despite the objectifying setting of a secure hospital (Cook et al., 2005). Validation is essential for patients carrying a personality disorder diagnosis (Romeu-Labayen et al., 2020), though previous studies show invalidation is typical in mental health services (Jones et al., 2020) . Patients in this study reflected on feelings of invalidation in secure services, yet found students validating, as they were keen to get to know the patients endorsing their experiences (Johansson & Martensson, 2019).

Patient identity

Such connections developed regardless of patients' diagnosis or criminal history, or the identity of the student. In their *bubble* they were just people; *being-with* (Heidegger, 1927/2019). Establishing a shared humanity is the antithesis of emphasising and demonising difference (McKeown & Dropkin, 2021; Taggart, 2018); in mental health care *'there needs to be a shared recognition of humanity rather than otherness'* (McKeown et al., 2020, p. 461). In environments such as secure units, such othering can result from people being defined for what they have done rather than who they are (or might be) (Mezey, Youngman, Kretzschmar, & White, 2016). Patients can feel dehumanised and monstrous (Mollerhoj & Os Stolan, 2018), particularly for patients carrying a personality disorder diagnosis, who often experience most stigmatisation (Sheehan et al., 2016).

Identity itself is under threat in secure services (Holmes, 2005; Hörberg & Dahlberg, 2015), where patients experience double stigmatisation of having a mental health problem *and* forensic history; seen as mad and bad (Austin et al., 2009; Marshall & Adams, 2018). Patients in Tomlin et al. (2019) study felt being in a secure unit reshaped their identity as '*other'* and voiceless. Such stigma is exacerbated by not being in the real world. Patients in secure settings can invoke a view of their identity, as '*mental patients'* (Fred) (Goffman, 1956/1990;

Greenacre & Palmer, 2018; Marshall & Adams, 2018), however, in experiencing their *bubble* with the students such identities dissolved in shared recognition of humanness. The relationship with students enabled development of alternate patient identities: rather than *mental patient* they were '*just people'* (Fred and Jasper).

Identities can be restricting and shift focus away from the mundane and the humane. '*Identity has been a strong preoccupation of philosophy and social science enquiry for hundreds of years, both individual identity and collective or group identity*' because identity shapes individual and social behaviour (Bell et al., 2015, p. 1). Foucault (1989/2003) considered individual and collective identity as social constructs created in language, such as '*mental patients'* or '*severe personality disorder',* are powerful '*othering'* tools that elicit stigma and construct a person as something other than a person (Peternelj-Taylor, 2004; Roberts, 2005). Peternelj-Taylor (2004) further states, othering occurs in relationships between the powerful and powerless, exploiting vulnerabilities. Language is powerful, and when a person's behaviour is labelled as manipulative, as the participants discussed, it reinforces othering (Peternelj-Taylor, 2004).

People in mental health care become subjects with damaged identities symbolic of otherness (Foucault, 1982, 1989/2003). Being admitted to inpatient services can lead to feelings of shame and loss of identity (Cutler, Sim, Halcomb, Stephens, & Moxham, 2021). However, due to the students' presence on the units, patients assumed roles teaching students and helping them '*settle in'* to placements, offering new more positive identities, with accompanying sense of purpose and value[126]. Being seen as an equal and treated as a person rather than a patient was also a key theme in Cutler, Sim, et al's (2021) study. The students opposed othering practices by creating closeness not distance and seeing the person not the label (Jacob et al.,

[126] Discussed in more depth in theme 3.

2009; Jones & Wright, 2017), listening to patients and hearing their voices (Peternelj-Taylor, 2004).

Thrownness

It is essential for students to see the person in front of them, not the label they carry (Hammarström et al., 2019; Jones & Wright, 2017; Spandler, 2011), to negate associated stigma (Marshall & Adams, 2018). Barker (1996) identifies seeing patients as a person as '*trephotaxis'* (p. 3). It is also important to acknowledge a persons' *thrownness* into the world[127] (Dibley et al., 2020; Heidegger, 1927/2019); our enculturation into a shared community (Thomson, 2011). Patients carrying a personality disorder diagnosis are likely to have experienced adverse childhood experiences [ACEs] (Bush, 2018; Ramsden, 2018). Moreover, patients in secure services, can come from the most deprived societies with high experience of abuse, neglect and insecure attachments (Mezey et al., 2016). Thus, their *thrownness* is into a traumatic world. Importantly, as Julie disclosed the students may have also experienced trauma (Ramluggun, Lacy, Cadle, & Anjoyeb, 2018).

We are our past, it goes ahead of us rather than something which follows along after us/ stands behind us (Dreyfus, 2010). It influences our present and future selves; we are who we are because of the world we live in (Dibley et al., 2020). As Heidegger (1927/2019) wrote, we may inhabit the world differently to others due to our experiences. Though there was the experience of the *bubble* where patients and students identified each other as people*,* students also empathised with the historical experiences of patients in addition to their experiences in hospital. Such understandings can manage reactions of blame, while acknowledging responsibility (Pickard, 2011). In recognising the person as a person while understanding their

[127] Hence the links with formulation; a psychologically informed structured process for making sense of a person's distress, attempting to understand the person, their past experiences and influences that impact on their present (Houghton & Jones, 2016).

past experiences, such empathy and appreciation of *thrownness* can help reduce othering practices (Peternelj-Taylor, 2004). The patients and students recognised their shared humanity despite unique experiences of *thrownness* (Heidegger, 1927/2019) and individual realities (Jaspers, 1913/1962).

Patients in secure settings commonly experience complications in their relationships (Rask & Brunt, 2007). In Jasper's (1913/1962) sense, due to their *thrownness* their connection to and sense of reality may be different to the students. However, perhaps patients and students can connect because they talk about the everyday and share common interests, reaching alignment in their reality (Jaspers, 1913/1962). This changes when different conversations are had, explaining perceived differences in role between students and '*regular'* staff who are the *holder of keys*[128].

Many patients may have experienced trauma, impacting on their response to limit setting and coercive practices (Maguire et al., 2014) as abuse of power is typically at the heart of trauma (Sweeney et al., 2016). Due to their *thrownness* patients can be disposed to view the world as hostile and rejecting (Mezey et al., 2016). If patients have a history of authority figures misusing their power, there can be resistance to openness (Ramsden, 2018). As students are not in authority positions they do not reinforce this struggle with being controlled. Drawing a line or enforcing boundaries can cause conflict (Hallett & Dickens, 2021), as it controls communication and can be seen as supressing patient voice. It is therefore possible to conclude that students were able to manage the balancing act of *therapeuticness* and professionalism as they were not reinforcers of power and hierarchy. An alternative perspective may be that the students are vulnerable to crossing boundaries or not enforcing them due to inexperience (Hanna & Suplee, 2012).

[128] Explored later.

Use of self and balance

In building the *bubble*, patients and students connected over common interests, sharing parts of themselves with each other. Such emotional involvement is essential to build trust and relationships[129] (Benefield & Haigh, 2020; Marshall & Adams, 2018; McAllister et al., 2019; Shattell et al., 2007; Travelbee, 1966; Warrender, 2020). However, Clarke (2006) states that nurses have a professional face and hide their feelings. Similarly, Cheetham et al. (2018) participants identified staff as being forbidden to express emotion or develop authentic relationships. They described being '*told off*' for simple human interaction in case they got '*too close'* or *'too friendly'* (p. 324). Likewise, Jacob (2012) found that nurses felt they had to be careful not being '*too caring'* or *'too friendly'* (p. 184) with patients carrying a personality disorder, specifically in relation to being viewed negatively by other staff. Cheetham et al. (2018) staff participants observed achieving an authentic and empathic relationship on a personal level was exhausting and had implications for professional boundaries. Staff were fearful that relating to patients was unprofessional and contra to their roles. Staff in secure settings can constantly struggle to be authentic in their relationships because of managing their feelings towards a patient's criminal history while not losing sense of the patient's humanity (Austin et al., 2009). Nurses are expected to share themselves while acting professionally (Warrender, 2020), a challenging balance the students also experience between *therapeuticness* and professionalism.

Balance of therapeuticness

The '*care versus custody'* debate has been widely explored in relation to secure services and tensions of managing these conflicting roles (Brown & Reavey, 2019; Cheetham et al., 2018; Gildberg et al, 2012; Holmes, 2005; Inglis, 2010; Mann et al., 2014; Marshall & Adams, 2018; McAllister et al., 2019; McKeown et al., 2020; Otte et al., 2019; Peternelj-Taylor, 1999, 2004;

[129] As explored in theme 1.

Rask & Brunt, 2007; Timmons, 2010). Tensions that arise from dual commitments impact negatively on a staff members ability to care (Holmes, 2005; Hörberg & Dahlberg, 2015; Simms-Sawyers et al., 2020). Secure care is a complex field due to ethical dilemmas of caring for patients while applying legislation and exerting control (Austin et al., 2009; Hörberg & Dahlberg, 2015; Sweeney et al., 2016). It is a '*moral minefield'* for nurses who act as '*double agents'* (Stone, 1984, p. 204) with competing obligations (Austin et al., 2009). Custody, enforcement, containment, authority, distance and security are in tension with care, empowerment, closeness and therapy, however seemingly not explored in relation to students and not through a hermeneutic lens.

Nursing in secure services is a unique role (Jacob, 2012; Stevenson & Taylor, 2020), that straddles this duality of responsibilities and obligations (Dikec, Baysan Arabaci, & Tas, 2017). Nurses provide comfort though are part of the system depriving patients of their liberty (Inglis, 2010; Stevenson & Taylor, 2020). Secure services have something of an identity crisis, sitting between the prison and healthcare systems (Austin et al., 2009; Brown & Reavey, 2019; Holmes & Murray, 2011). There are opposing forces of the justice service, public, patients, and nurses' own constructs (Stevenson & Taylor, 2020). Such is the therapy/ security paradox of opposing ideologies (Inglis, 2010) though critical commentaries on mental health care have emphasised its custodial nature (Foucault, 1973, 1975/1977, 1989/2003). Such views are symbolic of psychiatry and associated hierarchies; doctors in a position of power as decision makers, nurses' subordinate to psychiatrists (Barker, 2000; McKeown & White, 2015) and students rarely considered or referred to. From the 1970s custodial models of care were replaced with community-based services (Awty et al., 2010), however, secure settings have maintained custodial care.

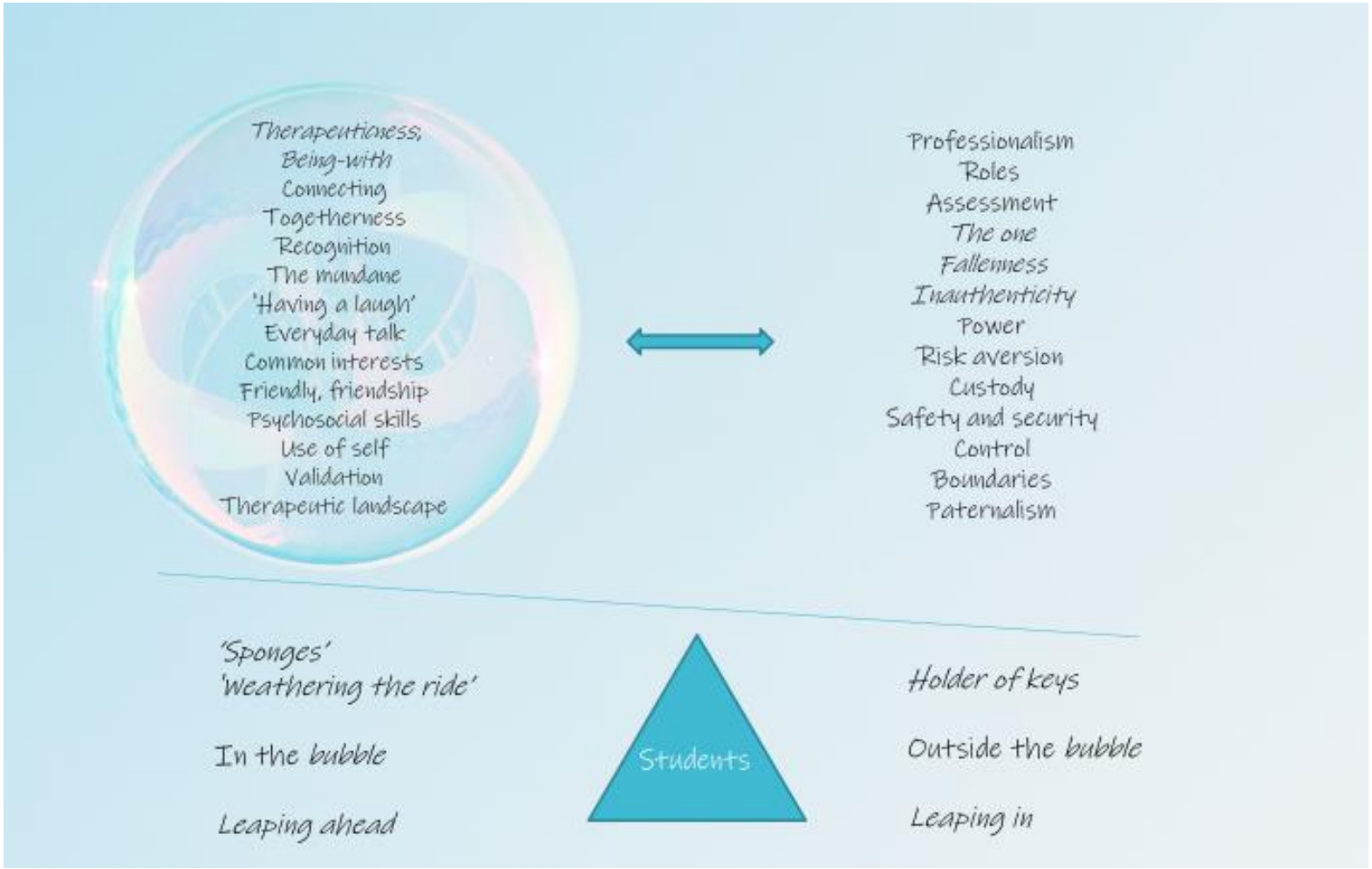
On the one hand *leaping-in*[130] (Heidegger, 1927/2019) is signified with fear, legal accountability, and risk aversion and on the other empowering, ordinary, mundane humane relating (*leaping-ahead*). Such '*care versus custody'* discussions have been explored previously in relation to the micro-social relations of care; for example, a focus on complexity of engagement (Walker, 2014). However there has been limited exploration of such a balance for students, except for specific considerations of humour (Flynn, 2020) empathy (Heggestad, Nortvedt, Christiansen, & Konow-Lund, 2016) or self-disclosure (Ashmore & Banks, 2003). Students do not hold the label of *professional* (Stickley et al., 2010), however there is an expectation of them to behave in a certain manner (Flynn, 2020; Nursing and Midwifery Council, 2018a) and closeness can be determined by professionalism expectations (Scanlon, 2006). For, often new and unconfident nurses the balance can be daunting (Sun et al., 2016).

This balance is shown in the Balance of *therapeuticness*[131], which signifies the balance between managing risk and safety linked to the custodial environment while being therapeutic and supporting recovery. I use the term *'therapeuticness'* which encompasses the experience of therapeutic practices; *being-with,* the mundane everyday, atmosphere, recognition, being friendly, use of self and so forth. While risk encompasses, restrictive identities and roles, professionalism, boundaries, power constructs and so forth. *Therapeuticness*[132] involves a holistic approach that is therapeutic; an all-encompassing supportive and human approach that lives through everyday stuff, sharing common interests, enabling the creation of a *bubble* and recognition of humanity. Although there may appear two sides, two opposing ideologies (Inglis, 2010) or opposing forces (Menzies, 1960) and many papers view custody and care as binary opposition (Hörberg & Dahlberg, 2015), there is in reality complexity and interaction between the two. They are more like a seesaw (Jackson & Stevenson, 2008), and flexible. For

[130] Referred to in chapter 4 and appendix 1.
[131] Figure 9.
[132] See appendix 30 for reflections on the development of the term *therapeuticness.*

example, ensuring appropriate boundaries is essential for consistency, which is vital when supporting patients carrying a personality disorder diagnosis (Jones et al., 2020; Lamb et al., 2018). Therefore, *leaping-in* is not necessarily *wrong*, and it is, of course, needed in some situations, hence the depiction of a balance rather than one side or the other, there needs to be both, and staff and students can *weather the ride* in achieving this balance (Schafer & Peternelj-Taylor, 2003).

Figure 9: Balance of therapeuticness



Leaping-in

Leaping-in, phenomenologically, means to take over or to take away care from the other (Dibley et al., 2020; Heidegger, 1927/2019; Riahi et al., 2020), to dominate or disempower. It shows itself in the focus on medical professionalism that often deters staff from authentic and empathic connections (Cheetham et al., 2018). It can create dependency (Heidegger, 1927/2019; Miles, Chapman, Francis, & Taylor, 2013). Such approaches restrict and restrain the body while the self is ignored (Cheetham et al., 2018). Participants in Gilburt et al. (2008) study reflected that staff wielding of power and control was due to fear of accountability, against a political and policy backdrop of criticism and scrutiny (see Darzi, 2018; Francis, 2013) heightening focus on professionalism and risk aversion (Flynn, 2020; Kingston & Greenwood, 2020). Such political demands increase the tensions experienced (Benefield & Haigh, 2020; Oeye et al., 2009). Due to such concerns around accountability; services and staff become risk averse, this now a defining feature of mental health settings (Brooks, Lovell, Bee, Sanders, & Rogers, 2018). Coffey et al. (2017) argue in a risk averse culture, bureaucracy becomes justified, such as paperwork which limits actual engagement with patients, as reflected in this study. The therapeutic role of the nurse can be lost and replaced by custodial roles (Peternelj-Taylor, 2004). Staff experience oppressive expectations to complete paperwork with threat of managerial disapproval (Brooks et al., 2018). Though, despite its importance, lack of engagement does not meet the same disapproval. A focus on such aspects of professionalism is unfulfilling for staff and patients, whilst *therapeuticness* is most fulfilling (Cheetham et al., 2018), clearly evident for study participants and their sense of recognition and humanness, despite set roles, identities and the landscape.

Participants in Cheetham et al. (2018) and Moreno-Poyato et al. (2016) studies refer to their relationships with staff as parent and child, viewing staff as paternalistic. Oliver (student) refers to the role of a nurse as '*almost like a parenting role sometimes'*. Despite rhetorical shifts away from notions of *paternalism* in healthcare towards more recovery focused care (Moreno-

Poyato et al., 2016), it is very much present and framed by *risk aversion* (Kingston & Greenwood, 2020; Stevenson & Taylor, 2020). Paternalistic approaches, value the professional as expert (Benner, 1984/2001; McCloughen et al., 2011), dismissing the expertise of patients, in counterpoint to Jasper's strongly expressed '*who else can tell you how it is for you better than yourself*'. Placing importance on professional knowledge over patient experience creates and consolidates power imbalances in relationships (Benefield & Haigh, 2020; Clarke, 2006). Patients can then view staff as authoritarian (Bennett & Hanna, 2021; Moreno-Poyato et al., 2016), enacting protective personal boundaries rather than showing their humanity to patients (Clarke, 2006).

Leaping-ahead

Opposing paternalism and risk aversion, *leaping-ahead* empowers, it enables (Dibley et al., 2020; Heidegger, 1927/2019).

> *…'there is also the possibility of a kind of solicitude which does not so much leap in for the other as leap ahead of him in his existentiell potentiality-for-being, not in order to take away his 'care' but rather to give it back to him…'* (Heidegger, 1927/2019, p. 122/158)

It frees others to move towards their possibilities (Heidegger, 1927/2019; Miles et al., 2013). It is a collaborative mutual partnership, valuing shared knowledge and promoting growth (McCloughen et al., 2011; Riahi et al., 2020). Ordinary and humane relating is the catalyst for the *bubble* and recognition between students and patients; thus, enabling patients' sense of self and the growth of relationships (Browning & Waite, 2010; Cheetham et al., 2018). Clarke (2006) describes staff who show their humanity as '*rare gems'* to be cherished (p. 525). Humanity is demonstrated with mutual understanding and friendship which ensures patient and staff relationships are more equal (Oeye et al., 2009), as found in this study.

Restricting roles

Timmons (2010) question if it is appropriate for a degree-based profession to have the role of security, and if nurses can balance a dual role of therapy and security. Similarly, Delaney and Johnson (2006) and Cheetham et al. (2018) reflect how it is contradictory that nurses employ both paternalistic (risk averse; *leaping-in*) and empowering (*leaping-ahead)* approaches and that such a balance complicates their role. They question whether ordinary relatability is safe in mental health care, which is disheartening considering the impact of everyday stuff for patients and students on their sense of value[133].

Nurses can balance closeness with containment, though relevant skills are not easily mastered or taught (Cleary, Hunt, et al., 2012). Marshall and Adams (2018) also found that despite a dual role of custodian and clinician, staff commonly consider the patients and how their interactions and relationships impact on them. This, however, can cause frustration for nurses attempting to be authentic and *with* the patients while managing staff shortage and burn out (Alshawush, Hallett, & Bradbury-Jones, 2020; Bille et al., 2015). Lloyd (2007) and Acford and Davies (2019) argue that maintaining patient involvement[134] in their care can assist in overcoming such frustration.

Generally, students were perceived as *leaping-ahead;* they were '***always there'*** and available compared to other ward staff, who were identified as not available and '***always busy'*** for

[133] Further explored in theme 3.

[134] '*Involving people in their care and treatment means supporting people to manage their own health and wellbeing on a daily basis'* (NHS England, 2017). Meaningful patient involvement ensures that the views of people accessing mental health services have the opportunity to be heard and make real change, it can occur in many ways at all levels of service provision (Terry & The Swansea University Service User and Carer Involvement Group for Health Programmes, 2018). The concept is complex and definitions vary, though it is essential in secure services to ensure high quality care (Selvin, Almqvist, Kjellin, & Schroder, 2016).

example, doing paperwork[135]. They were physically present but not available due to such roles (Bennett & Hanna, 2021; Jackson & Stevenson, 2008). Nurses are not seen as readily available to patients; lack of time being a major obstacle (Cutler et al., 2020; Moreno-Poyato et al., 2016), with nurses too busy to talk, despite its importance (Cheetham et al., 2018; Cutler et al., 2020; Mirhaghi et al., 2017; Stenhouse, 2011; Terry & Coffey, 2019).

Participating students reflected completing competencies took them away from sharing time with patients. Oliver and Molly described their competencies as being targets to be met. They also reflected anxieties with specific competencies they were unable to meet relating to physical health. New NMC standards (Nursing and Midwifery Council, 2018c), expect nurses to gain a wide variety of skills in all areas. This has appeared to be essential during the pandemic Covid 19 (Nursing and Midwifery Council (2020). For the students, however, having to meet such competencies could take them away from spending time with patients.

Bifarin and Jones (2018) state that the nursing curriculum is focused on *general* or *adult* approaches and more action is needed in developing mental health nursing with the appropriate skills for their practice. Gray (2015) argued this is due to a disparity between theory and practice, and student mental health nurses are prevented from developing skills to balance their professionalism with creativity, as highlighted in the Balance of *therapeuticness*[136]. This may be a relevant concern, though it is important to highlight the significance of Annex A: Communication and relationship management skills, in the proficiencies for nurses (Nursing and Midwifery Council, 2018c), and therefore should be embedded in nurse education, however focus on such skills are often limited (Bifarin & Jones, 2018; Hurley & Lakeman, 2021).

[135] Such could be considered splitting; viewing students as *good* and other staff as *bad*, an object relations theory construct, linked to patient's early development (Siefert & Porcerelli, 2014), as referred to in the chapter 2.
[136] Figure 9.

Caring relations are about being present and making a connection rather than being too busy completing tasks (Vincze et al., 2015) or certain competencies. Wojtowicz, Hagen, and van Daalen-Smith (2014), found that nurses can be focused on tasks rather than patients and can have difficulty in prioritising talking to patients due to lack of time (Bullington et al., 2019). Occupation in non-patient facing tasks creates alienation and distance from the patients, as it becomes just a job; staff become too busy (Delaney et al., 2017), further reinforced by this study. Harking back to 1960, Menzies' pivotal study found a task focused culture caused depersonalisation of patients and such detachment resulted in lack of staff satisfaction as they missed personally investing in their work. Fragmentation of tasks and diminished autonomy results in alienation of staff and patients, diminishing nurses gaining an esteemed identity (McKeown & White, 2015). Similarly, as argued by Coffey, Pryjmachuk, and Duxbury (2015) and Hurley and Lakeman (2021) nurses' denuded identity can be a result of role ambiguity.

Such role ambiguity is present in the paradox that staff who are possibly the most skilled have the least amount of time with patients (Coffey et al., 2017). Despite Jackson and Stevenson (2008) stating that other staff rely on nurses to provide them with information as they are viewed as the closest to the patient. Nevertheless, as discussed by Coffey et al. (2017), nurses often write about patients, make assessments and record these without patients or without spending time with them. Cheetham et al's (2018) participants described nurses as '*just ticking boxes, doing paperwork'* (p. 9) and how they had no time for patients, as mirrored in this study. This was associated with being a registered staff and associated roles. However, Cleary, Hunt, et al. (2012) challenges such discourse critically and argues nurses do interact with patients and such critique is due to poor understanding of complexities in mental health settings. Though in my study, Hollie, Julie and Bella (across different universities and trusts) each independently said that they would miss the time they can spend with patients once they qualify, reinforcing the view that as students they have time to spend with patients and once they are qualified nurses, will not, as they will have to be in the office completing paperwork.

As reflected by the students in my study, perhaps the reason for this is that students are '*not in the numbers'* being supernumerary (Nursing and Midwifery Council, 2018a, 2018b).

Power, roles and decision making

The patients found students to have a different identity compared to nursing and support staff, who make decisions on patients' care. The participants related how they felt students had '*more time'* compared to other staff, similarly to patients in Strömwall, Ozolins, and Hörberg (2018) study who also found students to be more flexible and open in their approach. The participants in my study reported students were '*more funny'*, had a better approach and less negative attitudes than '*regular'* staff, due to their '*studenting'* role (Leo). However, three of the students also at times worked in support worker roles which added some complexity to such comparisons. David reflected on treating support workers and students differently; he already had a view of them based on his previous experiences, demonstrating certain roles may be subject to prior judgement depending on past experiences. This highlights complexities in judgements of identity and role; maybe it's not the person who does the thing, it's the thing itself.

David said if students came to work as a support worker for a shift '*you'd see them just as a healthcare again… because they'd be running around like a blue-arse fly'*, demonstrating the difference in identity and highlighting that workers were seen as too busy for patient-focused relations. However, in other research, support workers were more visible than nurses, and described as invaluable with excellent rapport with patients (McKeown et al., 2020), or acknowledged as spending the most time with patients (Boardman, Clarbour, & Rayner, 2018). Cheetham et al. (2018) found support workers were seen as more human and relatable as compared to registered staff as they were able to have ordinary conversations and have a laugh. Conversely in my study, support workers *and* nurses were identified as *regular* staff, both being too busy with poorer attitudes and less desirable approaches. Support workers and

nurses, though viewed similarly as *regular* staff and being the *holder of keys*, are different in concomitant power and authority (Wilberforce et al., 2017). Comparisons based solely on job title are difficult because of varied roles '*support workers'* undertake and cross-over in roles with registered staff (Moran, Enderby, & Nancarrow, 2011).

In my study, experiencing their *bubble* and shared recognition appeared to reduce the impact of power imbalances in relationships. Students were not considered in the hierarchy of the care team. In Cheetham et al's (2018) study there were two mutually exclusive groups identified; staff and patients. In contrast, in my study, students were '*more like us*' (George), blurring distinctions between staff and patients; being in the middle, a liminal location. For Stickley et al. (2010) this is linked to staff being viewed as powerful and patients as powerless, and students can align themselves with patients. In my study demarcation of tasks, ascribed meaning to the patients. Students not being able to do certain tasks, in some respect, appeared to lower their value, yet alternatively appeared to humanise them. For example, support workers and nurses can restrain patients, a physical demonstration of power (Roberts, 2005), but students are not able to restrain. Thus, certain tasks signify power, and reflect a hierarchy of power across the care team.

Ultimately, nursing holds responsibility for keeping units safe and maintaining public protection (Bennett & Hanna, 2021; Delaney & Johnson, 2006; Mann et al., 2014), thus therapy becomes secondary, consolidating power constructs across services (Pilgrim, 2017) and often at the expense of recovery focused care (Mann et al., 2014). However, Cheetham et al. (2018) argue that emotional openness and togetherness can challenge power constructs. As I found, the students' presence, their openness and consequential togetherness and shared recognition, certainly challenged the experienced power constructs on the secure units. Similarly, as stated by Sweeney et al. (2016) relationships should be based on mutuality, recognition,

collaboration, empowerment, connection and hope to balance power dynamics, which the students achieved by focusing on the mundane everyday (*leaping-ahead)*.

Holder of keys

Although students may be inexperienced or novice (Benner, 1984/2001), this is outweighed by being '*sponges'* and learners without ingrained or '*jaded'* attitudes (Jasper). Conversely Benner (1984/2001) argued that novice nurses have problems seeing the patient individually and are more focused on practical tasks as compared to the expert nurse. This is in contrast to this study where *regular* nurses or experts were seen as having a less desirable approach and less time to spend with patients, as *holder of keys.* The students were identified positively as '*sponges'* but could become enculturated in the landscape to *holder of keys* (*the one*; (Heidegger, 1927/2019)) as fully-fledged nurses. In this regard they assume decision making responsibilities, must maintain professionalism, and become increasingly, spatially and temporally distant from patients. The keys signified power, a physical representation of custodial role. Thus, material objects like keys take symbolic form in the practice of territorialisation, wherein boundaries are set (Bennett & Hanna, 2021; Brown & Reavey, 2019). '*Real power lies with the one who holds a ward key'* (Gildberg et al., 2016, p. 124). Such objects do not implicitly hold meaning, this must be conferred by human beings (Dibley et al., 2020).

Foucault's (1989/2003) work makes clear such discursive elements of power, particularly in mental health care with patients subject to control and monitoring from health care workers (Roberts, 2005). Foucault acknowledged Heidegger's influence in critical phenomenology, including seminal observations on madness, power, sexuality and gender (Dibley et al., 2020), highlighting how our experiences and society are shaped by powerful discursive practices which do not just describe the world, they create and order the world as we know it (Foucault, 1975/1977, 1989/2003).

As human beings, we are always *being-with* others and subject to cultural norms, as part of *the one*; as Heidegger (1927/2019) described *Das Man*[137]. In our everyday lives we do what '*one'* does according to culturally accepted norms (Kay, Downe, Thomson, & Finlayson, 2017). The students are '*sponges'* that can be influenced by *others* and conform to become *the one* in the secure landscape. Students can experience '*fallenness'* to become *the one* when they become *holder of keys.* This transition is from learners with time to share with patients, valued because they were not paid, to being paid, busy and no longer learners. However, nurses do actually continue to learn throughout their careers (Nursing and Midwifery Council, 2018a, 2018c), but interestingly, this was not apparent to patients. Similarly, patients can view *regular* staff as believing they know everything (Andersson et al., 2020). The patients spoke of this transition from student to nurse as baby lambs (in a positive sense) becoming sheep (*the one*). This was in the sense that baby lambs are full of life, bright and eager to learn as compared with sheep, following the crowd. Similarly, patients can view students as unwritten sheets, without prejudice (Andersson et al., 2020). However, as described by the student participants, development occurs throughout the course, so learners do not remain unwritten sheets for long.

When the transition to *regular* staff occurs, students appeared as *fallen* (Heidegger, 1927/2019) through becoming accepted into the wider workforce culture (*the one*). Their state of *fallenness* is indicative of enculturation (Riahi et al., 2020), becoming *inauthentic* as *holder of keys*. Conversely, some staff may feel *authentic* as *holder of keys.* Heidegger (1927/2019) was careful to posit however, *fallenness* as not necessarily a negative state, rather *inauthenticity* was an essential way of *being-in-the-world,* a way of coping:

> *'Being which belongs to everydayness; we call this the "falling". This term does not express any negative evaluation… "Fallenness" into the 'world' means an absorption.'* (Heidegger, 1927/2019, p. 175/220)

[137] Often incorrectly translated as *the they,* as it includes us (Dreyfus, 2007a).

The one articulates the referential totality, in other words; conforming as *the one*, helps us make sense of cultural norms and function in society (Dreyfus, 2007f). However, Heidegger (1927/2019) also understood fear feeds *inauthenticity* and following *the one* can close possibilities. A person hiding behind a facade to protect themselves from what is feared, can be described as *inauthentic* (Miles et al., 2013).

Fear of litigation, risk and accountability, and the systems staff are governed by, close possibility and enforce a state of *fallenness* to the workforce. This state of fear fuels an *inauthentic* existence for healthcare staff (Thomson, 2011). Conversely, in taking risks and embracing possibility offers opportunity for a meaningful existence (Carman, 2010), which is what sets us apart from everything else as humans; we create space for new things (Wrathall, 2010), like the *bubble* created by the students and patients. Being a risk taker enables discovery of new things about the world. By *leaping-ahead* and not *leaping-in* (Heidegger, 1927/2019), students balanced *therapeuticness* over professionalism, embracing possibility and taking risks. In confronting situations, we open ourselves up to the best version of ourselves (Kelly, 2010). In this state we are free, comfortable and relaxed and truly *being-in-the-world* (Heidegger, 1927/2019). However, this creates vulnerability and tension between conforming and individualism (Dreyfus, 2010); focusing on the relational potentiates vulnerability (Wright & Schroeder, 2016).

Though Heidegger (1927/2019) was careful to reflect *fallenness* as a way of coping in a world of cultural norms, he also referred to the dehumanising impact of mindless conformity, destroying what is great and unique about us as *Dasein* (Dreyfus, 2010). So, although students may *fall* to become *holder of keys* (*the one*), they are coping in the world and can *weather the ride* and resist mindless conformity. However, as patient participants depict, there are nurses and support workers who mindlessly conform or become cognitively dissonant (Jacob, 2012). They become thoroughly conditioned into roles of *regular* staff, absorbed by

cultural traditions and practices of healthcare, and cannot see this (Carman, 2010). They '*become lost in an anonymous, formless and inauthentic 'they-ness''* (Thomson, 2011, p. 145). Thomson (2011) similarly found healthcare staff can operate in a state of *inauthenticity,* enforcing rules and standards commensurate with hospital cultures. In the state of mindlessly conforming, staff do not take risks, restrict possibilities and adhere to identities rather than demonstrate recognition of humanness and *therapeuticness*. They give up part of themselves to take the part of the nurse.

Weathering the ride: **Managing the balance**

Of course, as Thomson (2011) states, compliance with rules (becoming the *holder of keys*) does not always point to mindless conformity. Despite complexity in general comparisons, there is hope when students become *holder of keys* that they can *weather the ride* by focusing on the everyday mundane and connecting with patients to (re)create the *bubble.* Encouragingly, students can be creative and innovative within the landscape; balancing *therapeuticness* and professionalism, challenging norms and behaviour of *the one* (Dreyfus, 2007a). Reflective practice, supervision and patient involvement and feedback challenge mindless conformity (Bennett & Hanna, 2021; Riahi et al., 2020).

In this study, student participants recognised patients as people, '*like anyone else'* (Hollie). Such views are heartening as students reclaiming the humanity of those designated personality disordered (Wright et al., 2007), a turn congruent with trauma informed understandings of care (Sweeney et al., 2018). Patients reciprocally saw the students as '*like us'* demonstrating mutual recognition. More holistic approaches and focus on social nurturing (*therapeuticness/ leaping-ahead*) as compared to control (*leaping-in*) need to be balanced as they can significantly affect secure service care and patients' satisfaction and ultimately quality of life (Cook et al., 2005). We must address the taboo of self-disclosure in nursing practice

(Oates et al., 2017) negotiating the balance between *therapeuticness* and use of self, control and professional boundaries.

This study casts light on human relations operating across ambiguous boundaries of identity. Patients in mental health services, particularly those carrying a personality disorder diagnosis and detained in secure settings, are often viewed as abject (Marshall & Adams, 2018). Developments such as dangerous and severe personality disorder services (Bowers, 2002), although disbanded, contribute to a bolstering of otherness, extending separation between the public and people in secure services (Wright et al., 2007). There is potential for the new ICD 11 (World Health Organization, 2018) to continue to widen this gap with the term *severe* personality disorder returning. Patients may be viewed as abject, housed behind high walls away from '*polite'* society. However, people in the wider population do not have a monopoly on human goodness or positive personality characteristics nor do the patient population carrying a personality disorder diagnosis monopolise negative traits, nor nurses claim monopoly on caring (Griffiths, 2007).

7.2.3 Overarching theme 3: Impact

> *'If you treat an individual as he is, he will remain how he is. But if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be.' (Johann Wolfgang von Goethe)*

The impact of the time patients and students shared together in the landscape of the secure unit is explored in this theme. The landscape was permeated with overt and hidden power imbalances maintaining its institutional nature, with the pivotal point of separation, the staff office. In this landscape students had more time as compared with other staff in relation to their roles[138]. The concept of time was multifaceted, interlinking with elements analysed in the other themes. Time was experienced practically in relation to routines and length of student placements. While also experienced outside of measured time when *being-with* in their *bubble,* where they connected through common interests and having a laugh. Though there was potential for experiencing loss once students finished placement, patients chose to share time with students and spoke fondly of shared memories.

The time they shared enabled a powerful sense of value, through recognition of humanity and shared learning. Students felt they had made a difference and patients felt they had value through teaching students, giving them an alternative identity. The impact such *things* can have on patients can seem unclear in research due to limitations in studies, their methods and participants (Gildberg et al., 2010). This study demonstrated rigour from recruitment to analysis and thus the gravity of how the students and patients impacted on each other was clear, which I explore in this theme.

[138] Explored in theme 2.

Temporal relationships

Previous research has found longer student placements enable a better chance of developing relationships with patients (Johansson & Martensson, 2019). As stated by Askola, Nikkonen, Putkonen, Kylmä, and Louheranta (2016) and Scanlon (2006) relationships in secure settings take time and do not form instantly. For the participants, although students were on placement for a *short* amount of time, paradoxically, they were perceived by patients as having more time to spend with them. This appeared to be in relation to more '*quality time'* (George), students being able to allocate a greater proportion of available time, perhaps having less time pressure (Cleary, Horsfall, & Happell, 2012). In contrast with Johansson and Martensson (2019), Timmons (2010) and Askola et al. (2016), they developed strong connections quickly despite the short time frame. Steven depicts the complexity of time, in that although measured time is shorter, the sense of time is infinite based on the connections made:

> *'It just feels as though, once you get talking, that you've know them a long time even though you might have only known them a couple of hours'. (Steven, patient)*

Bergson spoke of time as having two faces, objective time (measured) and lived time (our inner subjective experience) (Leonard, 2020). Lived time is felt and acted. Despite its importance, we often do not pay attention to lived time as objective time is a constant measure (Leonard, 2020). Heidegger (1984/1992), and more recently, Crowther et al. (2015), use the term kairos time to describe an existential temporal experience that is rich in significant meaning, rarely spoken about yet touches those present. It involves shared connectedness (Crowther et al., 2015), as the participants experienced. van Manen (2007/1990) describes lived time (temporality) as felt experience, an ontological phenomenon. It is a moment of life altering possibilities (Crowther et al., 2015), as the students opened for the patients, explored later in this theme.

Within a mental health unit there are temporal rhythms and spatial delineations for example ward routines that impose on nurses time with patients (Gesler & Kearns, 2005). As found by

McKeown et al. (2020), when staff spend more time engaging face to face with patients, rather than engaging in routine practice, there was a higher quality of therapeutic relationships. For patients the main factor limiting development of the therapeutic relationship is time, due to workloads, administration tasks and staffing issues (Cameron et al., 2005; Lloyd, 2007; Moreno-Poyato et al., 2016). As found in this study, institutional routines take away focus from the mundane (Buse et al., 2018); an essential element to the creation of the *bubble* and recognition, explored in other themes. A disproportionate amount of time is taken up by other tasks, taking staff away from sharing time with patients (McAndrew et al., 2014; McKeown et al., 2020), this has been a common theme in healthcare services since the 1960s (Orlando, 1961).

Various research has explored ways of ensuring staff have time to spend with patients. Lloyd (2007), found that reorganisation can enable nurses to have more time to spend with patients. Some have found having staff time allocated and set can be effective (McAllister et al., 2019). However, Buse et al. (2018), argue that fixed time slots are difficult to locate due to the unpredictability of healthcare settings and clashes with institutional routines, such as those in secure services. McAllister et al. (2019) and Moreno-Poyato et al. (2016) found that set times with patients often fail due to administration and systems and a solution is yet to be found, despite the consensus therapeutic engagement should be prioritised. Additionally set times and the same routines can cause time to go slowly and blur (Tomlin et al., 2019). Students acted as an escape from the boredom of routines by '*just being around*', '*having a laugh'* and engaging in meaningful activities.

Boring yet stressful

The units were described as boring as well as stressful, showing the complexity of the landscape and associated experiences. Similarly other research has found that secure mental health settings are complex due to their unpredictability (Barr, Wynaden, & Heslop, 2019;

Brown & Reavey, 2019; Hammarström et al., 2019). Other studies have described mental health settings as boring (McKeown et al., 2020; Tomlin et al., 2019), noisy (Muir-Cochrane et al., 2013), chaotic (Kingston & Greenwood, 2020), and, as Oliver refers to, the most extreme and stressful environments in society (Peternelj-Taylor, 2004). Services have been described as safe havens while also fearful and coercive places, with the landscape impacting on a patient's sense of these two opposing experiences (Scholes et al., 2021). The environment can affect individuals differently depending on their perceptions and experiences (Hallett & Dickens, 2021).

The units were described as scary, though Hollie felt acute units, in comparison to secure settings, were '*very scary'* and secure units were '*more relaxed'.* This was in relation to the longer-term element of such services. Though there are risks, often there are more staff, detailed assessments and longer time enables relational security to be optimised (National Health Service, 2010). There are many views people can have of secure settings and the patients who reside in them, which can include fear and apprehension (Bowen & Mason, 2012). Particularly students, who can feel nervous about going on placement (Alshahrani, Cusack, & Rasmussen, 2018; Demir & Ercan, 2018; Nolan & Chung, 1999; Sun et al., 2016).

Unpredictability can result in staff burn out and sickness (Berry & Robertson, 2019); consequences of countertransference, often experienced in secure settings (Barr et al., 2019; Garnham, 2009) and when supporting patients carrying a diagnosis of personality disorder (Yakeley, 2019). Berry and Robertson (2019) recommend focus on positive ward environments including patient cohesion, safety and enhancing the therapeutic atmosphere. As explored in other themes the students created a therapeutic atmosphere for the patients, despite evidence reporting this is not a common experience (Brown & Reavey, 2019), or its importance in secure settings (Stevenson & Taylor, 2020).

Risk

Patients and students were aware of the importance of managing risk, boundaries and safety, while also having a positive and therapeutic landscape with space and time to develop rapport and trust, through activities, sharing common interests and having a laugh.

Self-disclosure[139] was important for developing connections, though the participants were mindful of ensuring they maintained appropriate boundaries, for example not sharing personal details of their lives, being aware of their location in the environment and acceptance of gifts. Nurses face challenges managing risks associated with boundary violations, hence the importance of maintaining relationship boundaries (Pettman et al., 2020; Valente, 2017). Safety is prioritised within secure settings, which can constrain communication and empowerment, ameliorators of restricting features of these environments (McKeown et al., 2016).

Barr et al. (2019) recommend education and support for staff to work confidently and safely. Because the *relational* is fuzzy, grey and unpredictable, it opens vulnerabilities for people, and thus there becomes a focus on physical security rather than relational security (National Health Service, 2010). Staff can (subjectively) feel more vulnerable and less confident when not focusing on physical elements as relational elements are viewed as more '*risky'* (National Health Service, 2010).

It is important to note that the patient participants were detained in a secure setting for a reason and were not free from risks. There may be a view that patients form a new truth with students and they are vulnerable to boundary violations (Blair, Kable, Courtney-Pratt, & Doran, 2016), however what was shown to me at interview is understood as the participants' reality

[139] As explored in theme 2.

(Dibley et al., 2020). Students appeared to illuminate patients' possibilities by recognising their humanity and enabling a positive identity shift. The students were aware of the risks present and importance of appropriate boundaries, in addition to understanding patients' *thrownness* into the world and continued to create their *bubbles.*

Institutional power

The impact of the environment of a secure service cannot be ignored in relation to the time patients and students share together. Power, control and authority are present physically and interpersonally and can operate counter to healthcare goals (Peternelj-Taylor, 2004). There are inherent difficulties from the off set for patients to be on an equal footing with staff, due to such power differences (Foucault, 1989/2003), exacerbated in secure services (Mann et al., 2014; McKeown et al., 2016), permeated by power and powerlessness (Hörberg & Dahlberg, 2015). Patients can feel stuck and experience misdiagnosis and wrong treatment, as discussed by the patient participants (Tomlin et al., 2019). There was a sense of powerless in their reflections of being '*stuck here for the rest of your life'* (Leo), highlighting the control and power staff had over patients. This similar sense of powerlessness was felt by patient participants in McKeown et al. (2020) and Simms-Sawyers et al. (2020) studies in secure services. Simms-Sawyers et al. (2020) found patients were aware of how hierarchies of power influenced whether they progressed through services. Tomlin et al's (2019) and Martin, Ricciardelli, and Dror (2020) noted staff emphasising adverse behaviour within clinical notes reinforced patients being stuck, which is concerning as nurses may only engage with patients for a short amount of time and yet complete daily records based on these brief interactions (Coffey et al., 2017), as reflected upon in this study. Consequently, patients can '*play the game'* and surrender to the power of those in authority in order to gain discharge and freedom (Hörberg & Dahlberg, 2015; Simms-Sawyers et al., 2020).

Conversely, although power and *leaping-in* can cause pain and anxiety, it can also provide soothing containment[140] (Cheetham et al., 2018), which can be essential for patients struggling to manage. Patients who are struggling may need some physical and emotional containment, and this can be free from power differences, where patients and staff are on equal footing according to Curtis, Gesler, Fabian, Francis, and Priebe (2007).

Patient involvement is essential to enable power sharing and collaboration (National Institute for Health and Care Excellence, 2019; Reed & Hall, 2018), however in order to achieve this nurses need to feel empowered and autonomous in their decision making which may be limited in roles, systems and processes of such institutions (Awty et al., 2010; McCloughen et al., 2011). McCloughen et al. (2011) found nurses were focused on controlling the environment and procedures rather than exploring power sharing and mutual relationships, as this is challenging and opens risk and vulnerability. Similarly to Awty et al. (2010), who found that nurses can struggle to maintain true to their beliefs and values in hostile systems and others who state that nurses can feel powerless and hopeless in relation to institutional hierarchies (Hörberg & Dahlberg, 2015; Wojtowicz et al., 2014).

Staff can feel under surveillance just as patients can (Holmes, 2005), nurses and patients can be caught in power dynamics as both are captives of institutional systems. It appeared students were on the periphery of such systems and therefore were able to manage the balance[141]. However, students can also feel unable or powerless to question or challenge due to specific institutional hierarchies (Allman, 2018; Wojtowicz et al., 2014). Staff have power over students on their placements due to completion of assessments, which can lead to

[140] Some patients can respond well to rules and authority (Young, 1996).
[141] Explored in theme 2.

students feeling unable to challenging staff (Stacey, Baldwin, Thompson, & Aubeeluck, 2018). Such experiences of assessment and observation are shared between students and patients.

Institutionalisation

Patients and students talked about the units being an inside world that is separate from outside, where patients are '*warehoused'* (Jasper) and unable to go outside, while aware that students (and staff) can leave. Such experiences resonate with Muir-Cochrane et al. (2013) findings, where patients felt a lack of freedom and also felt warehoused. Cutler, Halcomb, et al. (2021) found lack of privacy impacted on patients' sense of safety. Hörberg and Dahlberg (2015) participants described their bedrooms as a safe haven where they could escape and rest, in conflict with patients' experiences in this study, who felt that someone was always looking, as found in other research (Cutler, Halcomb, et al., 2021). When observations are completed without therapeutic engagement patients can feel dehumanised and distressed (Cutler et al., 2020). The students considered the patients in settings where they can feel like '*caged animals'* (Oliver). Just as O'Connell, Farnworth, and Hanson (2010) participants described secure services as a cage and patients in Tomlin et al. (2019) study described being herded like cattle and just being a number.

The impact of the unit became clear when Mike visited another hospital with Oliver, where they felt more comfortable and open to deeper conversations. Such experiences resonate with findings in McKeown et al's (2016) study where engagement in activities away from the secure setting acted as an escape from the oppressive institution. In addition, being able to explore something new together and sharing a sense of optimism at progressing through their care pathway. Increasing opportunities for leave and activities offer opportunity for increasing connectedness and development of sense of self for the patients (Clarke et al., 2016). In

addition to this, activities can deterritorialise spaces; open them up and transform them (Brown & Reavey, 2019).

Lengthy stays in institutions cause loss of independence and identity (Tomlin et al., 2019). Molly supported a patient who said he sabotaged his discharge plans because he was worried that the '*world had changed'* since he was admitted, highlighting the segregated nature of secure services and potential impact on patient discharge. Practices in secure settings can cause moral and self-degradation for patients (Goffman, 1956/1990). Such settings can be described as unhelpful and antitherapeutic, and even dehumanising and humiliating due to surveillance, poor landscapes[142] and lack of engagement (Cheetham et al., 2018; Nugteren et al., 2016; Reavey et al., 2019), as discussed by the participants.

Thou shall not pass

The design of hospital spaces can also impact the apportionment of time and how this may interact with other constraints, such as the previously mentioned privileging of record-keeping, to demarcate office space from general living space on wards. Simonsen and Duff (2021) highlight how the location and design of offices or nursing stations can operate to distance staff from patients, creating uncertainties, when a greater degree of *visibility* would be preferable for relational dynamics and, by implication, impact upon the prospects for time spent together in these therapeutic landscapes.

[142] Architects have more recently focused on creating therapeutic landscapes as a result of increasing patient involvement (Bille et al., 2015). Designs of health care settings are significant in enabling the development of relational connections between patients and staff (Brownlie & Spandler, 2018; Nettleton et al., 2018). Despite such research focus on therapeutic landscapes, landscapes of power continue to be present and identify control (McKeown et al., 2020; Muir-Cochrane et al., 2013). Muir-Cochrane et al. (2013) argued from their study that hospitals were not a therapeutic landscape. Mirrored by Brown and Reavey (2019) who stated that therapeutic landscapes are spaces with the power to heal, however secure services certainly do not meet this premise, they are corrosive landscapes that are under researched.

With regards to impact of the physical environment, students and patients referred to the office as a pivotal point within the spatiality of the ward like the television, though with a pejorative undertone. The distinctions between staff and patient identities are maintained with rituals in the institution in addition to the spatial demarcations (Goffman, 1956/1990), such as the physical space of the nursing office. As demonstrated in other studies patients and staff are subject to spatial separation, such via the office, encourage different worlds (McKeown et al., 2020). The office door adds to a *them and us* dynamic (Bennett & Hanna, 2021; Muir-Cochrane et al., 2013; Tomlin et al., 2019), resulting in these two worlds described in McKeown et al's. (2020) study, and as discussed by the study participants in this study, there was an '*invisible line'* (Oliver). Similarly, Gesler and Kearns (2005) referred to the invisible line across the office almost 20 years ago, demonstrating such practices have not changed despite evidence of the negative impact on patients (McKeown et al., 2020). Nurses continue to spend the most amount of time in the office, as identified by the participants and more contemporary studies, it can be a refuge or safe space for nurses overloaded by paperwork (Brownlie & Spandler, 2018; Cutler et al., 2020; Kingston & Greenwood, 2020; McKeown et al., 2020). It is a tangible barrier to nurses' availability (Cutler et al., 2020).

For the participants in this study, the office acted as the eye of the panopticon[143] (Foucault, 1975/1977). The office is thus an essential signifier of power, as reflected by the participants as a space where patients are not able to go, separated by an invisible line. The place of the office, often at the centre of the landscape, reinforces set hierarchy and power dynamics (Buse et al., 2018), in addition to the wider layout resulting in bringing people together or segregating them (Martin, Nettleton, Buse, Prior, & Twigg, 2015). Bentham's panopticon creates and maintains power (Foucault, 1975/1977). They are common place in hospitals and enables the

[143] Panopticon; '*a machine for creating and sustaining a power relation independent of the person who exercises it*' (Foucault, 1975/1977, p. 201).

view of human beings as subjects tying them to a set identity[144] and a subtle form of control (Roberts, 2005). It also becomes a space where patients have to go to ask staff for basic things, disempowering them (Ireland, Halpin, & Sullivan, 2014), like David and Jasper asking for milk.

Within mental health care there are numerous examples of panopticism, as referred to by the participants, in addition to the office; observations, record keeping, ongoing assessments and ward rounds (Roberts, 2005). Panoptic power is relevant to all staff not a single person, but a '*faceless gaze'* (Foucault, 1975/1977, p. 214). Similarly Tomlin et al. (2019) refers to the ever present gaze that causes patients to feel untrusted. Power in secure settings has been described as hidden or exercised invisibly (Hörberg & Dahlberg, 2015; Tomlin et al., 2019).

Other spaces alternately potentiate or constrain time for relationships (McKeown et al., 2020). For example, small rooms underutilised with communal areas favoured, as in my study where the communal lounge with the television was described as the '*focal point'* in the time students and patients shared together. In addition to this, other studies have also found that patients tended to isolate themselves in their bedrooms (Brown & Reavey, 2019; McKeown et al., 2020), which Hollie referred to, linked to identifying a deteriorating mental state. The communal lounge appeared to act as a safe place (Brownlie & Spandler, 2018), though appearing only so while students were present due to the homely and friendly atmosphere they created[145]. However, as argued by Brown and Reavey (2019) feelings of safety are continuously undermined by the practice of surveillance due to regular monitoring and observation.

[144] As referred to in theme 2.
[145] As referred to in theme 1.

There was an underlying seriousness of the environment; for patients it was as inpatients being watched and assessed, and for students they were learners also being watched and assessed to pass their competencies. Similarly Abram and Jacobowitz (2021) and Andersson et al. (2020) reflect on the mutual vulnerability students and patients experience being exposed to assessment. Such reciprocal experiences of being watched and assessed, were elements that connected students and patients in their *bubble.*

Impact of students

Through these shared experiences and *being-with,* patients felt recognised as people not patients, as explored in other themes. It gave them a sense of humanness and togetherness, when institutions take such fundamental concepts away (Goffman, 1956/1990). Supportive and encouraging interactions (*leaping-ahead*), that the patients described, helped them feel their own worth and qualities (Rask & Brunt, 2007).

The students were available to patients and by spending time with them and demonstrating investment it conferred feelings of value (Shattell et al., 2007). Time with students acted as an escape due to their experience in the *bubble*. Staff can disrupt (or pop) such precious moments, however (Crowther et al., 2015), and interruptions can be a reminder of institutional life, as David found.

Students had a significant impact on patients. This was overwhelming across all units for all patients. There were, of course, elements of more negative experiences. Students presence can be stressful for some (Andersson et al., 2020). Though these were overshadowed by the overall positive impact of students. Patients in secure services are often not given a voice (Rydenlund, Lindström, & Rehnsfeldt, 2019), however in my study the students appeared to facilitate patients' voice and worth. The students improved the quality of life for patients (Pitkänen et al., 2006). As Jasper remarked, the students gave him an anchor to the outside

world and a sense that he was '*okay'* because he was '*getting on with them',* having a laugh and connecting.

Patients can often find they are given labels and viewed as people with limited futures and without *being* (Awty et al., 2010). The students recognised their humanness and supported them in seeing their possibilities. Deegan (1996) wrote how nurses create opportunities for patient's personal growth and supporting them moving forwards to new possibilities. As the person begins to improve, the nurse walks alongside them. Ultimately the person will '*walk ahead to new possibilities with realistic hopes and dreams of a better tomorrow'* (Awty et al., 2010, p. 109). Good relationships with skilled staff who convey hope are key (Askola et al., 2018; Horgan et al., 2020; Sheridan Rains et al., 2021; Stevenson & Taylor, 2020). Hope has the potential to influence and motivate patients to achieve their goals, though nurses need to have hope themselves (Stevenson & Taylor, 2020).

The sense of supporting others to see their possibilities also related to the patients helping students. Patients felt a sense of pride when students they had supported became nurses. As explored in other pieces of research, patients feel they can influence the future workforce (Happell, Platania-Phung, et al., 2019; Happell, Waks, et al., 2019; Lesser & Paleo, 2016; Stickley et al., 2010). Patients in this study could see the impact of their teachings, their possibilities, in addition to the possibilities in the students they taught. Students were learners with time to share with patients which was valued because they were not paid, as compared to other paid staff, busy and not perceived as learners due to their roles. Patients can prefer to talk to students as compared to *regular* staff, because students want to learn (Andersson et al., 2020).

Reciprocal teaching and learning

When the patients and students shared time together, the patients became teachers an alternative identity giving them a role, purpose and feelings of worth, aiding their empowerment and opening possibilities. Rather than tying patients to unified identities they offered creation and innovation of another (Foucault, 2000). Patients also helped the students '*settle in'* and to better understand the needs of the patients. Students can take a few weeks to settle in to new placements, which can be underestimated (Menzies, 1960).

Teaching shifted the power balance for the patients (Breeze, Bryant, Bryant, Davidson, & et al., 2005). Such role reversals from helper to helped, benefit students as it challenges notions of labels (Hanson & Mitchell, 2001; Speers & Lathlean, 2015). Students can view themselves as learners in classrooms and nurses in practice, hence role reversals in practice can be illuminating for students, due to the different learning environments (Rush, 2008). Seeing patients in alternative identities disrupts traditional power constructs, and is essential for developing more reflective and empathic students (Perry et al., 2013).

Patient involvement in nursing education and the impact on nursing students' attitudes, knowledge and skills has been widely reported (Downe et al., 2007; Happell et al., 2019; Horgan et al., 2018; Kuti & Houghton, 2019). Most studies (Horgan et al., 2018) have explored patient experiences of education in university settings, rather than within practice settings, despite patients playing an essential role in students learning in practice (Suikkala et al., 2018). Andersson et al. (2020) explored patients' experiences of receiving care from students, stating that research has primarily focused on student nurse learning from a student or supervisor perspective; few studies have investigated patient experiences, as my study illuminates. Patients have valuable perspectives surrounding nurse education, though their involvement in practice is not well established (Andersson et al., 2020; Suikkala et al., 2018). Patients benefit greatly from taking on the identity of teacher in the classroom, in terms of

building their self-esteem (Hanson & Mitchell, 2001), and as found in my study, they equally benefit in practice. This does, of course, need mindful consideration of patients' mental health when they are teaching students (Lathlean et al., 2006).

Patients believe teaching students can make better nurses (Happell, Byrne, McAllister, et al., 2014). This is particularly true with regards to teaching students about personality disorder (Finamore et al., 2020). Andersson et al. (2020) found patients gain power and wellbeing through encounters with students, as a consequence of them being inquisitive about their experience of mental health problems. Patients often become involved in student educations for altruistic reasons (Suikkala et al., 2018). Such teaching contributions are not only beneficial for the patients, but also enable unity between patients if taking on this role together.

The patients spoke of teaching the students to play pool or cards, just as Hollie spoke of teaching patients to play scrabble, demonstrating the reciprocal nature of teaching and learning, enriching each other. For encounters to be genuine they should be mutually reciprocated relationships (Andersson et al., 2020; Ekebergh, Andersson, & Eskilsson, 2018). Scrabble, pool and cards, mundane materialities, enable social engagement (Bowers et al., 2010). Due to the reciprocal relationships, connections were built, which became lasting memories, for Leo especially. Reciprocal relationships should be a priority in secure services (Bennett & Hanna, 2021).

Practice assessors and the staff team are important for students settling in to their new placements; essential for a student's sense of belonging (Levett-Jones & Lathlean, 2008; Tremayne & Hunt, 2019) resulting in more positive experiences and higher levels of confidence (Cleary, Horsfall, et al., 2012; James & Chapman, 2009). Whilst, limited evidence surrounds the impact patients can have on helping students settle in (Tremayne & Hunt, 2019),

providing such help gave patients a role and perceived value. As a result of this it enhances placement experiences and student development (Cleary, Horsfall, et al., 2012).

Time is precious: Building attachments and coping with loss

With regards to ending of placements, student participants spoke of wanting longer placements; however, this may have invoked similar patient views of *regular* staff due to changes in role[146]. Perhaps the bounded nature of placement time meant the available time was appreciated as of value. Time is precious, our experience of temporality is only because life is limited. Experiences are meaningful because the possibilities realised in our *being-in-the-world* are finite (Svenaeus, 2011). Students are on placements for a set duration; thus, their time is treasured and used to make a difference. Which may be why students are viewed more positively than other staff, because of their limited time in the placement area.

However, patients have little control over the direction of the relationship as it cannot be reciprocally negotiated due to set placement duration. Patients said how it was sad when students finished and how they felt '*wounded'* (Leo). Ending relationships can leave patients feeling abandoned or rejected (Sheridan Rains et al., 2021), even retraumatised. Patients miss students when they are not present and feel something is lacking or empty (Andersson et al., 2020). Due to this, patients may self-protectively choose to engage in shallower interactions because their time with students will end[147] (Reed & Hall, 2018). Previous difficulties in early social connections as a result of *thrownness* into the world and adverse childhood experiences can result in attachment struggles (Feeney, 2004; Fuchs, 2007). For patients with personality difficulties they can experience fragmentation of lived time (temporality), where they are in the present without any depth resulting in being unable to draw

[146] As explored in theme 2.
[147] Students may also choose to distance themselves from patients due to short placements (Menzies, 1960)

on their past experiences to explain the present and thus the threat of abandonment evokes a loss of one's self (Fuchs, 2007). Hence, managing the ending of relationships is essential for students (Mann, 1973; Peplau, 1988; Reed & Hall, 2018; Shefler, 2000; Sheridan Rains et al., 2021). The students highlighted being clear from the start when their placement ends to prepare patients for ending their time together, an important approach to take, though often gaining little attention (Ashton, 2016). During the first encounter with a patient, it is important for students to consider such challenges (Hubbard, 2016).

Helping patients feel at 'peace'

Despite difficulties in managing the experience of temporality on placements, the students wanted to complete their nurse education to help others and make a difference, aligned with other studies (Awty et al., 2010; James & Chapman, 2009; Salzmann-Erikson et al., 2016; Welch, 2001). This was the participants' main drive for starting their nurse education. Awty et al. (2010) participants reflected that it could be them or a family member who could struggle with their mental health and thus wanted to help others, a core value of focusing on people was what lead my participants to nursing.

Julie spoke about helping patients feel at *'peace'.* For George this was described as students making him feel comfortable, safe and at home[148]. The students disclosed stories where they felt privileged patients had trusted them to provide support. They said sharing time with patients made it worth coming to placement. They also spoke of receiving feedback which built their confidence and, as found in other studies, can enhance their learning and ultimately improve patient care (Stickley et al., 2010; Suikkala et al., 2018). Patients express positive views on giving feedback (Suikkala et al., 2018), and feel it can develop bonds between themselves and students (Stickley et al., 2010). However, there can also be equally negative

[148] As explored earlier in theme 1.

experiences (Stickley et al., 2010). Speers and Lathlean (2015) state that the ability of feedback to make a difference is inconsistent as some students are more willing to engage than others. Patients can also struggle giving critical feedback and feel discomfort (Stickley et al., 2010). Nevertheless, patients in this study found it a positive experience to give students feedback and this was valued by the students, with benefits outweighing the complexity. Therefore, where appropriate patients should be encouraged to give feedback to nursing students to support their development (Inglis, 2010) and while in nursing education, the impact students can have on patients should be explicit.

Time is a gift

For the participants, time was a gift (Reed & Hall, 2018) or commodity (Chandley, 2000), the impact of the time they shared together was immeasurable. Despite the environment and roles, the relational aspect of *being-with* (connections, everyday stuff, humour) helped them cope. Despite missing the students when they left, patients felt happy for them, spoke of being hopeful for them in the future as nurses and treasured their shared memories.

As the Goethe quote beginning this theme depicts, the way students *treated* the patients, opened up and illuminated their possibilities to them. Humans have a desire to relate to others and trusting relationships can enable mutual recognition of humanness and strengthen a person's sense of self and their identity, ultimately giving them hope (Adnøy Eriksen et al., 2014; Greenacre & Palmer, 2018). The students recognised the humanity in the patients and connected with them on the same level in their *bubble.* Sharing time with students enabled patients to alter their identity from '*mental patient'* to David, Fred, George, Jasper, Leo, Mike and Steven and teacher. Supporting patients to become teachers moves away from paternalistic approaches (*leaping-in*) to a collaborative focus (*leaping-ahead*) (Suikkala et al., 2018). For Fred he became *'damn well not useless now',* despite residing in an institution.

Institutions aim to manage risk in a financially prudent way. Patients can therefore be seen as commodities associated with cost and risk (Cheetham et al., 2018). Collaboration and communication with patients therefore become resource intensive. Only by focusing on the relational can mental health services be restructured to address prevailing power imbalances and biomedical frames (Hörberg & Dahlberg, 2015). Staff can gain fulfilment in their work and sustain a valued professional identity through involvement practices (McKeown et al., 2016). Critical reflection, innovation and reciprocal exploration, explanation and clarity through open dialogue with patients are needed to challenge historical and political power constructs (Roberts, 2005).

The landscape of a secure unit is permeated with overt and hidden power imbalances maintaining its institutional nature, largely impacting on patients negatively. Such landscapes are complex; simultaneously boring yet stressful. The apotheosis of separation was the staff office, sucking in staff and blowing patients away with invisible lines and impermeable barriers. From the patients' perspective, students overwhelmingly enabled a positive landscape, resisting the vacuum of the office. Hence, evidence of resistance to power relations (Foucault, 1978).

7.3 Conclusion

This chapter has provided a rich tapestry of the participants experiences synthesised alongside key Heideggerian and other concepts.

In the time patients and students share together they were *being-with*. They had a laugh, engaged in activities and ordinary talk, and watched television with cups of tea, the everyday mundane, sharing a lasting connection. The patients and students shared common interests and through *being-with* created a temporal and spatial *bubble*, within which, via reciprocal

teaching and learning and shared experience of being assessed, a deep sense of recognition was transacted; of humanness, value and worth. Their relational connection forming the *bubble* is *leaping-ahead* (empowering) balanced alongside set identities operating to restrict recognition of humanity in the dehumanising landscape with *the one; holder of keys, leaping-in.* The impact the patients and student have on each other is immeasurable.

When patients and students experienced their *bubble* it allowed what mattered to be foregrounded, getting rid of the noise of the landscape, roles and identities. For the students it was being able to help someone and make a difference, consolidating their calling to nursing without reifying a professional identity or role. For patients, what mattered was being worth something, being valued and not just identified as a '*mental patient'*. They are '*just people'* (Fred and Jasper) and have value.

In the following chapter, I conclude my thesis and consider the strengths and limitations of the research. Recommendations for further research, practice and education are presented and I end, where I started, with personal reflections on my journey.

8 Conclusion chapter

The previous chapter discussed the findings from this study in relation to key concepts of Heidegger and other phenomenologists, other theorists in philosophy, sociology, psychology and pedagogy and key studies explored in the integrative review chapter among other research, which were explored as structured by the themes illuminated in the findings chapter. The three themes were *Everyday stuff, Balance and Impact.*

8.1 Introduction to the chapter

This final chapter concludes the thesis by giving a summary of the study findings, illuminating the unique contributions of the research and how the study has extended current knowledge. This is the first in-depth study to explore patients' and student mental health nurses' lived experiences of the time they share together on secure personality disorder units for men. Exploration through an interpretive hermeneutic lens offers a unique perspective. I will outline the strengths and limitations and also offer recommendations for further research, practice, and education, and give a final commentary. I end with personal reflections on my journey.

8.2 Aim

'To illuminate the lived experiences of the time patients and student mental health nurses share together on secure personality disorder units for men.'

This study has achieved its aim of illuminating the lived experiences of the participants' time shared.

The aim in hermeneutic research is to '*interpret human meaning and experience to give insight into understanding the human experience of being-in-the-world in ways which resonate with*

others' (Dibley et al., 2020, p. 117). Hermeneutic phenomenologists want to enlighten and make a difference to others for whom the topic matters (Dibley et al., 2020). I hope in your reading you have resonated somehow with the findings.

8.3 Summary of study findings

The study findings illuminate that when the students and patients shared time together they were *being-with* in their own time and space, where they shared an experience of togetherness which enabled them to feel that they were '*just people'* (Fred and Jasper) and had value, which had lasting impact*.* They connected with each other creating a *bubble,* despite their experiences of *thrownness* into the world and the landscape, or for patients through the bearing of diagnostic labels. Together, the patients and students engaged in the mundane everyday, such as activities, connecting over common interests and having a laugh. They shared reciprocal identities of teacher and learner, and the shared experience of being assessed. The time students and patients shared together was a gift that had a powerful impact on their sense of humanness, and feelings of value and worth.

The students experienced a balance between *therapeuticness* (*leaping-ahead*) and professionalism (*leaping-in*). *Therapeuticness* involved a holistic approach that was an all-encompassing, supportive and humane approach that lived through everyday stuff and *being-with,* ultimately enabling the creation of a *bubble* and recognition of humanness. Professionalism encompassed risk aversion, restricting identities, roles, and power constructs. Such a balance can be made through innovative practices and patient involvement.

The landscapes of the secure settings were permeated with overt and hidden power imbalances, with the pivotal panoptical eye of the staff office, sucking in staff and blowing patients away with invisible lines. Students were immune to the vacuum of the office and were

‘*sponges’*. Students were viewed as the most positive staff group to the patients. This appeared to be due to patients believing they had more time, were there because they wanted to be (not paid) and were learners. They were available. These elements are not fully present with other staff due to set roles, making students unique and valuable. Students, although positively viewed as ‘*sponges’,* could become *holder of keys* (the workforce, *the one)* when they became enculturated. However, some could ‘*weather the ride’*; by focusing on the everyday mundane, *being-with* and connecting with patients to create the *bubble.*

When the students and patients connected with each other it had powerful implications for their sense of humanness and value, highlighting the importance of having student nurse placements on such wards. In going back to the roots of the time people share together we can attempt to understand the parts and the whole of their experiences and make sense of what is important (Heidegger, 1927/2019).

8.4 Unique contributions

This study has made a number of unique contributions to the existing body of literature, filling gaps in the evidence base not previously researched on secure personality disorder units specifically, or more broadly. This study offers insight into what is known about the experiences of patients and students and their time shared on secure personality disorder units. This uniqueness is demonstrated by the following addition to knowledge:

1. Unique contribution to knowledge attributable to the first use of interpretive hermeneutic phenomenology as methodology and analysis to explore shared experiences between two groups: patients and students, in secure settings.

2. The impact the students have on patients' quality of life is overwhelming. This is in relation to their recognition of humanness, in addition to patients' development of the identity of teacher.

3. Development of the *bubble* metaphor to represent the time and space patients and students share together that impacts on them both significantly. In their *bubble* they connect and find '*we're just people'* and have value despite *thrownness* into the world and the landscape.

4. The mundane everyday, including having a laugh and connecting over common interests, are *the* most important factors in the development of connections between patients and students in secure services.

5. Patients help students settle into their placements and can teach them about their experiences and impact of diagnostic labels such as personality disorder. Such roles give patients an identity and worth.

6. Development of the Balance of *therapeuticness* to depict the students' experience of balance on their placements, where they must manage *therapeuticness* and professionalism. They can manage this well and challenge power constructs by being present (available), using themselves, engaging in the mundane everyday and being innovative and creative.

7. Students are '*sponges'*, they are learners and fresh, however they can become *holder of keys* and part of the institution as *regular* staff. Some can '*weather the ride'* and resist; by focusing on the everyday mundane, *being-with* and connecting with patients to create *bubbles.*

8.5 Strengths and limitations

It is essential to consider the strengths and limitations of any research project to ensure a considered approach is offered.

> '*Imperfection is a gift'* (Dibley et al., 2020, p. 104)

This specific research area had not been explored before, hence, conducting the literature search was a challenge; especially considering the lexicological nature of the search terms, particularly time and personality disorder. This led to a large review that was systematic and aided in the development of an in-depth understanding. However, as explored in the integrative review chapter[149], such an understanding has complexity in phenomenological research, with caution of influence of reading on the researcher (Holloway & Wheeler, 2010), and reduction in focus of the participants' lived experiences. Nevertheless such a review is essential for completion of doctorate study (Walsh & Downe, 2006). In addition to highlighting a gap and provoking thinking (Smythe & Spence, 2012).

Potential bias is often raised as a weakness of interpretive phenomenological studies, however in hermeneutic studies this '*bias'* or human factor is the interpretation of the research and a core component (Carman, 2003) and its greatest strength (Lewis-Hickman, 2015). As explored in the methodology chapter[150], such pre-understandings (Heidegger, 1927/2019) or *prejudices* (Gadamer, 1967/1976) are essential elements of hermeneutics and thus a strength of this research. This was an ontological project concerned with understanding lived experiences and bringing commonalities to light (Crowther, 2014) and thus I am always *in* the research.

[149] Chapter 3.
[150] Chapter 4.

Robust research rigor and uniqueness of this research are its key strengths. Through using reflective logs, focused supervision and robust data collection and analysis, the research project had sound research rigour[151].

The relatively small sample size is a strength of this study rather than a limitation, despite common conceptions in positivistic research (Crotty, 1998). Phenomenological studies do not seek to answer how much or how many. Hence, the complexity of measuring outcomes of relational approaches. As stated by McAndrew et al. (2014) you cannot quantify specific interactions. The limitations of qualitative research, for example sample size, are often in conflict with the research goals and are therefore not reason for concern (Soss, 2014). A preoccupation with generalisability in studies represents a misunderstanding of the importance of qualitative research (Walsh & Downe, 2006). Qualitative research aims to explore the '*how'* and '*why'* to illuminate phenomena not make generalisable findings. Smith (2018) argues that it is a misunderstanding to claim that qualitative research lack generalisability. Qualitative studies can be generalisable, but not in the same way as quantitative studies (Smith, 2018). Although this is one study in medium secure services for men (across two sites in the North of England), it may not be representative of other areas. However, in exploring the contemporary evidence base this study has resonance with other areas. Of course, further research would bring added insights into this minimally researched area.

One limitation of the study was participation choice. Dickens et al. (2014) and Simms-Sawyers et al. (2020) argue that patients who choose to participate in research may be more compliant and less likely to share strong opinions. Hence, participants who are considerate and

[151] As explored in chapter 5.

thoughtful may engage in research, however participants who have different, though equally important experiences may not.

A further consideration Carolan (2004) highlights is if the participants potentially offer the right story as there can be an inherent bias of social desirability in social science research. However, the participants did discuss more problematic experiences as well as joyful ones. Additionally, retrospective accounts, though valuable, may not be wholly accurate (Simms-Sawyers et al., 2020), hence the decision to interview participants while students were on placement rather than after completion.

It is also important to consider power imbalance in the interviews, although I was external to the unit and a *researcher.* Simms-Sawyers et al. (2020) argue that patient participants particularly may still view researchers as part of the system, resulting in censored responses. Nevertheless, the participants enjoyed exploring their experiences, and feedback from patients when presenting my study early in the research journey, they believed participating would be therapeutic. Having the space and time with someone interested in your experiences can certainly be of a therapeutic nature, and certainly appeared to be for the participants.

8.6 Recommendations

6.4.2 Practice

1. Where possible any service supporting patients with mental health problems, should have student mental health nurses on placement continually. Liaison between local university academic assessors (link lecturers), practice education facilitators and practice staff should occur regularly to review and increase student capacity, with clearer promotion of the value of students for practice landscapes and patients.

2. There needs to be increased support from placement staff for students to share time with patients and prioritise this time. Exploration in staff team meetings to develop an approach to this, with patients input, would be helpful. Students' time with patients should focus on the mundane everyday, having a laugh, engaging in activities, watching television, having a cup of tea, spending time just being around, building connections through sharing common interests and everyday talk. Ward staff should ensure access to activities and support for students accessing materials needed.
3. Secure services and services supporting people carrying a personality disorder diagnosis should focus on the mundane everyday and recognise humanity (*therapeuticness* and *leaping-ahead*) while managing roles, risk, power dynamics and identities (*leaping-in*) to enhance the quality of care for patients. Services should support innovative practices and patient involvement to effectively manage this balance.
4. Practice areas should support patients in teaching students and helping them settle in. As part of this they could explore giving patients identified roles, while protecting the spontaneity of such experiences. Exploration of such approaches, during community meetings with patients, to gain expressions of interest in addition to considering practical planning, would be an important element. This should include liaison with named/ key nurses and the multidisciplinary team where appropriate. For example, patients may want to meet students on their first day, introduce them to other patients and the environment, or patients may like to teach students about certain topics.
5. Patients should be encouraged by practice staff to feedback on student nurses' time on their placements to support student nurse development. This would include exploration in community meetings with patients to develop an appropriate approach to this.

6.4.3 Education

1. There should be a stronger foundation and deeper understanding on the significance of the mundane and everydayness in nurse education. Higher education institutes should embed the importance of the mundane in curriculum planning and ensure a core thread throughout nursing courses. This would be through each module (part), aligned with learning on placements, with theoretical and practical sessions at various points in the curriculum and ongoing reflections to build on development and knowledge. This maps to Annex A of the (Nursing and Midwifery Council, 2018c), and though included in nursing curriculums is often not a core component.
2. Further focus is needed in nursing education to support students to build hobbies and interests to support the building of connections with patients over common interests. Universities should consider the planning of sessions around student union schedules to ensure nursing students have access to activities. In addition to this, placement staff could support students, where possible, in planning their shifts to incorporate time for these activities, of course while considering the completion of their practice hours.
3. Higher education institutes should encourage students to review positive feedback they have received regularly and especially when struggling with self-confidence. Academic advisors (personal tutors, year tutors) could utilise home (year) group meetings or individual meetings to specifically explore any feedback students have received from patients in their placement areas and build this into reflective diaries or portfolios.
4. Further focus is needed on exploring the recruitment process and potential for the development of specific sections in recruitment paperwork around the importance of psychosocial skills and friendliness. In addition to interviewers' joint discussions to enable a robust approach.

6.4.1 Further research

1. Minimal research has explored the use of humour in secure services or with patients carrying a personality disorder diagnosis or with students, hence further exploration of the experiences of patients carrying a personality disorder diagnosis and of the use and impact of humour in secure services is warranted. In addition to exploration of mental health nursing students' experience of the use of humour on their placements.
2. Exploration of secure nurses' and patients' experiences of sharing time in secure personality disorder units. Joint and individual interviews could be considered. In addition to more specific qualitative exploration of patient and staff experiences of the mundane everyday in secure services and settings supporting patients carrying a diagnosis of personality disorder.
3. Further exploration of patients' experiences of sharing time with staff; specifically linked to perceived identities and roles, and the impact of these on patient perceptions and experiences. In addition to exploration around the concepts of *holder of keys* and the panoptical eye of the office in secure settings.
4. Specific exploration of experiences of the balance of *therapeuticness* and professionalism for students, other staff and patients is warranted. Also, in relation to the experience of the transition from student to nurse and the impact on their time with patients, as experienced in this balance.

8.7 Final comments

This thesis is a call to all to foster the mundane, the everyday and recognise the humanity in others. Student nurses, you can balance *therapeuticness* and professionalism. Be yourselves, have a laugh with patients, connect with them over shared interests and make *bubbles*. This thesis is a message of hope for people residing in often dehumanising places, such as secure units, who may have experienced *thrownness* into the world and traumatic experiences and labels, that you can experience humanity and you have worth and value.

To students, the time you share is powerful, beautiful and a gift to patients. To patients, the time you share is powerful, beautiful and a gift to students.

'*We're just people after all'* (Fred, patient)

8.8 Concluding reflections

I began the thesis by introducing myself and throughout the thesis you can see *me* in the writing. I will therefore end the thesis by reflecting on my experiences of completing the study, in true interpretive hermeneutic phenomenological study style. Throughout my study I have completed a reflexive diary, it has been enlightening to read previous entries as I have continued on my research journey, making note of my reflections at all points. Seeing my personal and academic development over time has been empowering. Please see the appendices[152] for some excerpts from my reflective diary in addition to a summary of key experiences below.

[152] Appendix 30.

Overtime, the focus on my research question developed, as Dibley et al. (2020) states, the researcher should move back and forth between ideas in a nonlinear fashion, to give the golden thread to tie the methodology and philosophy. My initial aim was to explore participants' experiences of the therapeutic relationship, however, as discussed in earlier sections, that would have been presuming there was a relationship, and that this was the phenomena and would potentially restrict the showing of the true phenomena/s. A further initial focus was on antisocial personality disorder, however this raised concerns of identifying patients with that diagnosis which, as discussed in the background chapter[153], is inherently flawed. The focus was therefore on patients and students experience of the time they share together. As my knowledge increased from completing my integrative review, methodology chapter and various training and specialist hermeneutic courses, so too did my study aim and focus.

Completing ethics and accessing the units were difficult and time-consuming periods during my doctorate, though I was rewarded with the rich, powerful, and exciting findings from my time with the participants.

I connected with the literature and participant data as the findings joined with my own thinking, creating a fusion of horizons (Gadamer, 1967/1976, 1975). I became attuned to the value, powerfulness, and beauty of the *bubble* the participants experienced. Although *I* changed and my understandings developed as I read and re-read the stories, my attunement gave the findings life and maintained a thread.

Part way through completing the study I had my first baby, Arthur, and so interrupted my studies (Oct 2018-Dec 2019). I had already written some chapters in draft and conducted some interviews. Which I transcribed while on maternity leave. It is important to acknowledge

[153] Chapter 2.

this as considering Heidegger's *fore-structures*, mine changed/ adapted/ altered with becoming a mother. My plans, goals and interests shifted. I found myself keen to complete my study and doctorate while managing going back to work and being a parent. I found it difficult returning to work, continuing to study, and ensuring I was being a present mum. Time management was the biggest challenge.

In March 2020 shortly after returning from maternity leave, Covid-19 pandemic affected the world. During this time, I was working from home without childcare and had limited time and space to focus on my study. This was an exceptionally difficult time, where I needed counselling to manage and I am proud that I continued to keep working on my thesis. It was something I enjoyed and was passionate about. Alongside my family, it became a positive focus for me. I could see the progression and development in completing it, aiding to my sense of achievement and it was also something I was in control of during a time when I had little control.

At many points I reflected on myself, my learning and development, no time more than when I was lucky enough to undertake a sabbatical from work. During this period, I delved deeply into philosophical reading, particularly Heideggarian and other concepts, which was enlightening while also perplexing, the state Heidegger was aiming for (Cerbone, 2008). At this point everything I was reading and experiencing was somehow linked to my study and my learning from it.

I continued to develop myself and my thesis during the second hermeneutic course I was privileged to attend, which was essential in developing my understanding of hermeneutics. The difficulty I felt in completing the final version of my thesis was huge, there had to be a time when I stopped and was happy I had done enough at that point, accepting that it was only the beginning of my next journey.

I have experienced periods of euphoria and excitement that I will treasure, alongside confusion and exhaustion, which I will also treasure.

> *'Perhaps one becomes wise; yet paradoxically one is left feeling humble.'* (Smythe, 2011, p. 51)

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10 Appendices

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APPENDIX 1: Glossary

Here I provide a glossary of common terms referred to through the thesis. I do not provide references for these as they are provided in the thesis text. Heideggarian terminology is in many ways unusual and frequently described as complex, hence in order to aid the reading of this work, and prevent constant definition throughout, I provide a brief summary of terms.

These are my understandings and interpretations of these terms at this point in time from my exploration and reading up to this point, others may have alternate, equally acceptable interpretations. They are not a definitive nor perfect list, merely an additional resource for the reader for ease. I acknowledge the challenge and restriction of language and hence understand Heidegger's decision to invent terms and hope I do them justice. As Dreyfus reflects of his work, I may return to these in the future and develop my understanding or even change my thinking.

Authentic	Heideggarian term. To be *authentic* means to be our own, it is not about being morally good, it is to make our own decisions and take more agency over our lives and questioning what we do. This may mean behaving against cultural norms.
Being-with	Heideggarian term. We are always with others, physically or influenced by, we share our world, we are interconnected, never without others. We are social beings. Being-in is *being-with.*
Bubble	My term. The space and time students and patients share where they connect to each other. Through just being around, having a laugh, engaging in the everyday and connecting over common interests, they share a recognition of humanness and value, outside of identities, roles, landscapes and temporality.
Dasein	Heideggarian term. Literal translation *being-there.* It is the notion of the existence of *being.* Heidegger's term for explaining the interconnection of a *being* and the world; *being-in-the-world. Dasein* is a *being* that relates itself to/ toward itself[154]. The kind of *being* that belongs to persons, an entity itself.
Fallenness	Heideggarian term. To become *fallen* away from itself and absorbed in the world is to be *inauthentic,* which is not a bad thing, it is a way of coping or dealing in the world. We are doing as *one* does.
Hermeneutics	The philosophy of interpretation, moving beyond description. Hermeneutic research interprets data; often written information to make sense of its meaning, to reveal the meaning of human experiences.
Idle talk	Heideggarian term. Where people make conversations or engage in chatting (not in a disparaging way). It is a positive phenomenon of the kind of *being* in the everyday. Can lead to derivative talk that leads to trivialisation or gossip, idle curiosity can cover up what really matters and become a distraction.
Inauthentic	Heideggarian term. When we are *inauthentic* we are conforming and adopting what others do without challenge, we have *fallen. Inauthenticity* is not necessarily a negative state, it is a state of coping in the world.

[154] Liz Smythe's anecdote explains *Dasein* in an accessible way on page 45 of her chapter in Thomson, Dykes and Downe (2011) book: Qualitative research in midwifery and childbirth.

Interpretivism	A paradigm/ perspective attempting to understand and explain human and social reality. Hermeneutic phenomenology sits with interpretivism. We constantly interpret the world. Interpretative research acknowledges and values the researcher being *in* the research.
Leaping-ahead	Heideggarian term. A mode of solicitude (care). Empowering others, being an enabler, leaping forth and liberating.
Leaping-in	Heideggarian term. A mode of solicitude (care). Deciding for or controlling others, dominating, taking over or taking care away.
Mundane	Ordinary/ everyday things and talk, everyday stuff. Mundane materialities are places, buildings and objects like the television or a pack of cards. Mundane care relates to ordinary/ everyday practices, that are fundamental.
Phenomenology	Philosophical approach/ movement/ style/ tradition of thought interested in understanding experiences. Phenomenology means letting things show themselves as they are. Phenomenological research explores participants' experiences of everyday life to uncover and illuminate a phenomenon (something of interest and importance; something that shows itself as it is in itself). Hermeneutic phenomenological research explores the complex nature of *being human* and asks what means to *be human.* It values participants and researchers in all aspects of the research.
The one	Heideggarian term '*Das Man'*. Or sometimes referred to as *the they* or *the Anyone*, people following cultural norms. We do as one does. We can conform to *the one* and become *fallen.*
Therapeuticness	My term. A holistic approach that is therapeutic; a supportive and human approach that lives through everyday stuff, sharing common interests, ultimately enabling the creation of a *bubble* and recognition of humanness. Encompasses the experience of therapeutic practices, activities, atmosphere and landscapes, recognition, being friendly, use of self, self-disclosure, validating practices etc.
Thrownness	Heideggarian term. We are *thrown* into the world/ come into the world, *thrown* into a life situation or particular circumstances (culture) that can shape our existence/ lives.

Care structure (fore-structures/ temporality)

I also include a visual presentation of my understanding of various terms and concepts Heidegger uses. This helped me attempt to understand the concepts. Again, making clear that these are my understandings and interpretations of these terms at this point in time from my exploration and reading up to this point, others may have alternate, equally acceptable interpretations. They are not a definitive nor perfect list, merely an additional resource for the reader for ease and clarity. I also want to highlight that boxes and lists are not fitting with free-flowing hermeneutic phenomenology, however as a novice hermeneutic researcher was an aid to my learning.

Past (already being in a world)	Present (being alongside/ amidst)	Future (being ahead of itself)
Fore-having	Fore-sight	Fore-conception
Thrownness Facticity Historicity Moods	Fallenness, coping in the world (absorption), inauthentic acting as the one Idle talk (and discourse)	Understanding Projection Pressing into possibilities Authentic (ability to be)
Being-with		

Ways of being ('as' structure)

Present-at-hand	Ready-to-hand (unready-to-hand)	Existence
Substance/ Objects	Equipment	Dasein

APPENDIX 2: Further information to supplement background chapter

Mental health

'Mental health' is a broad term which is difficult to define (Ellis & Day, 2018; Kingdon, Rathod, & Asher, 2017). It is unique to all of us, what might be *'mentally healthy'* for one person may not be for another. It is a completely individual concept and is influenced by surrounding environmental and societal systems that we develop and live in.

Anyone can develop a mental health problem at any point. 1 in 4 people experience a mental health crisis at any time in their life (Ryrie & Norman, 2018; The Health & Social Care Information Centre, 2009). There are many reasons why someone may develop a mental health problem, which can be due to biological, psychological or social reasons (Kingdon et al., 2017). If someone is struggling to cope, is unable to function on their own or are a risk to themselves or others, because of their mental health problem, they may come in to contact with mental health services.

Some common mental health problems associated with diagnoses include; depression, anxiety, dementia, personality disorder, schizophrenia, bipolar, posttraumatic stress disorder to name a few (National Institute for Health and Care Excellence, 2011).

History of personality disorder

Both ancient Chinese and Greek offer psychological explanations for personality types, with the first system in 371BC (Crocq, 2013). The term ''*personality' has been used since the 18th century to designate the distinctive individual qualities of a person'* (Crocq, 2013, p. 149), Zachar and Krueger (2013) argues 19th century France. '*Philippe Pinel (1745–1826) was the first author to include a personality disorder in psychiatric nosology'* (Crocq, 2013, p. 149). *'Emil Kraepelin (1856–1926) introduced personality types into modern psychiatric classification, under the term 'psychopathic personalities''* in approximately 1904 (Crocq, 2013, p. 151), he conceived them on a continuum with other mental disorders, as further developed by Kretschmer (Livesley, 2001a). In the 1920s Schneider used '*psychopathic personality'* as a general term for all personality disorders and considered theses to be clinical rather than moral conditions (Zachar & Krueger, 2013). Jaspers distinguished between personality development and disease processes and argued against simple diagnostic categories in the DSM (Livesley, 2001a).

Antisocial personality stemmed from the term '*moral insanity*', then psychopathy or sociopathy (Walsh & Wu, 2008) and has been included in all the DSM classifications. However this does not bare resemblance to the modern construct (Zachar & Krueger, 2013). Borderline and narcissistic personality disorders only entered the DSM-III (American Psychiatric Association, 1980), although emotionally unstable was included in the first edition (American Psychiatric Association, 1952). The term '*borderline personality'* was proposed by Adolph Stern in 1938 from individuals presenting on the edge of neurosis and psychosis (Iqbal, French-Rosas, Banu, Jin, & Shah, 2020). Since the publication of the DSM III in the 1980s interest in the topic has grown (Livesley, 2001a; Zachar & Krueger, 2013).

Medication

Although medication can offer '*symptomatic relief*' (p. 13) for people with a personality disorder diagnosis, there is no evidence to support the effectiveness of medication (Royal College of Psychiatrists, 2020). Thus, it is concerning that 92% of patients carrying a personality disorder

diagnosis are prescribed medication in the United Kingdom (Paton, Crawford, Bhatti, Patel, & Barnes, 2015), despite NICE guidance discouraging the use of medication (National Institute for Health and Care Excellence, 2009, 2013). There are additional concerns raised around polypharmacy and overuse of medication for patients carrying a personality disorder diagnosis (Royal College of Psychiatrists, 2020).

Trauma informed care

Trauma-informed care/ approaches, although beginning in the United States of America are now being focused upon in United Kingdom services and are showing to be beneficial for people who have experienced trauma or adversity (Sweeney et al., 2016; Sweeney et al., 2018) and particularly for people carrying a borderline personality disorder diagnosis (Muskett, 2014). Often such terms as '*manipulative'* and '*attention seeking'* are used to describe people who carry the diagnosis, however trauma informed approaches see this as people trying to cope using an interpersonal strategy as a result of experiencing ACEs (Stevenson & Taylor, 2020; Sweeney et al., 2016). Team formulations have been found to be particularly important in supporting patients carrying a borderline personality disorder diagnosis to work towards their recovery (discovery) and also help teams work more consistently (Dean, Siddiqui, Beesley, Fox, & Berry, 2018). Trauma informed formulations are recommended in the Consensus statement (Consensus Statement, 2018).

Measuring attitudes

The research on attitudes towards personality disorders is mainly quantitative using survey methodology, for example the Attitude towards Personality Disorder Questionnaire [APDQ] (Bowers & Allan, 2006) or the Personality Disorder – Knowledge, Attitudes and Skills Questionnaire [PD-KASQ] (Bolton, Feigenbaum, Jones, & Woodward, 2010). Such surveys are useful to gather data about attitudes (McKenna, Hasson, & Keeney, 2010) or evaluate educational programmes, such as the Knowledge and Understanding Framework [KUF] (Finamore et al., 2020). However, if a person is aware a study focuses on attitudes they may change their response or respond in a perceived socially desirable way (Linden & Kavanagh, 2011). It is important to combine surveys and qualitative methodologies to allow for deeper exploration of issues (Munro & Baker, 2007). Although attitudes and thoughts are fundamentally linked, the term 'attitudes' has an emotional tone attached (Sapsford, 2007). The diagnosis of personality disorder is an interpersonal diagnosis therefore it may be difficult to quantify thoughts; they need to be explored and discussed, hence the importance of further qualitative exploration.

Pedagogy

Student nurses' learning is divided between university and clinical placements, with universities deploying a range of teaching strategies. It is important that students' learning styles be considered in nursing education (Race, 2020). However, although students may have a dominant learning style, they adopt various styles depending on the situation (Race, 2020). For example, students who are reflectors need time and space to think through any activities set them by lecturers, and activists need opportunities to try new things. As Freire said, humans are gifted with creative imagination to see what is but also what could be (Crotty, 1998). Arguably, higher education nursing programmes should encourage such creativity.

In line with the Pyramid of Learning (Bloom & Krathwohl, 1956) through each year of education, student nurses develop from observing practice to performing skills independently or with minimal supervision, as knowledge, and confidence or feelings of empowerment grow (Bradbury-Jones, Irvine, & Sambrook, 2010). Students' learning experiences have to be

relevant to the professional role (Hurlimann, 2013) such as utilising case examples to consolidate theory-practice links. Teaching that integrates theory and practice develops a positive learning environment (Neary, 2000; Race, 2020).

Engagement

The term '*engagement'* can be problematic, it has been widely used which has led to a blurring of its meaning (Barker & Buchanan-Barker, 2005). It can describe a '*service'* that is empowering and experienced, or the initial forming of a relationship, making a connection (Ellis & Day, 2018), that is necessary to work with people in distress (Barker & Buchanan-Barker, 2005). Making an initial connection opens opportunities for dialogue in order to examine a person's story (Ellis & Day, 2018). Engagement is often used interchangeably with interaction (Videbeck, 2009).

It is important that patients feel safe to discuss their story. For this to be facilitated nurses must engage with patients to develop the trust crucial for the establishment and maintenance positive relationships (Langley & Klopper, 2005; Reyre et al., 2017). An important aspect of developing trust is to build on common interests, which can be enhanced by use of humour (Ghaffari, Dehghan-Nayeri, & Shali, 2015; Gildberg et al., 2014; Greenberg, 2003; Minden, 2002). Doing things together or talking about '*normal stuff*' are engagement strategies that promote positive experiences for patients and staff (Jones & Wright, 2017, p. 536). Staff members' interpersonal style is an important part of this (Daffern et al., 2010).

Person centred core conditions

Core principles when engaging with patients that Rogers (1951) and others highlight include empathy, genuineness, honesty and unconditional positive regard (Ellis & Day, 2018). Empathy is the outcome of active listening skills nurses use during interactions with patients (Maatta, 2006). However as stated by Stenhouse and Muirhead (2017) it has been argued that nurses struggle expressing empathy. This has been highlighted during large scale health care reviews such as the Mid Staffordshire investigation (Francis, 2013) and more recently Darzi (2018). Empathy enables us to see and meet the needs of patients enabling the development of therapeutic relationships (Khodabakhsh, 2012). It is therefore important that nursing students develop their ability to empathise with patients (Heggestad et al., 2016). A study by Khodabakhsh (2012) found that if students have a secure attachment style they are more likely to experience and show empathy, which strongly influences the relationship.

By positively engaging with each other, nurses and patients collaborate to develop and achieve goals (Arnold & Boggs, 2015). Arguably, the quality of engagement is the most important factor in determining nursing effectiveness (Brough, 2004), hence, McAllister and McCrae (2017) argue for greater focus on therapeutic engagement in nurse education. It is important however, to maintain boundaries in therapeutic relationships and be aware of self-disclosure (Ashmore & Banks, 2001; Ashmore & Banks, 2003). Self-awareness is a key tool to ensure appropriate and helpful engagement leading to development of trust and positive nurse-patient relationships (Barker & Williams, 2018; Scheick, 2011).

APPENDIX 3: Medical subheadings search terms

Medical subheadings [MeSH] terms were reviewed to ensure the search terms were correct.

Table 7: Medical subheadings search terms

MESH	Nurse-Patient Relations	Personality Disorders	Antisocial Personality Disorder	Students, Nursing Education, Nursing		Qualitative Research	Interview	Forensic Nursing	Patients	Psychiatric Nursing Mental Health Services
Cinahl	Nurse-Patient Relations Professional-Client Relations Student-Patient Relations	Personality Disorders Antisocial Personality Disorder		Students, Nursing Students, Pre-Nursing Students, Nursing, Practical Education, Nursing	Phenomenology Phenomenological Research	Qualitative Studies	Interviews	Forensic Nursing	Psychiatric Patients	Psychiatric Nursing Mental Health Services Hospitals, Psychiatric Psychiatric Nursing
PsychARTICLES PsychINFO	Dual Relationships Therapeutic Alliance Interpersonal Relationships Therapeutic Processes	Personality Disorders Antisocial Personality Disorder		Nursing Students Nursing Education	Phenomenology	Qualitative Research	Interviews Interviewing	Forensic Psychiatry?		Psychiatric Nurses?
Mesh 2017 thesaurus on Proquest	Nurse-Patient Relations	Personality Disorders Antisocial Personality Disorder		Students, Nursing Education, Nursing		Qualitative Research	Interview			Psychiatric Nursing Hospitals, psychiatric
Proquest	Nurse-patient relationships Client relationships	Personality Disorders Antisocial Personality Disorder Dissocial personality disorder		Nursing education	Phenomenology Phenomenological Research	Qualitative Research	Interviews		Patients	Mental institutions

APPENDIX 4: Ovid search 1946-31.05.17

Following identification of the MeSH terms for each of the areas highlighted in the search term diagram, the table below shows the search terms used in the finalised search strategy.

Table 8: Search terms used (Ovid search 1946-31.05.17)

Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to Present

	1	2	3	4	5	6	7	8	9	10
Starting terms OR All fields to ensure full inclusion	Time Interact* Engag* Trust* Relation* Allianc* Nurse-patient relation* Therapeutic relation* Therapeutic alliance Helping relation* Working relation* Helping alliance Working alliance Professional relation* Professional-Client Relation* Student-Patient Relation* Dual Relation* Client relation* NOT (searched separately) Interpersonal relation* Therapeutic milieu 274 Therapeutic landscape 330 Therapeutic environment 303	Patient* Service user* Client*	Nurs* student* Nurs* education Students, nurs*	Personality disorder*	Qualitative Qualitative research Qualitative Stud* (to refine)	Antisocial personality disorder* Dissocial personality disorder* EXTRA	Phenomenolog* Phenomenolog* Research Lived experienc* (to refine)	Interview* EXTRA	Secure Forensic Secure mental health Forensic mental health Forensic nurs* EXTRA	Mental health service* Psychiatric nurs* Psychiatric hospital* Psychiatr* Patient* Hospital*, psychiatry* Mental institution* EXTRA
Medline using OVID 31.05.17	6649973	6075791	47964	26130	186628	9807	24078	324056	106501	128820

Table 9: Narrowed search (Ovid search 1946-31.05.17)

To explore specific studies, I narrowed my search terms further as highlighted in the tables below. Please refer to table 10 for search terms- 1- time and so on.

31.05.17	Shortlisted	Saved [Duplicates removed]		Shortlisted	Saved [Duplicates removed]
1AND2AND3 – 5099			1AND2AND3AND5AND8 – 331	39	34 [25]
AND 4 – 6	5	5 [4]			
AND 5 – 706			6NOT4 – 60	2	2
AND 6 – 1	1	1 [0]			
AND 7 – 146	20	13	Interpersonal relation* NOT 1 – 0		
AND 8 – 666			Therapeutic environment not 1 – 167		
AND 9 – 27	5	5	Therapeutic milieu not 1 – 129		
AND 10 – 369	79	66 [58]	Therapeutic landscape not 1 – 220		
			OR – 511 AND 10 - 95	9	9

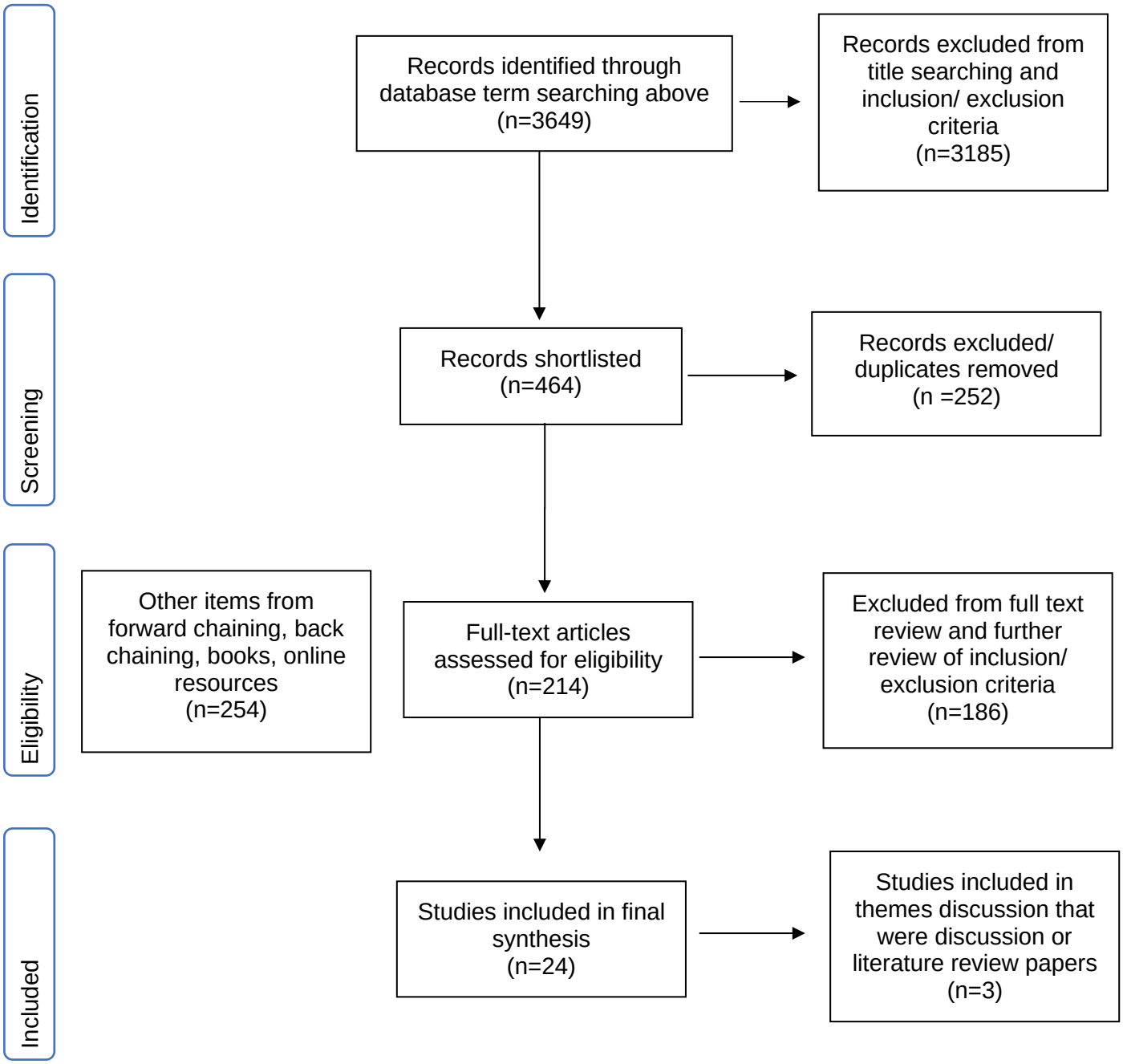
Table 10: Specific searches (Ovid search 1946-31.05.17)

25.06.17-07.10.17		**Shortlisted articles**	**Saved [Duplicates removed]**		**Shortlisted**	**Saved [Duplicates removed]**
1AND2 – 1890208	1AND2AND4AND7 – 73	8	6 [4]	1AND2AND4AND10AND7 – 10	3	3 [0]
1AND2AND4 – 4717	1AND2AND4AND5 – 86	10	9 [4]	1AND2AND5AND7AND10 – 145	13	10 [0]
1AND2AND5 – 35609	1AND2AND4AND9 – 260 [not 7 or 5]	9	7	1AND2AND5AND7AND9 – 22	4	4 [0]
				1AND2AND5AND7AND4 – 10	2	2 [0]
1AND2AND7 – 4506	1AND2AND4AND10 – 770			1AND2AND5AND10AND4 – 25	3	3 [0]
1AND2AND9 –7419	1AND2AND5AND7 – 1934			1AND2AND5AND10AND9 – 80	13	13 [0]
1AND2AND10 – 25500	1AND2AND5AND10 – 1601			1AND2AND9AND10AND4 – 124	21	13
	1AND2AND5AND9 – 354	23	23 [13]	1AND2AND9AND10AND7 – 14	3	3 [0]
	1AND2AND7AND10 – 345	32	30 [19]			
	1AND2AND7AND9 – 49	6	6 [1]			
	1AND2AND9AND10 – 1033					

	Shortlisted	**Saved [Duplicates removed]**		**Shortlisted**	**Saved [Duplicates removed]**
1AND3 – 14393			1AND3AND5AND10 – 103	22	
1AND3AND4 – 11	6	6 [0]	1AND3AND5AND9 – 15	2	2 [0]
1AND3AND5 – 1894			1AND3AND5AND7 – 161		
1AND3AND7 – 390			1AND3AND5AND4 – 4	2	2 [0]
1AND3AND10 – 652	27	26 [17]	1AND3AND10AND4 – 5	3	3 [0]
1AND3AND9 – 55			1AND3AND10AND7 – 21	4	4 [0]
			1AND3AND10AND9 – 13	2	2 [0]
	3	3 [0]			

	Shortlisted	**Saved [Duplicates removed]**		**Shortlisted**	**Saved [Duplicates removed]**
2AND3 – 10284			2AND3AND10AND5 – 98	22	22 [5]
2AND3AND4 – 6	5	5 [0]	2AND3AND10AND7 – 21	7	7 [0]
2AND3AND10 – 590			2AND3AND10AND4 – 3	3	3 [0]
2AND3AND5 – 1170			2AND3AND10AND9 – 14	2	2 [0]
2AND3AND7 – 214			2AND3AND5AND4 – 2	2	2 [0]
2AND3AND9 – 49			2AND3AND5AND9 – 11	2	2 [0]
	22	22 [11]	2AND3AND5AND7 – 99	14	14 [4]
	4	4 [0]			

Figure 10: Study eligibility flow diagram PRISMA (Ovid search 1946-31.05.17)



APPENDIX 5: Updated OVID search 2017-03.02.20

Following identification of the MeSH terms for each of the areas highlighted in the search term diagram, the table below shows the search terms used in the finalised search strategy.

Table 11: Search terms used (updated OVID search 2017-03.02.20)

Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to Present

	1	2	3	4	5	6	7	8	9	10
Starting terms OR All fields to ensure full inclusion	Time Interact* Engag* Trust* Relation* Allianc* Nurse-patient relation* Therapeutic relation* Therapeutic alliance Helping relation* Working relation* Helping alliance Working alliance Professional relation* Professional-client relation* Student-Patient relation* Dual relation* Client relation* NOT (searched separately) Interpersonal relation* Therapeutic milieu Therapeutic landscape Therapeutic environment	Patient* Service user* Client*	Nurs* student* Nurs* education Students, nurs*	Personality disorder*	Qualitative Qualitative research Qualitative Stud* (to refine)	Antisocial personality disorder* Dissocial personality disorder* EXTRA	Phenomenolog* Phenomenolog* Research Lived experienc* (to refine)	Interview* EXTRA	Secure Forensic Secure mental health Forensic mental health Forensic nurs* EXTRA	Mental health service* Psychiatric nurs* Psychiatric hospital* Psychiatr* patient* Hospital*, psychiatry* Mental institution* EXTRA
OVID	1195713	1122012	7303	4082	62372	727	6930	73017	23817	15557

Table 12: Narrowed search (updated OVID search 2017-03.02.20)

To explore specific studies, I narrowed my search terms further as highlighted in the tables below. Please refer to table 13 for search terms- 1-Time and so on.

	Initial shortlisting	**Duplicates removed [second shortlisting] [full text]**		Shortlisted	**Duplicates [second shortlisting]**
1AND2AND3 – 1236			6NOT4 – 0		
AND 4 – 1	1	0			
AND 5 – 266	28	8 [7] [0]	Interpersonal relation* NOT 1 – 0		
AND 6 – 1	1	0	Therapeutic environment NOT 1 – 5	0	
AND 7 – 34	8	7 [5] [1] Johansson	Therapeutic milieu NOT 1 – 7	0	
AND 8 – 202	31	7 [1] [1] McAlister	Therapeutic landscape NOT 1 – 80	0	
AND 9 – 14	3	2 [0]			
AND 10 – 41	15	7 [0]			

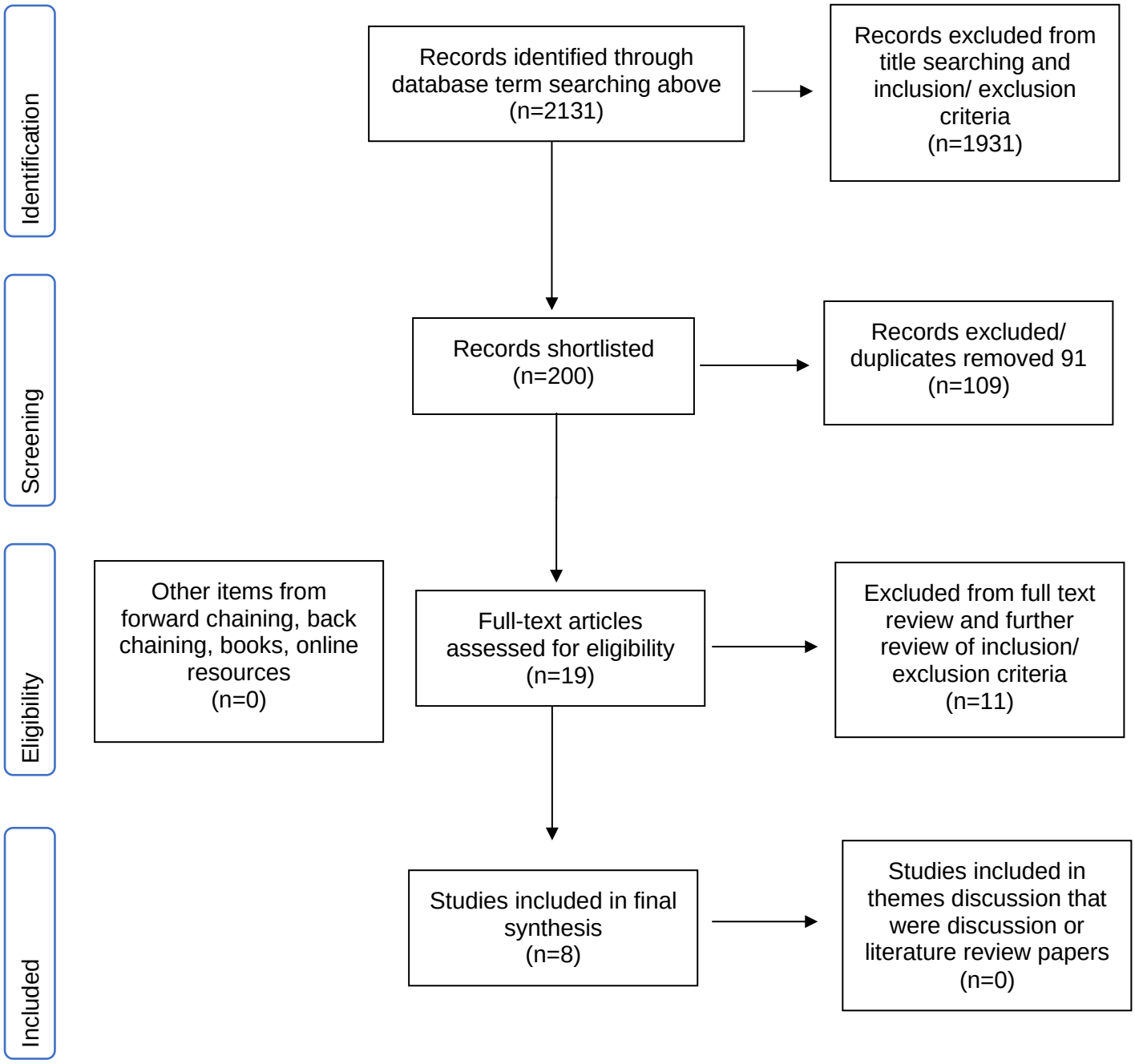
Table 13: Specific searches (updated OVID search 2017-03.02.20)

	4	Initial shortlisting	Duplicates removed [second shortlisting] [full text]	5	Initial shortlisting	Duplicates [second shortlisting] [full text]
1AND2 – 390216 1AND2AND4 – 822 1AND2AND5 – 1241 1AND2AND7 – 1409 1AND2AND9 – 2262 1AND2AND10 – 3908	1AND2AND4AND7 – 25 1AND2AND4AND5 – 40 1AND2AND4AND9 –52 1AND2AND4AND10 – 140 1AND2AND5AND7 – 860 1AND2AND5AND10 – 605 1AND2AND5AND9 – 179 1AND2AND7AND10 – 19 1AND2AND7AND9 – 118 1AND2AND9AND10 – 248	0 4 4 7 6 2 6 19	 3 [0] 2 [2] [1] Oostvogels 3 [0] 5 [2] Reavey, Mollerhoj 1 [0] 5 [1] Bacha 14 [0]	1AND2AND5AND7AND10 – 74 1AND2AND5AND7AND9 – 14 1AND2AND5AND7AND4 – 10 1AND2AND5AND10AND4 – 17 1AND2AND5AND10AND9 – 39	5 0 1 3 6	3 [1] Eldal 0 0 2 [0]

	Initial shortlisting	Duplicates [second shortlisting] [full text]	4	Initial shortlisting	Duplicates [second shortlisting] [full text]
1AND3 – 3030 1AND3AND4 – 1 1AND3AND5 – 714 1AND3AND7 – 97 1AND3AND10 – 85 1AND3AND9 – 23	 1 7 12 1	 0 5 [0] 7 [0] 0	1AND3AND5AND9 – 4 1AND3AND5AND7 – 65	1 5	0 3 [0]

	Initial shortlisting	Duplicates [second shortlisting] [full text]	4	Initial shortlisting	Duplicates [second shortlisting] [full text]
2AND3 – 2470 2AND3AND4 – 2 2AND3AND10 – 95 2AND3AND5 – 501 2AND3AND7 – 60 2AND3AND9 – 24	 1 10 6 1	 0 3 [0] [1] Yildiz 3 [0] 0	2AND3AND5AND9 – 6 2AND3AND5AND7 – 43	1 4	 1 [0]

Figure 11: Study eligibility flow diagram PRISMA (updated OVID search 2017-03.02.20)



APPENDIX 6: EBSCO search 1946 to 03.02.20

EBSCO- Academic Search Complete, AMED - The Allied and Complementary Medicine Database, British Education Index, Child Development & Adolescent Studies, CINAHL Complete, Criminal Justice Abstracts with Full Text, eBook Collection (EBSCOhost), Education Abstracts (H.W. Wilson), Educational Administration Abstracts, ERIC, Humanities International Complete, MEDLINE with Full Text, PsycARTICLES, PsycINFO, SocINDEX with Full Text, Social Sciences Full Text (H.W. Wilson)

Additional search terms included in EBSCO from OVID search in 1. Temporal*, Talk*, Connect*, Click*, Interpersonal relation*, Therapeutic milieu, Therapeutic landscape, Therapeutic environment.

Table 14: Search terms used (EBSCO 1946 to 03.02.20)

	1	2	3	4	5	6	7	8	9	10
Starting terms OR All fields to ensure full inclusion	Time Interact* Engag* Trust* Relation* Allianc* Nurse-patient relation* Therapeutic relation* Therapeutic alliance Helping relation* Working relation* Helping alliance Working alliance Professional relation* Professional-client relation* Student-Patient relation* Dual relation* Client relation* Interpersonal relation* Therapeutic milieu Therapeutic landscape Therapeutic environment Connect* Click* Talk* Temporal*	Patient* Service user* Client*	Nurs* student* Nurs* education Students, nurs*	Personality disorder*	Qualitative Qualitative research Qualitative Stud* (to refine)	Antisocial personality disorder* Dissocial personality disorder* EXTRA	Phenomenolog* Phenomenolog* research Lived experienc* (to refine)	Interview* EXTRA	Secure Forensic Secure mental health Forensic mental health Forensic nurs* EXTRA	Mental health service* Psychiatric nurs* Psychiatric hospital* Psychiatr* patient* Hospital*, psychiatry* Mental institution* EXTRA
	16,209,730	13,366,375	336,138	166,794	1,034,992	36,826	226,428	2,070,617	433,589	883,618

Table 15: Narrowed search (EBSCO 1946 to 03.02.20)

To explore specific studies, I narrowed my search terms further as highlighted in the tables below. Please refer to table 16 for search terms- 1-Time and so on.

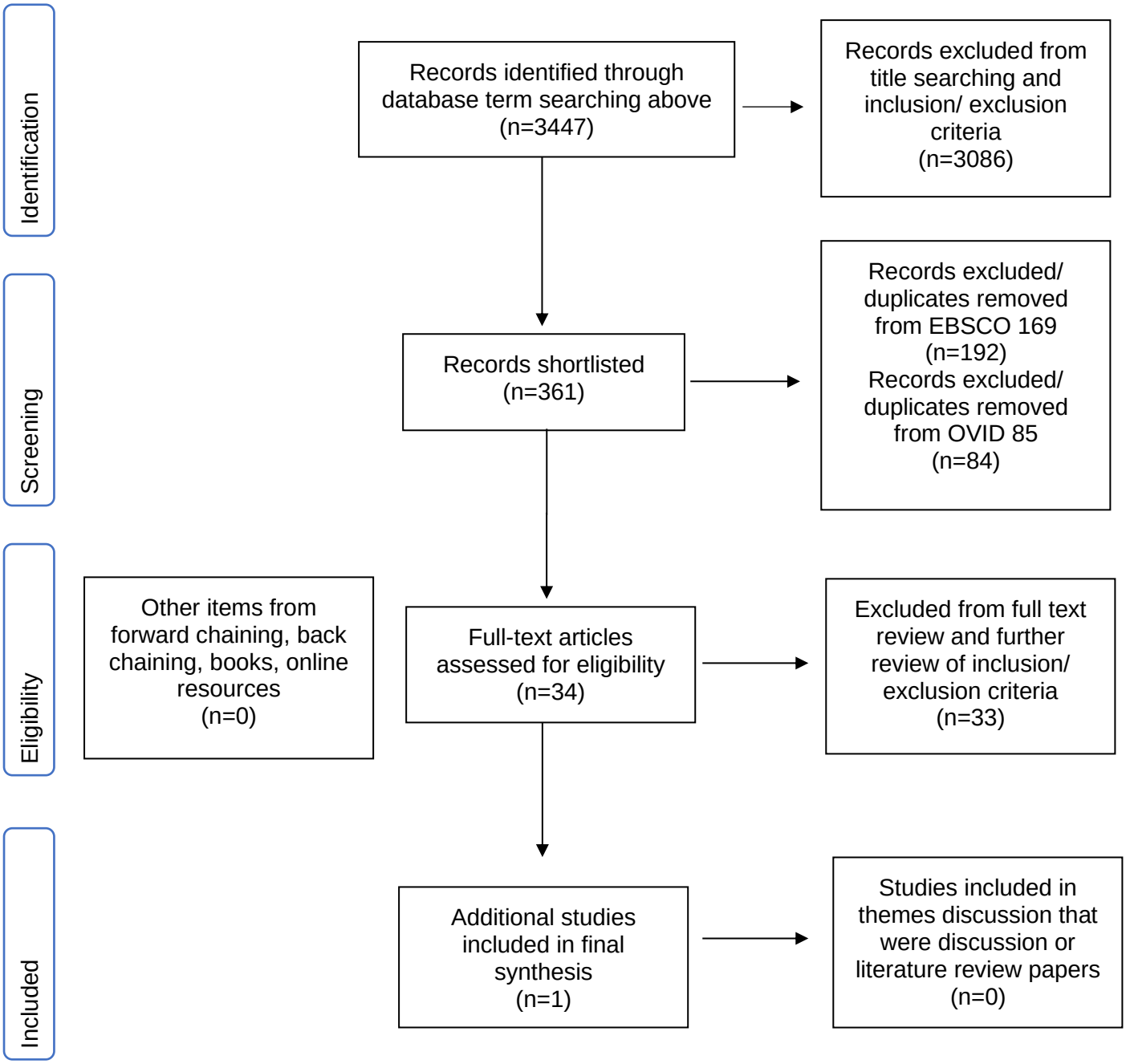
	Initial shortlisting [after duplicates on EBSCO removed]	**Exclude endnote saved already [second shortlisting] [full text]**	Underlined added searches below	**Initial shortlisting [after duplicates on EBSCO removed]**	**Exclude endnote saved already [second shortlisting] [full text]**
1AND2AND3 – 37,431			1AND2AND3AND5AND7 – 614		
AND 4 – 71	8	3 [0]	1AND2AND3AND5AND10 – 549		
AND 5 – 5,512			1AND2AND3AND7AND10 - 144	24	11 [6] [0]
AND 6 – 2	1	0			
AND 7 – 1299			1AND2AND3AND5AND7AND9 - 1	0	
AND 9 – 250	22 [18]	13 [7] [1]	1AND2AND3AND5AND7AND10 - 47	13	10 [6] [0]
AND 10 – 3,324		Rask			
			1AND2AND3AND5AND10AND9 - 16	4 [3]	1 [0]

Table 16: Specific searches (EBSCO 1946 to 20.01.20)

	4th searches	Initial shortlisting [after duplicates on EBSCO removed]	Exclude endnote saved already [second shortlisting] [full text]	5th searches	Initial shortlisting [after duplicates on EBSCO removed]	Exclude endnote saved already [second shortlisting] [full text]
1AND2 – 4,633,642 1AND2AND4 – 31,856 1AND2AND5 – 155,465 1AND2AND6 – 3579 1AND2AND7 – 27,180 1AND2AND9 – 30,891 1AND2AND10 – 207,988	1AND2AND4 AND5 – 711 AND6 - 3579 AND7 – 575 AND9 – 2,129 AND10 – 9,121 1AND2AND5 AND6 – 27 AND7 – 11,593 AND9 – 1,919 AND10 – 15,010 1AND2AND6 AND7 – 15 AND9 – 686 AND10 – 1050 1AND2AND7 AND10 – 3,395 AND9 – 430 1AND2AND9 AND10 – 7,605	1 [0] 0		1AND2AND4AND5 AND6 - 51 7 - 102 9 - 71 10 - 311 1AND2AND4AND6 AND7 - 15 9 - 686 10 - 1051 1AND2AND4AND7 AND9 - 17 10 – 142 1AND2AND4AND9 AND10 - 1003 1AND2AND5AND7 AND9 – 178 10 - 1426 1AND2AND5AND9 10 - 653 1AND2AND6AND9 AND10 - 311 1AND2AND7AND10 AND 9 - 147 ***6th searches*** 1AND2AND4AND6AND9AND5 – 4 1AND2AND4AND6AND9AND7 – 3 1AND2AND4AND6AND10AND5 – 5 1AND2AND4AND6AND10AND7 – 4 1AND2AND4AND9AND10AND7 – 7 1AND2AND5AND9AND10AND6 - 2 1AND2AND5AND7AND10AND6 – 1 1AND2AND9AND10AND4 AND5 - 25 AND6 - 319	0 11 [7] 10 [7] 33 [18] 0 5 [0] 15 [5] 20 [8] 10 [9] 25 [19] 1 [0] 0 1 [0] 0 3 [0] 2 [0] 0 13 [2] 13 [5]	 3 [0] 2 [2] [0] 8 [0] 2 [0] 4 [1] [0] 3 [1] [0] 6 [3] [0] 1[0] 3 [0]

	Initial shortlisting [after duplicates on EBSCO removed]	**Exclude endnote saved already [second shortlisting]**	**4**	**Initial shortlisting [after duplicates on EBSCO removed]**	**Exclude endnote saved already [second shortlisting] [full text]**
1AND3 – 97,440 1AND3AND4 – 120 1AND3AND5 – 12,818 1AND3AND6 - 3 1AND3AND7 – 3,014 1AND3AND9 – 489 1AND3AND10 – 5,639	 14 [5] 0	 2 [0]	1AND3AND5AND10 – 874 1AND3AND5AND9 – 111 1AND3AND5AND7 – 1,382 1AND3AND9AND7 – 8 1AND3AND10AND7 – 226 1AND3AND10AND9 – 124 (5th searches already completed in other searches)	 10 [2] 0 27 [5] 20 [0]	 1 [1] [0] 5 [3] [0]
	Initial shortlisting [after duplicates on EBSCO removed]	**Exclude endnote saved already [second shortlisting]**	4	**Initial shortlisting [after duplicates on EBSCO removed]**	**Exclude endnote saved already [second shortlisting] [full text]**
2AND3 – 81,131 2AND3AND4 – 114 2AND3AND5 – 8,926 2AND3AND6 - 5 2AND3AND7 – 1,921 2AND3AND9 – 458 2AND3AND10 – 6,242	 12 [1] 1 [0]	 1 [0]	2AND3AND5AND7 – 913 2AND3AND5AND9 – 88 2AND3AND5AND10 – 872 2AND3AND7AND9 – 7 2AND3AND10AND7 – 218 2AND3AND9AND10 - 135 (5th searches already completed in other searches)	 0 0 24 [6] 18 [3]	 4 [3] [0] 2 [1] [0]

Figure 12: Study eligibility flow diagram PRISMA (EBSCO additional search 1946 to 03.02.20)



APPENDIX 7: Key paper table

Table 17: Key papers

Authors	Year	Title	Place	Study type	Sample	Main findings
Aiyegbusi and Kelly	2015	'This is the pain I feel!' Projection and emotional pain in the nurse–patient relationship with people diagnosed with personality disorders in forensic and specialist personality disorder services: findings from a mixed methods study	UK	Mixed methodology- Delphi study and qualitative study	12 nurses Delphi 13 nurse interviews 12 patients in focus groups	This paper discusses one of its themes; Pain: processing or passing on (from a wider mixed methods study), which describes highly painful emotional phenomena arising primarily from patients' trauma impacting on interpersonal transactions, including the nurse-patient relationship. They conclude that training should be accessed by staff to build resilience and increase awareness of attachment processes to enhance nurses' understanding of the patient.
Bacha, Hanley and Winter	2020	'Like a human being, I was an equal, I wasn't just a patient': Service users' perspectives on their experiences of relationships with staff in mental health services	UK	Interpretative phenomenology	8 patients	The participants in this study struggled to find relationships that they experienced as therapeutic in the mental health system. They conclude that mental health services should be more focused upon care, rather than control. Relationships between patients and mental health staff can encourage recovery if they are consistent, safe, trusting, provide protective power and mirror a positive sense of self.
Borg and Kristiansen	2004	Recovery-oriented professionals: helping relationships in mental health services	Norway	Qualitative	15 patients	Article from a larger study. It found that staff who were recovery-orientated had courage to work with peoples' complexities by using their professional skills and collaborative working. The participants valued staff who conveyed hope, shared power, were available when needed, were open regarding diversity and willing to stretch boundaries.
Bowen and Mason	2012	Forensic and non-forensic psychiatric nursing skills and competencies for psychopathic and personality disordered patients	UK	Survey	990 secure, 500 non-secure nurses	The skills identified by secure nurses to work with people in secure settings were; being firm, setting limited and defining boundaries. For non-secure nurses they were: being non-judgemental, listening skills and good risk assessment. Showing more prioritisation for active management from secure nurses rather than the development of positive skills to

						build relationships from non-secure nurses, which indicates a differing approach, possibly due to the environment. This research concludes with the need for training that supports the development of engagement skills, communication skills and an ability to use reflection in action as a means of providing therapeutic care.
Bressington, Stewart, Beer and MacInnes	2011	Levels of service user satisfaction in secure settings: A survey of the association between perceived social climate, perceived therapeutic relationship and satisfaction with forensic services	UK	Cross-sectional survey design	44 patients	The patients who responded were satisfied with the secure service. Their rehabilitation and safety were viewed positively. Better perceptions of social climate correlated with satisfaction and perceptions of the therapeutic relationship with staff. Patients' experience of the therapeutic relationship and social climate of the unit indicated a higher level of satisfaction.
Cleary and Edwards	1999	'Something always comes up': Nurse-patient interaction in an acute psychiatric setting	Australia	Qualitative	10 nurses, 10 patients	The four themes from the patient interviews were; nurses' attributes, role perceptions, clinical care, and time. Key areas that were highlighted included the environment and how this can impact on the time nurses spend with patients. This could be with regards to how busy the environment was and how busy the nurses were, which influenced how much time they could spend interacting with patients. They conclude by stating that rather than being reactive, nurses need to be organised so that they are not just responding to something coming up.
Eldal Natvik, Veseth, Davidson, Skjolberg, Gytri and Moltu	2019	Being recognised as a whole person: A qualitative study of inpatient experience in mental health	Norway	Interpretative phenomenological analysis	14 patients	A key finding was the importance for the patients of being recognised as a person; having an identity. The nurse-patient relationship was fundamental to this recognition and ultimately in fostering recovery. Nurses need to prioritise interpersonal interactions and relationships over task-oriented duties and balance closeness and distance. They highlight patients' experiences provide rich and unique learning opportunities for nurses, enabling them to further understand and reflect on their interactions.
Evans, Murray, Jellicoe-	2012	Support staffs' experiences of relationship formation and	UK	Interpretative phenomenological analysis	10 unqualified support staff	The three themes were; developing relationships, seeing the person and managing risk, and maintaining boundaries. They conclude that staff need to be mindful of how they interact with

Jones and Smith		development in secure mental health services				patients and the factors that can impact on their style of interaction such as attachment style.
Horberg, Sjogren and Dahlberg	2012	To be strategically struggling against resignation: The lived experience of being cared for in forensic psychiatric care	Sweden	Phenomenology	11 patients	They found, that for patients, secure service care can be 'non-caring' with only moments of 'good care,' and to adapt to demands of staff, patients develop strategies to gain privileges. They found that patients were lacking meaningful relationships and longed to be discharged from services. They reported that being cared for entailed struggling against an overwhelming sense of resignation.
Jenkins and Coffey	2002	Compelled to interact: Forensic community mental health nurses' and service users' relationships	UK	Mixed method	57 nurses	They discuss the importance of the therapeutic relationship in often complex situations and how education and preparation of staff should include the value of this relationship.
Johansson and Martensson	2019	Ways of strategies to knowing the patient described by nursing students	Sweden	Qualitative content analysis	10 students (adult)	The results show that the nursing students prepared themselves to meet with patients the first time by reading journals, asking other staff for information and research. They also consider how to behave and to be present in their encounters to create a good relationship, which can only be done by spending time together. The students discussed being open-minded while listening to the patient to get to know the person.
Jones and Wright	2015	"They're really PD today": An exploration of mental health nursing students' perceptions of developing a therapeutic relationship with patients with a diagnosis of antisocial personality disorder	UK	Qualitative	Two focus groups 7:3 students	They found four key themes: diagnosis, safety, engagement, and environmental influences. Both groups of students (secure and non-secure placements) commented on looking beyond the diagnosis and seeing the person. The student nurses cited other staff in their placement areas as hugely influential in terms of the development of their perceptions of patients with antisocial personality disorder and how to relate to them.
Ketola and Stein	2013	Psychiatric clinical course strengthens the student-patient relationships of baccalaureate nursing students	US	Survey	67 students	They found that during the students' placements, they developed listening, communication and self-reflection skills which resulted in the development of empathy for the patients they were working with. The students stated that their time with patients had changed them. They reported growing, both professionally and personally, from their relationships with patients.

Kurtz and Turner	2007	An exploratory study of the needs of staff who care for offenders with a diagnosis of personality disorder	UK	Qualitative	13 multi-disciplinary staff	They found that particularly in secure settings the skills and needs of staff are important in order for them to manage their own countertransference to be able to support patients and indeed build relationships with them. Good multidisciplinary working and group supervision, utilising a reflective approach, were highlighted as factors to assist staff in coping with working in secure services and feelings of vulnerability that the participants reported.
Langley and Klopper	2005	Trust as a foundation for the therapeutic intervention for patients with borderline personality disorder	South Africa	Qualitative (grounded theory)	6 patients, 10 staff	The article focuses on the first theme of trust, which was identified by both patients and staff as crucial for the establishment and maintenance of the therapeutic relationship. Trust was highlighted by every patient as a foundation for any relationship, and the staff described trust as an anchor to maintain a relationship.
Long, Knight, Bradley and Thomas	2012	Effective therapeutic milieus in secure services for women: The service user perspective	UK	Qualitative participatory research	Two focus groups with patients	The themes identified included; interpersonal relationships, treatment programming, patient empowerment, the ward as a place of safety and hope for the future. The patients in this study highlighted the importance of hope, active engagement in treatment and developing a sense of self-worth as integral to an effective treatment milieu.
Looi, Savenstedt and Engstrom	2016	"Easy but not simple": Nursing students' descriptions of the process of care in a psychiatric context	Sweden	Journal analysis	14 student journals	They found three themes; trusting the trusting relationship, voicing unspoken needs, and balancing the dynamics of doing and being. They concluded that providing nursing care based on trusting relationships is not a demanding task, but it takes place in a complex environment that has a tendency to make easy things complicated.
Lord, Priest and McGowan	2016	Therapeutic engagement in medium-secure care: An interpretative phenomenological analysis of service users' experiences	UK	Interpretative phenomenological analysis	10 patients	The authors conclude that the social climate of the environment is important in building trusting relationships. Offering choice to patients, being direct and open can prevent patients from feeling excluded and more likely to be willing to develop trusting relationships.
MacInnes, Courtney, Flanagan, Bressington and Beer	2014	A cross sectional survey examining the association between therapeutic relationships and service user satisfaction in	UK	Cross-sectional survey	77 patients	Staff need to be available and accessible while having good listening and information giving skills. It is important to have both positive therapeutic relationships and patient satisfaction in secure settings. Showing interest, honesty and care are important for patients.

		forensic mental health settings				
McAllister and McCrae	2017	The therapeutic role of mental health nurses in psychiatric intensive care: A mixed-methods investigation in an inner-city mental health service	UK	Mixed-methods	Observations 234 staff, 309 patient activities, interviews with 4 staff, 6 patients	Although both patients and nurses in this study wanted more therapeutic contact, nurses wanted longer time to spend in individual sessions, patients preferred brief but more frequent interaction with nurses. Organisational constraints and lack of definition and practice of therapeutic engagement were deemed problematic. They conclude that there should be more emphasis on therapeutic engagement in nurse education, ward management and clinical supervision.
Mollerhoj and Os Stolan	2018	'First and foremost a human being …': user perspectives on mental health services from 50 mentally disordered offenders	Denmark	Qualitative	50 patients	It was important for the patients that nurses acted with respect and empathy in their interactions, that the communication between nurses and patients was responsive, decision making was shared and a variety of activities were offered. A poignant finding when the patients were asked what it was like to be a secure patient, responding; '*despite severe mental illness, social marginalisation as well as various criminal records they are still, first and foremost, human beings. However, they often feel dehumanized and monstrous'*.
Mukumbang and Adejumo	2014	Patients' experiences of being nursed by student nurses at a teaching hospital	South Africa	Phenomenology	10 patients	Three main themes arose from their thematic analysis: methods of identification of the student nurses by the patients and positive and negative perceptions of student nurses. Negative perceptions arose from poor experiences of interacting with students. The patients felt this was due to the student's lack of experience of using communication skills.
Muller and Poggenpoel	1996	Patients' internal world experience of interacting with psychiatric nurses	South Africa	Phenomenology	13 patients	They found that nurse-patient interaction promoted good mental health in the patients. The results emphasise the importance of a facilitative nurse- patient interaction to assist the patient in the promotion, maintenance, and restoration of mental health.
Oostvogels, Bongers and Willems	2018	The role of emotion regulation, coping, self-reflection and insight in staff interaction with patients with a diagnosis of personality disorder in forensic settings	Netherlands	Cross-sectional design	76 secure staff	They found that staff who cope with difficult situations by getting upset, blaming themselves or fantasising about solutions (emotion-focused coping style) needed more support, encouragement and back-up (support-seeking behaviour) from patients. Staff who better understand their own thoughts, feelings and behaviour (insight) needed less support from patients. Insight, emotion-focused coping and emotional

						regulation of staff influence the quality of care of patients with a diagnosis of personality disorder in secure settings.
Rask and Brunt	2006	Verbal and social interactions in Swedish forensic psychiatric nursing care as perceived by the patients and nurses	Sweden	Quantitative-survey	20 patients, 87 nurses	There were significant differences between patients' and nurses' perceptions about the frequency of all the different groups of interactions, but greater agreement as to the importance. In general, the patients perceived that the interactions occurred less frequently than the nurses.
Reavey, Brown, Kanyeredzi, McGrath and Tucker	2019	Agents and spectres: Life-space on a medium secure forensic psychiatric unit	UK	Qualitative-visual study	Interviews with 20 patients	They conclude that by increasing a greater sense of physical movement and liberty there can be improvements in the therapeutic landscape, and thus reversal of any effects of narrowing patients' sense of agency. Environments and activities in these environments should be designed based on mapping of relations and patients' experiences.
Salzmann-Erikson, Rydlo and Wiklund Gustin	2016	Getting to know the person behind the illness: The significance of interacting with patients hospitalised in forensic psychiatric settings	Sweden	Qualitative	5 nurses	Nursing needs to focus on care and taking time to see the patients as individuals. Including developing trust from daily activities promoting recovery, rather than stereotypical policing and custodial roles.
Schafer and Peternelj-Taylor	2003	Therapeutic relationships and boundary maintenance: The perspective of forensic patients enrolled in a treatment program for violent offenders	Canada	Qualitative	12 patients	The development of relationships is a complex process. The participants discussed time in a multidimensional way, being a measure of their value to staff and how they used it to assert themselves in the unit. They conclude that if the relationship is the heart of nursing then nurses need to understand the complexity of relationships from the perspective of their patients.
Scheick	2011	Developing self-aware mindfulness to manage countertransference in the nurse-client relationship: An evaluation and developmental study	America	Mixed methodology	15 students	They conclude that is important to develop self-awareness using mindfulness to manage countertransference when working in mental health services. This is especially important as nurses and students bring their own world in to interactions with patients.
Shattell, Andes and Thomas	2008	How patients and nurses experience the acute care psychiatric environment	USA	Phenomenology	10 patients, 9 nurses	The study themes were contextualised by time, which was a source of stress to both groups: for patients there was boredom, and for nurses, pressure and chaos. Nurses felt

						caged-in by the nursing station, and patients felt caged-in by the locked doors of the unit. The findings do not support the existence of the therapeutic milieu as described in the literature. Although the nurse-patient relationship was yearned for by nurses, it was nearly absent from patients' descriptions. The caring experienced by patients was mainly derived from interactions with other patients.
Shattell, Starr and Thomas	2007	'Take my hand, help me out': Mental health service recipients' experience of the therapeutic relationship.	USA	Phenomenology	20 patients	They found that it was important for staff to take the time to get to know the patients as a whole person so they could relate to them and support them in finding solutions. They concluded that building therapeutic relationships with people with mental health problems requires in-depth personal knowledge, which is acquired only with time, understanding, and skill. It was important for staff to know the whole person, rather than knowing the person only as a patient.
Walsh	1999	Shared humanity and the psychiatric nurse-patient encounter	Australia	Phenomenology discussion paper	7 nurses	The main theme Walsh discusses is ‘shared humanity’; where just being with people, sharing common ground and being human should be at the forefront of any nurse and patient encounter.
Yildiz	2019	What do nursing students tell us about their communication with	Turkey	Qualitative-Content analysis	26 student nurses	They conclude that students' use effective therapeutic communication strategies with patients and are conscious about providing a therapeutic environment, despite encountering many communication barriers with individuals with mental health problems. Students need to receive supervisory support in their practice.

Table 18: Discussion and literature review key papers

Authors	Year	Title	Place	Study type	Main findings
Cameron, Kapur and Campbell	2005	Releasing the therapeutic potential of the psychiatric nurse: A human relations perspective of the nurse-patient relationship	UK	Discussion paper	They discuss that despite nurses being the largest profession, caring on an everyday basis for services and being in a pivotal position to establish valuable therapeutic relationships, a disproportionate amount of their time is taken up by administration, impacting negatively on the time they spend talking to patients.
Chandley	2000	Time and confinement: Towards a common sense of socio-temporality in a special hospital	UK	Discussion paper	Time can be isolating and the environment of a secure hospital is very much a unique environment where time is experienced differently than outside of the service. This is due to the routines imposed and lack of control the patients have of their time. The time staff spend with patients can be seen as a commodity, which can be used and abused.
Cleary, Hunt, Horsfall and Deacon	2012	Nurse-patient interaction in acute adult inpatient mental health units: A review and synthesis of qualitative studies	Australia	Qualitative analysis and review	This paper explores the nurse-patient interaction in adult acute inpatient units. They found six themes: 1) sophisticated communication; 2) subtle discriminations; 3) managing security parameters; 4) ordinary communication; 5) reliance on colleagues; and 6) personal characteristics. They conclude that nurse communication involves interpersonal approaches that require specifically complex and developed personal skills in often challenging and chaotic settings.
Gildberg, Elverdam and Hounsgaard	2010	Forensic psychiatric nursing: A literature review and thematic analysis of staff-patient interaction	Denmark	Literature review	The two themes identified were; paternalistic and behaviour-changing care, and relational and personal quality-dependent care. They conclude that despite care being expressed as personal qualities in a relationship aspect, secure nursing care focuses on relationship security and comes from a custodial perspective rather than a caring one.

APPENDIX 8: Quality appraisal table

Table 19: Quality appraisal of key papers (Walsh & Downe, 2006)

Authors	**Scope and purpose** - Clear statement of, and rationale for, research question/ aims/ purposes - Study thoroughly contextualised by existing literature	**Design** - Method/ design apparent, and consistent with research intent - Data collection strategy apparent and appropriate	**Sampling strategy** - Sample and sampling method appropriate	**Analysis** - Analytic approach appropriate	**Interpretation** - Context described and taken account of in interpretation - Clear audit trail given - Data used to support interpretation	**Reflexivity** - Researcher reflexivity demonstrated	**Ethical dimensions** - Demonstration of sensitivity to ethical concerns	**Relevance and transferability** - Relevance and transferability evident	**Broad judgement of quality** **High, medium or low**
Aiyegbusi and Kelly	Clear aims, well evidenced	Mixed methods including phenomenology which has complexity, data collection stated	Staff and patients, Delph, interviews and focus groups, further clarity needed	Thematic, Husserl and psychoanalytic mentioned, further detail warranted	Focused on nurses, minimal on patients' experiences	Psychoanalytic approach discussed	Ethical approval granted	One theme discussed, relevance discussed	Medium
Bacha, Hanley and Winter	Clear aims, in-depth background with vast supporting evidence	Discussed method and methodology choice, good consideration of data	Clear recruitment, appropriate sample	Data analysis discussed	Clear table of themes, supporting extracts included, interpretation	Discussed in analysis	Ethical approval granted	Abstract seems to focus away from the findings,	Medium

		collection given			lead to conclusion			limitations discussed	
Borg and Kristiansen	Brief background, clear aims (slight differences to open questions used)	Clear qualitative design, data collection clear	Appropriate sampling	Group level analysis discussed	Interpretation lead to conclusion	Group level analysis stated, from a larger study	Not referred to specifically	Good discussion, limitations not discussed	Medium
Bowen and Mason	Clear focus, use of evidence	Clear design, data collection clear	Appropriate sampling	Quantitative analysis discussed	Statistics interpreted	None-quantitative study	Ethical approval granted	Relevance to practice discussed	High
Bressington, Stewart, Beer and MacInnes	Clear background and evidence, clear aims	Clear design, data collection clear	Appropriate sampling	Clear analysis discussed	Statistics interpreted	None-quantitative study	Section on ethics	Limitations discussed, new insights, aims achieved, practical relevance	High
Cleary and Edwards	Clear focus, use of evidence	Clear design, data collection clear	Clear sample explained	Clear analysis discussed, joint analysis	Clear interpretations lead to discussion	Joint analysis reflections	Not referred to specifically	Limitations discussed in relation to generalisability	Medium
Eldal Natvik, Veseth, Davidson, Skjolberg, Gytri and Moltu	Clear aim identified, good introduction and evidenced background	Broad mention of methodology further depth needed, very good overview of data collection	Clear sample discussed	Analysis discussed in-depth	Clear themes identified, interpretation lead to conclusion	Discussed implications well	Section on ethical approval	Very good, clear discussion and conclusion, limitations highlighted. Validity and reliability discussed	High
Evans, Murray, Jellicoe-	Clear aims and purpose, good background	Clear design, data collection clear	Clear and in table	Interpretative phenomenol ogical analysis	Results and discussion clear	Good section discussed in relation to analysis	Section on ethical approval	Originality and value discussed,	Medium

Jones and Smith				clearly discussed				limitations discussed	
Horberg, Sjogren and Dahlberg	Clear aims and good background	Clear design, data collection clear	Clear sampling	Discussed very well	Very good	Detailed reflection section	Section on ethical approval	Implications for practice section supported with evidence	High
Jenkins and Coffey	Clear focus, use of evidence	Clear design, data collection clear	Appropriate sampling	Comprehensive diagrams completed, appraisal conducted	Interpretation lead to conclusion	Diary extracts included, joint analysis	Section on ethical approval	Limitations insightfully acknowledged, practical and educational implications discussed	High
Johansson and Martensson	Clear aims, good background	Methods clear, data collection clear	Sampling identified	Many themes identified in a table, analysis discussed	Good thematic analysis laid out in discussion	Rigour considered, both authors involved	Section on ethical approval and considerations	Good discussion and clear conclusion, reviews paper strengths	High
Jones and Wright	Good background Clear aims	Clear design, data collection clear	Sample identified	Clear analysis discussed	Themes discussed	Refer to reflexivity	Section of ethical approval	Limitations and relevance acknowledged	High
Ketola and Stein	Good background, clear aims	Clear design, data collection clear	Appropriate sampling	Clear analysis discussed, both authors involved in analysis	Findings discussed clearly	Author discussion during analysis	Review board application approved	Recommendations made, limitations discussed	Medium
Kurtz and Turner	Research questions stated, use of evidence	Clear design, data collection clear	Appropriate sampling	Grounded theory discussed	Discussion of findings compared with previous studies	Rigour considered	Not referred to specifically	Discussion and summary joined, evidence used, recommendations discussed	Medium

Langley and Klopper	Research question stated, use of evidence	Clear design, data collection clear	Appropriate sampling	Thematic analysis discussed	Findings discussed alongside other literature	Field notes taken	Ethical approval granted considerations discussed	One theme discussed, wider implications of findings discussed	High
Long, Knight, Bradley and Thomas	Clear aims given, background with evidence supported	Clear design, data collection clear	Appropriate sampling	Thematic analysis discussed	Themes identified, interpretation lead to conclusion	Joint discussions in analysis	Ethical approval granted considerations discussed	Limitations and strengths discussed, conclusion joined with discussion	Medium
Looi, Savenstedt and Engstrom	Clear focus, background given	Journal analysis discussed more detail would have been useful	Sample stated clear	Journal analysis-theme table included	Clear result and discussion	Brief reference to reflection	Ethical approval granted	Implications for practice and research discussed	Medium
Lord, Priest and McGowan	Aim stated, good background	Clear design, data collection clear	Interviews, sample clearly stated	Interpretative phenomenological analysis discussed	Themes clearly stated in relation to each case. In discussion compared with other studies	Discussed, section on diary completed	Ethical approval granted and considerations discussed well	Strengths and limitations noted, clinical implications discussed	High
MacInnes, Courtney, Flanagan, Bressington and Beer	Clear aims stated, good background given	Clear design, data collection clear	Clear participant data shared and data collection	Scoring discussed	States SPSS, interpretation of others studies	None-quantitative study	Ethical approval granted and considerations discussed well	Concluding statements given, limitations discussed	High
McAllister and McCrae	Clear aim and focus, good	Clear data collection and	Sampling clear	Clear analysis presented,	Interpretation lead to conclusion	Reflexive journals kept, section on	Ethical approval granted and	Good discussion of findings,	High

	background and evidence	appropriate, rationale, triangulation		thematic analysis approach clear		rigour, table of trustworthiness	considerations discussed	limitations and relevance statement	
Mollerhoj and Os Stolan	Clear aim, background and evidence provided	Clear design and collection	Clear sample, good detail	Questions given and discussed, analysis briefly referred to	Good interpretation, quotes used	Briefly mentioned in relation to analysis, discussion between researchers	Approval at unit, ethical approval not specifically referred to	Good discussion and conclusion	Medium
Mukumbang and Adejumo	Clear focus, use of evidence	Clear phenomenology	Appropriate sampling	Thematic analysis- table included, second opinion on coding	Discussed in themes and discussion	Trustworthiness discussed, second opinion on coding	Ethical approval granted and considerations discussed well	Recommendations for practice, limitations discussed	High
Muller and Poggenpoel	Could be clearer	Clear design, data collection clear	Numbers could be clearer	Table included, content analysis	Discussion and results are together	Section included, consideration of interviewer	Ethical considerations section	Discussion of reliability/ validity in qualitative studies, brief conclusion, limitations discussed	Medium
Oostvogels, Bongers and Willems	Clear aims, abstract not as clear as in discussion	Quantitative approach in keeping with aims, appropriate methodology	Clear sample	Statistical analysis discussed	Interpretation lead to conclusion	None-quantitative study	Ethical approval granted	Good discussion and conclusion, aims achieved, limitations discussed	Medium
Rask and Brunt	Clear aims, good background well referenced	Survey research in line with aims	Very detailed overview of participants	Statistical analysis, good consideration	Tables of results included	None-quantitative study	Ethical approval granted	Limitations discussed, study meets aims of study,	High

				of methodology				conclusion given	
Reavey, Brown, Kanyeredzi, McGrath and Tucker	Clear aim, very comprehensive background	Very detailed overview of design	Detailed	Group analysis conducted	Participant quotes used in interpretation	Reflection on interviewers' observations	Ethical approval granted	Good discussion and conclusion, brief mention of limitations, part of bigger study	Medium
Salzmann-Erikson, Rydlo and Wiklund Gustin	Clear focus, use of evidence	Clear and section on methodological considerations	Appropriate sampling	Broad descriptive approach	Discussion comparing other studies, rationale given for their minimal interpretative approach, minimal discussion on findings, in-depth discussion section	Minimal reference	Ethical approval granted	Section on contribution, also methodological considerations	Medium
Schafer and Peternelj-Taylor	Aims could be clearer, background included	Clear design, data collection clear	Appropriate sampling	Discuss Glaser and Strauss but not grounded theory study, triangulated hypothesis testing	Sound interpretation in discussion section	Field notes taken, reflective journal	Ethical approval granted	Recommendations made, limitations discussed in data collection, discussion, recommendations and conclusion discussed together	Medium
Scheick	Could be clearer	Could be clearer	Appropriate sampling	Complex use of model,	Group development of template	Quantitative and qualitative,	Institutional review board approval	Limitations referred to in abstract, new	Medium

				statistical analysis		reflexivity not specifically referred to for qualitative approach		model, conclusions based on evidence	
Shattell, Andes and Thomas	Questions posed, good background	Clear design, data collection clear	Setting outlined and sample clear	Thematic, unclear specific approach, group analysis used	Discussion of other evidence, group interpretation	Group interpretation of findings	Approved by institutional review boards	Limitations referred to, new insights	Medium
Shattell, Starr and Thomas	Comprehensive background, clear aims	Another study, clear data collection	Secondary results, clear sample	Secondary analysis	Interpretation in discussion	Joint analysis, presented to participant	Approved by institutional review board	Some links to practical implications	Medium
Walsh	Case study approach, no literature review in keeping with article aim	Methodology discussed, further detail in other article	Case study approach	Phenomenological analysis discussed	Clear discussions of interpretation	Aligned to methodology although not specifically referred to	Not specifically referred to in this paper	In keeping with methodology	Medium
Yildiz	Clear aims, good background, specific background of study area given to provide context	Design discussed, conflict between phenomenology and saturation	Sampling is clear	Topic guide presented, themes presented	Sound interpretation	Rigour section included and detailed	Ethics section included	Good discussion and conclusion based on evidence, strengths and limitations discussed	Medium

Table 20: Quality appraisal of discussion and literature review key papers

Authors	**Scope and purpose** - Clear statement of, and rationale for, research question/ aims/ purposes - Study thoroughly contextualised by existing literature	**Design** - Method/ design apparent, and consistent with research intent - Data collection strategy apparent and appropriate	**Sampling strategy** - Sample and sampling method appropriate	**Analysis** - Analytic approach appropriate	**Interpretation** - Context described and taken account of in interpretation - Clear audit trail given - Data used to support interpretation	**Reflexivity** - Researcher reflexivity demonstrated	**Ethical dimensions** - Demonstration of sensitivity to ethical concerns	**Relevance and transferability** - Relevance and transferability evident	**Broad judgement of quality High, medium or low**
Cameron, Kapur and Campbell	Clear, good background and evidence throughout	Discussion paper	Discussion paper	Themes of discussion	Discussions and interpretations based on evidence	None as discussion paper	None as discussion paper	Relevance discussed, conclusions based on evidence	Low as discussion paper
Chandley	Clear, good background and evidence throughout	Discussion paper	Discussion paper	Themes of discussion	Discussion	None as discussion paper	None as discussion paper	Relevant, interesting piece	Low, however very relevant
Cleary, Hunt, Horsfall and Deacon	Very clear aims stated, thorough background	Clear searching strategy stated	Searching strategy and tables included and discussed	Analysis discussed; their interpretation considered	Considered, clear data trail	Their interpretation of findings considered well	None as literature review	Very interesting and relevant piece	Medium as secondary evidence (High quality)
Gildberg, Elverdam and Hounsgaard	Clear aim, background given	Literature review design	Databases	Content analysis	Themes discussed	None as literature review	Considered in review of literature	Summary given and limitations discussed in-depth	Low as literature review

APPENDIX 9: Key paper findings and appraisal narrative

Psychosocial skills

Bowen and Mason (2012) investigated the skills needed to be a secure and non-secure nurse. Bowen's study was a postal survey, whilst having a large sample size, 415 secure nurses and 382 non-secure nurses, this study provided no in-depth exploration of the skills needed that a qualitative approach may have achieved, nor patient perspectives. Nevertheless, it is an interesting study highlighting which skills nurses believe are important to working in a secure setting. The skills identified by secure nurses to work with people in secure settings were being firm, setting limited and defining boundaries. For non-secure nurses they were being non-judgemental, listening skills and good risk assessment. This research concludes with the need for training that supports the development of engagement skills, communication skills and an ability to use reflection in action as a means of providing therapeutic care.

Cleary, Hunt, et al. (2012) qualitative paper explores the nurse-patient interaction in adult acute inpatient units. They found six themes: sophisticated communication; subtle discriminations; managing security parameters; ordinary communication; reliance on colleagues; and personal characteristics. They conclude that nurse communication involves interpersonal approaches that require specifically complex and developed personal skills in often challenging and chaotic settings.

An America study, Ketola and Stein (2013), use a mixed methods approach to explore mental health students' experience of their relationships with patients, which has resonance to this study. Ketola and Stein found that during the students' placements, they developed listening, communication and self-reflection skills which resulted in the development of empathy for the patients they were working with. The students stated that their time with patients had changed them. They reported growing, both professionally and personally, from their relationships with patients. In building relationships, they developed their self-awareness and sensitivity to the feelings of another person and communication skills. The students recognised the need for these skills in all nursing. For such a study it was a relatively small sample size, making it difficult to generalise the findings.

Kurtz and Turner (2007) interviewed 13 staff working with patients with a personality disorder diagnosis in a secure setting. They found that the skills and needs of staff in secure settings are important in order for them to manage their own countertransference to build relationships with patients. Good multidisciplinary working and group supervision, utilising a reflective approach, were highlighted as factors to assist staff in coping with working in secure services and feelings of vulnerability that the participants reported.

Oostvogels et al. (2018) completed their study in the Netherlands using cross-sectional design with 76 staff. Although a quantitative design exploring potentially qualitative data, it is a clear and relevant study. Its aim was to test which factors influenced the interaction between staff and patients with a personality disorder diagnosis in a secure service. They conclude that insight, emotion-focused coping and emotion regulation of staff influence the quality of care of patients with a diagnosis of personality disorder in secure settings. They recommend training using reflective discussion as well as organisational management to enhance compassionate behaviour, in addition to compassion focused training focussing on self-compassion and building insight.

Scheick (2011) mixed methods study considers the impact of countertransference in nurse-patient relationship in mental health services. It explores the importance of using self-awareness development guide to manage countertransference when working in mental health

services. Fifteen nursing students used the self-awareness development guide compare with seven who did not. The study found that when the students were exposed to the '*template'* they described growing in their ability to self-monitor countertransference and a positive effect on their learning in other areas of nursing. They conclude that is important to develop self-awareness using mindfulness to manage countertransference when working in mental health services. This is especially important as nurses and students bring their own world in to interactions with patients.

Yildiz (2019) Turkish study explored 26 student experiences with people with mental health problems. There is some conflict in alignment between their methodology and use of saturation, in phenomenological studies, saturation is not aimed for (Moran, 2000). Yildiz (2019) do however present an interesting paper which has a detailed rigour section and inclusion of a topic guide. Their study revealed that nursing students encountered many communication barriers with patients during their placements. However, they experienced effective therapeutic communication strategies and were conscious about providing a therapeutic environment, as referred to in theme three. The study concludes that students need to receive supervisory support in their practice due to experiences of fear.

Relationships

The Aiyegbusi and Kelly (2015) study focused on some similar elements to my study, justifying a detailed review, discussed below. This study aimed to explore the experiences of nurses and people with a diagnosis of personality disorder of the nurse-patient relationship in a therapeutic community and secure setting. They used mixed methodology, integrating a Delphi study with a phenomenological approach. Some research phenomenologists would argue that phenomenology should not be part of a mixed method approach as it loses the authentic nature of the lived experience (Moran, 2000). However Mayoh and Onwuegbuzie (2015) argue at phenomenological methods work extremely well as a component of mixed methods research.

It is unclear whether the Delphi part to Aiyegbusi and Kelly's study met the original aim of the study; it does, however, state it was used to inform the topic guides for the interviews and focus groups. A person's true experience can be explored in-depth utilising qualitative methods. This does not necessarily invalidate scoping exercises to ascertain the breadth of inquiry, or refine questions. However, the authors refer to data saturation when conducting interviews with the nurses and in phenomenological studies it is not a concern (Dibley et al., 2020). This potentially exposes a lack of thorough consideration of their methods.

In this paper there is only one theme discussed and it appears to focus purely on the interviews with staff. The use of language depicts a sense of negativity, for example '*emotional brutality'*, '*penetrating emotional pain'*, '*the onslaught'* etc. The findings focus on the negative experiences the nurses had rather than experiences of the relationship. In this article there are a number of units/ areas reported on, however a therapeutic community is a different environment to a dangerous and severe personality disorder unit, and yet they are compared. The authors offer a limited discussion with little reference to other sources to support or refute what was found in their study. Despite being part phenomenological study there is no mention of reflexivity. They conclude that training should be accessed by staff to build resilience and increase awareness of attachment processes to enhance nurses' understanding of the patient. Despite the original aim of exploring the nurse-patient relationship the discussion gives limited to focus to this, perhaps as only one theme of the study is discussed.

Bacha et al. (2019) aimed to explore patients' thoughts about the emotional impact of relationships. Despite clear aims and good discussion and conclusion sections, the abstract seems to lose focus and steer away from the findings. In the study the participants (eight

patients) struggled to find relationships that they experienced as therapeutic in the mental health system. The key components for relationships, discussed from interpretive phenomenological analysis, were power, safety, and identity. The authors conclude that mental health services should be more focused upon care, rather than control and if services and the staff in them are sensitive to issues surrounding power, safety and identity, when responding to a patient's needs, can enhance the quality of care and how it is perceived.

Cameron et al. (2005) discussion paper explores the therapeutic potential of the mental health nurse. Although a discussion paper, it is well researched and interesting points are highlighted. It discusses the pivotal role of the mental health nurse in establishing a therapeutic alliance with patients. Like, Scheick (2011) discussed in theme one, Cameron also considers countertransference in relation to interpersonal experiences between patient and nurse. Cameron discusses the negative impact of administration on the time that nurses are able to spend with patients building relationships despite the importance for patients. They discuss that despite nurses being the largest profession caring on an everyday basis for services and being in a pivotal position to establish valuable therapeutic relationships, a disproportionate amount of their time is taken up by administration, impacting negatively on the time they spend talking to patients.

Evans et al. (2012) qualitative study interviewing 10 participants explored the experiences of support staff developing therapeutic relationships with patients in secure services. This is a well written article and discusses an area minimally researched. The study utilised interpretive phenomenological analysis to analyse the data from the interviews. The three themes were; developing relationships, seeing the person and managing risk and maintaining boundaries. They conclude that staff need to be mindful of how they interact with patients and the factors that can impact on their style of interaction; the importance of being aware of patients' attachment styles to inform interactions and to avoid conflict; and finally the value of information sharing and how teams can effectively do this and use the information effectively.

Gildberg et al. (2010) completed a literature review and analysis of staff-patient interaction in secure services, reviewing articles from 1997 until 2009. Gildberg analysed 17 quantitative and qualitative studies using content analysis. As they identify, the studies reviewed are diverse and do not have a common focus limiting the conclusions that can be made from them. Despite that care is expressed as personal qualities in a relationship aspect, secure nursing care focuses on relationship security and comes from a custodial perspective rather than a caring one. However only a few of their findings represent a clear account of interactional characteristics and their impact on patients.

Jenkins and Coffey (2002) mixed methodology study explored 57 staff questionnaires about restriction orders and supervised discharge mechanisms. Although not aligned with the themes in their aims, they discuss the importance of the therapeutic relationship in often complex situations and how education and preparation of staff should include the value of this relationship. It addressed the patient/ nurse relationships and risk. The authors note the limitation of questionnaires to gain qualitative data. As Cameron et al. (2005) highlights, the importance of the nurse-patient relationship is also a theme discussed in Jenkins and Coffey (2002) study.

Johansson and Martensson (2019) interviewed 10 students analysing the data using content analysis. They aimed to describe what strategies students used to '*know the patient'*. Although the students were adult field students, their findings are transferable to mental health field students. The results show that the nursing students prepared themselves to meet with patients the first time by reading journals, asking staff members for information and research. They also consider how to behave and to be present in their encounters to create a good

relationship, which can only be done by spending time together. The students discussed being open-minded while listening to the patient to get to know the person.

A study of my own (Jones & Wright, 2017) explored the perspectives of student mental health nurses of developing a therapeutic relationship with patients with antisocial personality disorder. I conducted two focus groups, one where the students had experience in secure services and the other without experience. Both groups saw the importance of seeing the person rather than the diagnosis. However, both groups discussed that other staff members had a negative impact on their perceptions, they stated that they clouded their judgement of patients. The students in both groups also discussed the importance of doing normal stuff with patients on their placements, which other studies have also found (Borg & Kristiansen, 2004).

Langley and Klopper (2005) conducted interviews and focus groups with patients and staff in South Africa in order to develop a model for supporting people with a diagnosis of borderline personality disorder in the community. The article focuses on the first theme of trust, which was identified by both patients and staff as crucial for the establishment and maintenance of the therapeutic relationship. Unlike the other studies explored, Langley and Klopper interviewed both patients and staff to ensure experiences were gained from both parties involved in the relationship. Trust was highlighted by every patient as a foundation for any relationship, and the staff described trust as an anchor to maintain a relationship.

Looi et al. (2016) found three themes; trusting the trusting relationship, voicing unspoken needs, and balancing the dynamics of doing and being. They found that providing nursing care based on trusting relationships is not a demanding task, but it takes place in a complex environment that has a tendency to make easy things complicated. Looi analysed student nurses' journals following experience of gaining a therapeutic relationship with '*challenging'* patients. Although a unique and interesting way of exploring students' experiences, the way the researchers specifically analysed the journals was discussed minimally. The researchers also state the students '*were included due to their successful work with patients with challenging behaviour'* (p. 34), which is not explored in more detail; exactly how they were included and the term '*challenging'* behaviour and how this was determined and by who. They do, however, explore the methodological considerations of the influence of feedback the students may have received on their journals and the impact of the feedback on future additions.

McAllister and McCrae (2017) aimed to investigate nurses' therapeutic roles in a psychiatric intensive care unit. Although not a secure service as such a psychiatric intensive care unit has similar relational security and physical security as secure units (National Association of Psychiatric Intensive Care and Low Secure Units, 2014; National Health Service, 2010). The researchers observed various time points during the week on the unit using a tool designed by the researchers, though not tested for reliability or validity. They did however use triangulation to ensure robust findings and the paper includes a good section on rigour, enhancing the credibility of their findings. In addition to observation, four staff and six patients were interviewed. There was disparity between the actual and desirable levels of therapeutic interactions as experienced by nurses and patients. Although both patients and nurses wanted more therapeutic contact, nurses wanted longer time to spend in individual sessions, patients preferred brief but more frequent interaction with nurses. Organisational constraints and lack of definition and practice of therapeutic engagement were deemed problematic. The authors conclude that there should be more emphasis on therapeutic engagement in nurse education and clinical supervision.

Rask and Brunt (2006) Swedish study used a survey methodology to explore how patients (n=20) and nurses (n=87) perceive the frequency and importance of verbal and social interactions in secure services. The paper discusses the limitations of survey methodology

and response rates. It gives clear aims which are met and explored in the discussions. A very detailed overview of the participants demographics is offered. They found significant differences between patients' and nurses' perceptions about the frequency of interactions, but agreed its importance. Nurses' perceived interactions occurred more frequently than the patients. Their recommendations link with theme one: Psychosocial skills, in indicating priority for skills training to promote effective interactions.

Salzmann-Erikson et al. (2016) explored nurses' expectations of relationships with patients in a secure hospital. They conducted in-depth interviews with five nurses. They provide a descriptive analysis of their findings, which included getting to know the person and making a difference. They conclude that care in secure services needs to focus more on the role of the future nurse and less on stereotypical views of nurses. Also, more emphasis should be given to take the time to establish a trusting relationship and see patients as individuals. While abandoning custodial roles and activities in favour promoting recovery. Nurses should '*use simple strategies in their daily practice such as sitting on the sofa with patients to establish trust'* (p. 1426).

Shattell et al. (2007) aimed to explore patients' experiences (n=20) of the therapeutic relationship in the community using an existential phenomenological approach. They found that it was important for staff to take the time to get to know the patients as a whole person so they could relate to them and support them in finding solutions. This study, interestingly, discussed the grounding of their findings, considering the context of the patients they had interviewed and their prior experiences which may have influenced on the perspectives/ experiences/ impact of relationships. For example, considering the patients experience of stigma and how this impacted on building relationships with staff, hence their '*relate to me'* theme. As previous studies have explored earlier, time was again discussing in Shattell's findings. This was in relation to staff investing their time and spending the time getting to know the patients to understand them. They concluded that building therapeutic relationships with people with mental health problems requires in-depth personal knowledge, which is acquired only with time, understanding, and skill. It was important for staff to know the whole person, rather than knowing the person only as a patient.

Walsh (1999) phenomenological discussion paper explored the nurse and patient encounter. Seven nurses were interviewed based on an encounter with a patient. What felt missing from this paper was quotes from the participants, particularly as it was a phenomenological study. The main theme Walsh discusses is '*shared humanity'*; where just being with people, sharing common ground and being human should be at the forefront of any nurse and patient encounter. Walsh interviewed nurses, not patients, limiting full understanding of the encounter as only exploring one side of the encounter.

Environment

Cleary and Edwards (1999) aimed to explore factors that help or impede the nurse-patient interaction in mental health acute services. They interviewed 10 patients and 10 nurses. From these interviews six themes emerged from the nurse's interviews, which were; '*environment, something always comes up, nurses' attributes, patient factors, instrumental support and focus of nursing'*. Four themes emerged from the patient interviews, which were; '*nurses' attributes, role perceptions, clinical care and time*' (p. 469). In the article all these themes are discussed briefly, arguably losing the depth of the findings. Key areas that were highlighted included the environment and how this can impact on the time nurses spend with patients. This could be with regards to how busy the environment was and how busy the nurses were, which influenced how much time they could spend interacting with patients. Cleary and Edwards conclude by stating that rather than being reactive, nurses need to be organised so that they are not just responding to something coming up.

Chandley (2000), although a discussion paper, it is based on his PhD study exploring the experience of temporality in a high secure hospital. He found that time can be isolating and the environment of a secure hospital is very much a unique environment where time is experienced differently than outside of the service. This is due to the routines imposed and lack of control the patients have of their time. The time staff spend with patients can be seen as a commodity, which can be used and abused.

Hörberg et al. (2012) found, that for patients (n=11), secure service care can be '*non-caring'* with only moments of '*good care,'* and to adapt to demands of staff, patients develop strategies to gain privileges. They found that patients were lacking meaningful relationships and longed to be discharged from services, with a struggle against being cared for. They reported that being cared for entailed struggling against an overwhelming sense of resignation. Horberg's interesting and well considered study conclude the need for further knowledge, understanding and support from staff for patients in secure services, highlighting the importance of a caring culture brought about by reflective and questioning environment.

Long et al. (2012) explored patients' experience of the therapeutic milieu in secure services. They conducted two focus groups in low and medium secure units for women, with a total of 19 participants. The themes identified were '*interpersonal relationships, treatment programming, patient empowerment, the ward as a place of safety and hope for the future*' (p. 567). The paper utilised a user-led participatory research approach, where focused groups were led by a patient and patient involvement support worker. The questions were generated by the patient author and analysis conducted by two other authors. The finding highlighted the importance of engagement, development of self-worth and hope as integral to an effective treatment milieu.

Reavey et al. (2019) study aimed to examine how environments contribute to recovery by exploring interactions and agency as experienced by 20 patients in a secure service. By increasing a greater sense of physical movement and liberty there can be improvements in the therapeutic landscape, and thus reversal of any effects of narrowing patients' sense of agency. In viewing relationships as spatial and temporal a person's understanding of relationship dynamics and ultimately promotion of recovery can be enhanced. They conclude that environments and activities should be designed based on mapping of relations and patients' experiences.

Shattell et al. (2008) paper also considers time as a theme in their study, in addition to bridging across a number of themes identified in this literature review; relationships and environment. Although conducted in the United States of America, it has many similarities to studies completed in the United Kingdom, despite the differences in healthcare services. The researchers interviewed 10 patients and 9 nurses using a phenomenological approach. The study aimed to explore patient and nurses' experiences of a hospital environment, which they found was contextualised by time as a source of stress for both patients and nurses. '*Relationships'*, were not found to be described as others had in the literature, although they were sought after by nursing staff but absent from interviews with the patients. The patients found that their caring experience was derived from other patients rather than nursing staff. Their experiences of the mental health acute unit was not described to be a '*therapeutic milieu'*, patients felt bored, that their needs were unmet and the environment was not only ineffective but harmful. Time was a source of stress to both groups: for patients there was boredom, and for nurses, pressure and chaos. Nurses felt caged-in by the nursing station, and patients felt caged-in by the locked doors of the unit.

Impact

Borg and Kristiansen (2004) interviewed 15 patients about their experience of helping relationships. The authors' state the study was inspired by a phenomenological approach however it does not give more detail than this. It reports that the article is part of a larger study which may be why there is limited detail about the methodology. Although the aim in the abstract states the study was exploring patients' experience of helping relationships, later it is stated that this is a sub-aim of the central aim, which aimed to explore a persons' experience of recovery. It found that staff who were recovery-orientated had courage to work with peoples' complexities by using their professional skills and collaborative working. The participants valued staff who conveyed hope, shared power, were available when needed, were open regarding diversity and willing to stretch boundaries. Interestingly Borg uses the term '*humanity'* as does Walsh (1999), discussed earlier. The patients in Borg's study also discuss developing relationships based on '*common factors'*, which is referenced to in other studies (Jones & Wright, 2017).

Bressington et al. (2011) conducted a cross-sectional survey and assessment measures aiming to assess patient satisfaction how the therapeutic relationship and social climate affected their satisfaction in secure settings. 44 patients completed assessments to examine satisfaction with regards to the therapeutic relationship and environment. A number of assessment scales were used, some limitations of such scales were briefly discussed. The authors discuss the limitations of the study well, highlighting other potential influential factors. The patients who responded were satisfied with the secure service. Their rehabilitation and safety were viewed most positively. Better perceptions of social climate correlated with satisfaction, and even more so did perceptions of the therapeutic relationship with staff. Patients' experience of the therapeutic relationship and social climate of the unit indicated a higher level of satisfaction.

Eldal et al. (2019) study utilised a user-involved research framework to interview 14 patients, analysing the data using interpretative phenomenological analysis. Although they broadly mention their underpinning methodology, further depth was needed. A key finding was the importance for the patients of being recognised as a person, having an identity. The nurse-patient relationship was fundamental to this recognition and ultimately in fostering recovery. Nurses need to prioritise interpersonal interactions and relationships over task-oriented duties (Terry & Coffey, 2019). Nurses need to balance patient competing needs for both closeness and distance. As Eldal et al. (2019) highlight patients' experiences provide rich and unique learning opportunities for nurses, enabling them to further understand and reflect on their interactions.

Lord et al. (2016) interviewed 10 patients in a secure hospital using interpretative phenomenological analysis. They aimed to explore what factors influence therapeutic engagement in a secure setting. Lord discusses the recruitment process thoroughly including their reflexivity during the research, an essential element of phenomenological studies (Dibley et al., 2020). The authors conclude that the social climate of the environment is important in building trusting relationships, showing the links between the themes identified in this study's literature review. Lord also concluded that offering choice to patients, being direct and open can prevent patients from feeling excluded and more likely to be willing to develop trusting relationships.

MacInnes et al. (2014) completed a survey in two secure settings about the therapeutic relationship and patient satisfaction. They found that patients who felt respected and well regarded by staff had a higher level of satisfaction of their experience in the secure settings. Honesty, care and interest from the staff enabled the patients to feel respected, in addition to being accessible and having good listening skills. The participants were asked to complete

two self-report questionnaires: The Forensic Satisfaction Scale and the Helping Alliances Scale, both with good reliability and validity. 77 patients completed the two questionnaires, a relatively small-scale quantitative study, of which the authors recognise. The authors conclude that it is important to have both positive therapeutic relationships and patient satisfaction in secure settings.

Mollerhoj and Os Stolan (2018) large qualitative study aimed to explore 50 patients' perspectives on their hopes, expectations and interactions with staff in secure services. It was important for the patients that nurses acted with respect and empathy in their interactions, that the communication between nurses and patients was responsive, decision making was shared and a variety of activities were offered. A poignant finding when the patients were asked what it was like to be a secure patient, responding; '*despite severe mental illness, social marginalisation as well as various criminal records they are still, first and foremost, human beings. However, they often feel dehumanized and monstrous'* (p. 593).

Mukumbang and Adejumo (2014) explored patient's experiences of being '*nursed'* by student nurses. 10 patients were interviewed with an underpinning descriptive phenomenological methodology. Although the study was completed in Africa and on medical wards it provides an interesting perspective on patients' perspectives of working with students in any country. Three main themes arose from their thematic analysis: methods of identification of the student nurses by the patients and positive and negative perceptions of student nurses. Negative perceptions arose from poor experiences of interacting with students. The patients felt this was due to the student's lack of experience of using communication skills.

Although an older study, Muller and Poggenpoel (1996) is an interesting one, considering the patient's perspective of interactions with nurses. A phenomenological approach was used to interview 13 patients. The authors state they did 20 interviews and 7 were not suitable for analysis, although do not state why. They found that nurse-patient interaction promoted good mental health in the patients. The authors conclusion is minimal, not appearing to actually conclude the key points of the paper. They refer to patient perceptions of interactions in their environment which include stereotypes, custodian implications, rule enforcement, intimacy, friendliness, empathy and care. The results emphasise the importance of a facilitative psychiatric nurse-patient interaction to assist the patient in the promotion, maintenance, and restoration of mental health.

Schafer and Peternelj-Taylor (2003) explored the perspectives of patients (n=12) in a secure hospital in Canada. The concluded that developing a therapeutic relationship is a complex process, however the term '*therapeutic relationship'* was used and briefly defined by the researchers, in addition to '*boundaries'*, they were not terms introduced by the participants, raising questions of understanding of such language and therefore the findings in general. The participants discussed time in a multidimensional way, being a measure of their value to staff and how they used it to assert themselves in the unit. This mirrors discussions in Chandley (2000) paper. They conclude with; '*if the interpersonal relationship is the heart of nursing then forensic mental health nurses need to understand the complexity of therapeutic relationships from the perspective of their patients'* (p. 605).

APPENDIX 10: Ontology and epistemology

Often, terminology used within philosophy and research texts can be overwhelming for the novice researcher (Ihde, 2012). Sadly language can be a barrier, an abuse of power and an exclusion strategy (Network for Mental Health, 2014). Each term can be interpreted in a different way and mean something different to each person. Hence, I will now give an overview of my understanding of epistemology and my epistemological stance, whilst acknowledging that my own experiences influence both the methodology and methods chosen for my research (Crotty, 1998).

It is important to first acknowledge that academics such as Guba (1990) write that the distinction of ontology and epistemology should be abolished. Nevertheless, it is important to consider their place and meaning as the context and background of the research. Ontology sits beside/ or before, depending on a person's opinion, epistemology, and is about understanding '*what is*' (Crotty, 1998). Ontology is derived from the Greek word for '*being'* (Blackburn, 2008). Ontology asks; what does it mean to be a human being? What does it mean to be a thing at all? What is existence? At what point does something exist and not exist? What is the nature of existence itself? It is the nature of *being* (Dibley et al., 2020). Heidegger's philosophy is an ontological one.

Rene Descartes (1596-1650) and Jean-Paul Sartre (1905-1980) were pivotal in relation to existentialism and the epistemology of phenomenology. Descartes has been credited with being the founder of modern philosophy (Skirry, 2018) and Sartre was a Cartesian who developed some of Descartes' ideas. Sartre worked with Husserl and Heidegger (Blackburn, 2008). Sartre's career focused on the construction of existentialism, which is a philosophy of existence (Onof, 2018).

Epistemology is the theory of knowledge; the questioning of the origin or nature of knowledge (Blackburn, 2008; Grayling, 1998). Epistemology is philosophical theory, basic assumptions and nature of knowledge (King, 2010), it is a way of understanding and explaining '*how we know what we know'* (Crotty, 1998, p. 8). According to Reiners (2012) Husserl, explored later, was interested in the nature of knowledge, while Heidegger was interested in the nature of *being* and temporality; an ontological focus.

One well known, although criticised (Thornton, 2016), framework for understanding research is that of Crotty (1998) who lays out four elements to research. These are epistemology, theoretical perspectives, methodology and methods, all having a role in ensuring the trustworthiness of research and make its outcomes credible (Crotty, 1998). Focusing and understanding these four areas can enable researchers to determine the suitability of methodologies and methods used, furthermore, when determining the importance of findings these can be best represented by showing the theoretical assumptions that underpin the research (Crotty, 1998). However as Thornton (2016) writes, it seems dangerous to state some of Crotty's claims as truth in such writings as PhDs due to problems in the text making distinct conclusions about objectivism and constructionism which may be in contrast. Darbyshire (1999) also criticises Crotty for taking a narrow view of Heidegger's work, that it was misguided and poorly informed. They highlighted that Crotty's view of phenomenology was self-referential rather than appreciating the experiences of others. Nevertheless, Crotty's text has been an informative entry point for the development of my understanding and makes sense of a complex and bewildering arena.

Theoretical perspectives are the philosophical stance informing the methodology, they provide a context for the research process and they are the approach to understanding and explaining the human world (Crotty, 1998). Each piece of research is based on a theoretical perspective

or paradigm on which research questions are based (Bowling, 2009). Bowling states that it is essential for the researcher to be aware of their perspectives about the research topic and to report on these in their research (Bowling, 2009), although Guba merely focussed on the paradigm dialogue (Guba, 1990). Epistemology is embedded in the theoretical perspectives and therefore in the methodology according to Crotty (1998). For example, he may propose my epistemological stance can help explain my perspective as interpretivism, and why phenomenology is my chosen methodology.

Constructionism/ Constructivism

There is little consistency in how the terminology of '*constructivism'* and '*constructionism'* are used (Barkway, 2001). Barkway (2001) writes that constructivism proposes that we give meaning to realities in our world and these are a construction and interpretation on our part as humans. It is focused on individuals and their unique experiences. Constructionism or '*social constructionism'* proposes that meaning is not primarily constructed by us but socially constructed from inheriting meaning from our cultures, aligning with hermeneutics (Dibley et al., 2020). It comes in to being from human interaction (Barkway, 2001). This concept aligns with my study as I am exploring experiences of the time people share together and their human interactions. Therefore, constructionism is my epistemological stance in this regard, while appreciating constructivism. Our individual interpretation of the world is informed/ influenced by our social interactions and vice versa (Guba, 1990).

Guba (1990) states constructivists feel that other paradigms are flawed and must be replaced. He argues that no paradigms are relevant and sees them as being taken to another level with a new paradigm in the future. Guba (1990) writes of subjectivism as an epistemology, and in considering it in research, where the researcher and participant are fused into a single entity and the findings are the creation of both the researcher and participant in their interactions (Guba, 1990). For me, this aligns with elements of hermeneutic phenomenology which is about interpretation, the participants' interpretation of their experiences and the researchers' interpretations of the participants' experiences. What is interesting, though makes exploring such subjects confusing and difficult, is that Crotty (1998) views subjectivism alongside constructionism, in contrast to Guba (1990). Marion (2002) on the other hand warns again constructivist approaches in phenomenology. It is useful that Guba begins his book by making his constructivist approach clear. He identifies his stance and states that it is not gospel and is merely his interpretation and understanding. Just as Thornton (2016) highlights that Crotty (1998) writings are that of his own understandings, which does not necessarily mean that they are '*correct'*. Nevertheless, it is important to consider such views and explore them in relation to my study. While also giving credence to my focus on interpretivism in the methodology chapter[155].

By taking either a constructionist or constructivist approach can enable participants to provide rich and meaningful data that would not be possible with a quantitative approach (Jensen & Laurie, 2016).

[155] Chapter 4.

Research elements (based on Crotty, 1998)
Below is where this research study is situated within each element, presented in a table for clarity though acknowledging the interlinking nature and complexity of such concepts as discussed.

Area	Where my study is situated	Further information
Epistemology	Constructionism	Though appreciating other epistemologies
Theoretical perspective	Interpretivism • Phenomenology • Hermeneutics	Existential Concerned with language
Methodology	Phenomenological research Qualitative	Heideggerian
Methods	Interview	In-depth One to one Unstructured

APPENDIX 11: Phenomenologists

Husserl (1859-1938) (Descriptive and lifeworld phenomenology)

Edmund Gustav Albrecht Husserl (1859-1938) is regarded as the principle founder of phenomenology, more specifically, descriptive (Husserlian) or transcendental phenomenology (Moran, 2000). He was inspired by Brentano, and as some would argue, a co-founder alongside Scheler (Moran, 2000). He became disillusioned with the way psychology attempted to study humans using natural science methods. Coming from a mathematical background, he hoped that philosophy would be recognised as a science is its own right. Husserl believed that philosophy should be a description of experience (Dreyfus, 1987). Husserl hoped to find the essence of human experience through eidetic reduction. Husserl developed bracketing or '*epoche'* as a way for philosophers to suspend their assumptions and thoughts to isolate the phenomena under exploration (Moran, 2000). He discussed the natural or default attitude, and by suspending our belief of the natural attitude and value judgments is to bracket which can ensure we find the essence of experience. Bracketing remains a contentious issue within phenomenology with other phenomenological philosophers rejecting the approach (Moran, 2000). However, the importance of reflecting on your experiences and thus, their influence, is obviously a strong thread through other phenomenological thinkers. He later developed the concept of the '*lifeworld'* (developed further by Merleau-Ponty and van Manen) which is the world before objectifications and judgements (Churchill & Ameriks, 1975). Some would argue as a result of his developed thinking influenced by Heidegger (Moran, 2000).

Merleau-Ponty (1908-1961) (Lifeworld phenomenology)

Maurice Merleau-Ponty was a French philosopher who recognised the importance of language (Merleau-Ponty, 1945). He was interested in '*perception'* and how it impacts on peoples understanding of, and engagement with the world. He believed that people's perceptions of the world cannot be seen in isolation from personal experience. He brought in perception and also the body to phenomenology (Dreyfus, 1987). Merleau-Ponty focused on the '*lifeworld'* (initially coined by Husserl) and proposed four existentials (domains); lived space (spaciality), lived body (corporeality), lived time (temporality) and human relations (relationality) (Merleau-Ponty, 1945). He talked about '*space'* as being the connection between everything we experience, physical space and other. '*Body'* is biological, psychological and sociological and an objective body (existing conceptually) or phenomenological body (soul). Merleau-Pointy talked of '*time'* as much more complex than a river; flowing from the past to the present and to the future, it is not a real process, it exists only with subjectivity. He described a '*cultural environment'* (p. 406) and that we live in physical and social world. All as '*lived'* from our experiences and perceptions, they are all linked. van Manen also adopted these existential themes. Merleau-Ponty makes reference to Kant (1724-1804) frequently, who proposed that all of reality is a construction of the mind and that we view the world through a lens, as discussed by Heidegger, showing their interconnected inspiration.

van Manen (1942-present) (Descriptive and interpretive phenomenology)

Max van Manen comes from the Dutch school (Utrecht tradition) which is interested in phenomenology as a reflective and practical method rather than viewing phenomenology as a philosophy (van Manen, 1990). His approach converges descriptive and interpretive phenomenology (Dowling, 2011). van Manen pursues phenomenology in a way that bridges the philosophical underpinnings and the methodological framework in research (Wright, 2013). From being heavily influenced by Heidegger and Merleau-Ponty, he acknowledges the strengths of hermeneutic phenomenology. He also considers the existentials and the lifeworld coined by Husserl and Merleau-Ponty. He does however contradict the hermeneutic

perspectives believing that our pre-understandings cause us to know too much (van Manen, 1990). van Manen proposed a six stage framework by which to which to consider research. In contrast to other interpretive phenomenologists van Manen, although recognising you cannot forget your pre-understanding, asks us to suspend and set aside our assumptions. van Manen is also commonly attributed to the concept of the phenomenological nod (developed from Otto Bollnow (Dibley et al., 2020), referring to the way in which we indicate agreement though the gesture of a nod; an affirmation that the meanings have resonance (Dibley et al., 2020).

APPENDIX 12: Pilot exploration feedback

Three students were consulted to gain feedback on the questions and interview style. They also briefly answered the proposed question and prompt questions.

	Student one	Student two	Student three	Summary
Feedback on the study/ questions/ style etc.	Questions are easy to understand		Good questions	Good, easy to understand questions
	Open questions	Broad questions to get a more varied experience		Open/ broad questions will help get a more varied experience
		Interesting study		It's an interesting study
	They all fed back the importance of ensuring it felt like a comfortable and informal experience, not a formalised interview			
Feedback on their experiences of spending time with service users	On this placement felt there was less time than wanted to spend with service users	Felt more time as a student to spend with service users, staff are busy, students are supernumerary	Students have time to listen, nurses don't have time	Generally, students feel they can have more time to spend with service users than nurses, though they can want more time
	Focus on physical observations and assessments, but service users don't like them	Structure of doing assessments, rigid but can help build relationships	Do physical observations to get to know service users, but they don't like them	Students do assessments for university which can include doing physical observations which can help to get to know the service user, but service users don't like having them done
	Enjoyed doing crosswords to build relationships	Sit with the service users, share their stories	Spending time with service users helps develop skills and build confidence	Students enjoy spending time with service users, sharing stories and doing activities, it helps develop their skills and build their confidence
	Risk issues difficult as first ward placement	Impact of ward environment	Impact of ward atmosphere, risk issues, impact of incidents	The ward atmosphere/ environment, risk and incidents can affect the students experience on placement
	Cultural barriers impacting on assessment		Challenge of lack of understanding/ knowledge	They can experience difficulties on placement due to barriers or lack of understanding
		Impact of being supervised on flow of discussions		Students get supervised on placement which can impact negatively on the flow of discussions with service users
	Nice to see service users recover		Help with recovery	Students like to support service users' recovery and see them recover

Student one-

This feedback was received by email.

'The questions are easy to understand, are you looking for a certain amount of content? As the first one is quite open? I've written next to them how I would answer them. You've put that your study is about ward placements so I've answered for my ward placement rather than my most recent placement.

-Tell me about your time with service users on your last placement- on my ward placement, I wasn't able to spend as much time with service users as I would have liked. At times it felt like I was only able to talk to service users when asking them questions e.g. For the LUNSARS or about admission related matters and didn't have as much opportunity to build therapeutic relationships. I was able to spend time with a service user for my storyboard and sometimes in the art room with OT if I wasn't allocated other tasks.

-What is it like spending time with service users/ Tell me about talking to service users- as above, it was also eye opening experience as it was my first ward experience, I became more aware of the environment and ensuring I was more vigilant of what the service user was doing. As one service user stole one of the blood monitoring finger prick devices to self harm with and I didn't realise until she told another member of staff.

-Tell me about the first time you spent some time with a service user on your last placement- I found it difficult at times because as previously mentioned I didn't have as much time as I would have liked to talk to/spend time with service users. I feel that this made it difficult to build rapport with service users because often my first contact would be doing physical health observations for the NEWS chart and some service users were not happy about having obs taken and found this intrusive.

-Tell me about a good time you spent with a service user- I felt that I built a good relationship with one lady as we spent some time together doing crosswords, it was also lovely to see her recovery and be involved in this.

-What about a challenging time- I was given admission paperwork to do for a new service user. This was the first time I had tried to do an admission, the service user was a Muslim lady observing Ramadan. She refused to talk to me and would only speak to people of her own faith. I had to ask a Muslim member of staff to speak to the service user, it was challenging as I felt like I had failed to complete the task but did make me consider how I would approach the situation if it happened again.'

Student two-

This feedback was gained via telephone and the notes below are my notes on what they discussed, my thoughts are in brackets.

'Questions broad, get a more varied experience.
As students we have more time to spend with service users than the staff.
As a student nurse- build rapport, staff/ nurses are busy, we're the middle area, share stories with us they want to, their past experiences. Sit somewhere with them.
Depends on the ward environment
As supernumerary spend lots of time with service users.
We do DONAs (direct observation of nursing care) that are rigid, but structure can help build relationships.
(I need to say first time on that unit, first time with service user/ student) It's broad but can answer.
Easier not being supervised, doesn't flow as well if three in a room, but can be easier if a few people to talk between.
'Ask tell me about a time you spent with a service user that was good' (as well as challenging)- good question.
Good practice to be a nurse.
Hope there will be a positive outcome/ good experience on placements.
Sounds like it will be interesting.
Ice breaker- ask them about themselves. (I keep agreeing, 'yes, definitely', need to be mindful of this)'

Student three-

This feedback was gained via telephone and the notes below are my notes on what they discussed, my thoughts are in brackets.

'(Really interesting conversation, made me excited about doing the interviews. I hope the participants are as good to interview as XXX. Interesting answers and useful feedback. More holistically focused on details rather than practical stuff).
(She asked whether it was in general or during 1:1- I said both.)
Can be challenging because of the atmosphere on the ward.
After incidents like ligatures- you can take it too much on yourself. The service users don't see it out of the ordinary.
Building confidence, therapeutic for me as well as them (spending time together).
Open up to them, talking to them about their conditions broadening understanding.
1:1 nurses haven't got time, students have the time to listen.
Students help with recovery
Most staff want it their way, service users can be more comfortable with students. Students need to hand over to the staff about the conversations. Students can collect more information because they spend more time with service users and they are more comfortable.
Workload of nurses, service users want to be listened to, students are learning.
It is supportive for students, informative, educational.
During 1:1s, not comfortable at first, didn't know what to say or how to start, but confidence builds.
When the service users talks then that's it… ignites (confident, feel more relaxed)
A good time- see the positive reaction, doing specific work with service users.
Challenging- middle of it all felt like throwing it away- lack of understanding/ knowledge/ felt frustrated. This changed over time, now I know better.
There is a blaming culture- staff about people with a personality disorder. Staff tell you- handover, risk.
Staff pre-empt the way the service users will engage, cloud student judgments.
Communication- need to use reflection.
service users, staff, students, the ward environment.
If you're willing to learn, you get back based on what you respond. Be polite, without a preconceived conclusion.
As a student you need to take charge of things like physical observations to get to know the service users, it's a good avenue. Helping with other tasks like meals. Builds your confidence, more time to spend with them. But students complain about doing those tasks.
service users start conversations with you.
'Good questions, better to not have a time constraint. Keep your approach, keep it simple, informal'.

APPENDIX 13: Research proposal

You will notice here the initial term service user was used, as described in the introduction to the thesis, patient was later decided upon as the term the participants used.

Professional Doctorate study
Emma Jones, Researcher, University of Central Lancashire ejones14@uclan.ac.uk
Supervisors- Dr Karen Wright, Head of School; Dr Mick McKeown, Reader

Title
The lived experience of the time service users and students spend together on male personality disorder units: A phenomenological study.

Question
What is the lived experience of the time students and service users spend together on male personality disorder units?

Aim
To illuminate the lived experiences of service users and students of the time they spend together on male personality disorder units

Background
The time students and service users spend together is an area that has not been explored before. It is important that service users and student's experiences are explored. Other studies have explored experiences of the '*relationship'* (Aiyegbusi & Kelly, 2015; Hörberg et al., 2004; Jones & Wright, 2017; Walton & Blossom, 2013) however that is assuming there is a relationship and also restricts the focus of participants' experiences purely on this relationship rather than experiences of the wider time together. Students are the future of nursing and often have the most contact with service users (Jones & Black, 2008), they are new and fresh into nursing and may not have the engrained views that qualified staff have (Bowers et al., 2007). It is therefore important to consider experiences of the time service users and students spent together.

Service users are people who may need support at some point in their lives from mental health services. Many will, as part of their treatment, be given a diagnosis of a mental health problem. One of these diagnoses is personality disorder. The term *personality disorder* has been known to create stigma and its usefulness for service users has been questioned because of this (Bolton et al., 2014). It has been a subject of dispute for many years leading to questions regarding the whole concept (Tyrer et al., 2015). The United Kingdom Government has produced a number of documents over the past two decades focusing on the assessment and treatment of people with a personality disorder in a variety of settings (Bolton et al., 2014; Bradley, 2009; Department of Health, 2009; Home Office & Department of Health, 1999; National Institute for Health and Care Excellence, 2009, 2013; National Institute for Mental Health in England, 2003a, 2003b; National Offender Management Service & NHS England, 2015). These documents focus on enhancing the services that are provided and support the upskilling of the workforce to ensure high quality care for service users with a personality disorder. There are 10 different types of personality disorder. Service users with cluster B diagnoses are considered to more commonly present to services (National Institute for Health and Care Excellence, 2009, 2013), therefore the service users in the study will most likely have a cluster B diagnosis. In '*cluster B*' there is antisocial, histrionic, narcissistic, and borderline, which are referred to as the '*dramatic and erratic*' cluster of personality disorders (American Psychiatric Association, 2013). Many studies exploring personality disorder focus

on women and borderline personality disorder (Binks et al., 2006; Gibbon et al., 2010), hence this study aims to recruit participants on a male unit.

Student mental health nurses complete a three year degree and as part of this course they spend 50% of their time out on clinical nurse placements. When on these placements they are expected to spend time with service users, support them and help them work towards their recovery. It is important to explore what their experiences are of the time they spend with services users to understand the phenomena's present in this time.

Significant contribution to professional practice

Phenomenological studies do not aim to be generalisable or make bold claims of contribution. However, the experiences of people are important and can show us rich and insightful data that can contribute to people's understanding and learning. The experiences of service users and student mental health nurses of their time together has not been explored before. An exploration of these experiences will add rich and meaningful insights into this area. Minimal previous research has explored service users with personality disorder views of the '*relationship'* (Aiyegbusi & Kelly, 2015); and none of the '*time'* people spend together and not with students. Students' views of relationships with service users with personality disorder have been explored before (Jones & Wright, 2017) but not concerning their lived experiences of the time they spend with service users. Much of the literature focuses on attitudes towards people with a personality disorder; this study is taking a holistic approach and focusing on the time service users and students spend together.

Methodology

My qualitative study will be informed by a phenomenological perspective as I aim to explore the participants lived experience (Dowling, 2007). I aim to describe, explore, interpret, and understand the participants' experiences of certain phenomena to determine meaning (Tuohy et al., 2013) which makes phenomenology an ideal underpinning philosophy. Essentially I aim to explore the participant's experiences and enable their voices to be heard by collecting raw and meaningful data. Only by seeking the participants' perspectives, thoughts and feelings can I truly understand their experiences of the time they spend with each other.

I acknowledge my biases and understand that this study is not only about the participants' stories and experiences but my interpretation of them, hence a Heideggerian Hermeneutical approach is appropriate (Chang & Horrocks, 2008; Smythe et al., 2008). The values of the researcher and participants, impact on all aspects of the research, it is important to acknowledge this (Morgan et al., 2015). My approach is grounded in constructionism, believing that knowledge and reality are dependent on human practice and their construction from interactions between others in the social context (Crotty, 1998).

Method

Semi-structured interviews are the chosen method as they bring raw and meaningful qualitative data (Jones, 1996) which is essential in phenomenological research. They are effective in collecting opinions and exploring experiences (Marshall & Rossman, 2011) which is what my study aims to do. I will ensure the interviews are made accessible to the participants using an appropriate environment on the unit. They will last between an hour and an hour and a half, they may take less than this and the participants can take breaks as they need. This is clear in the information sheet.

Reflexivity is vital in phenomenological studies (Finlay, 2003; Lacey & Luff, 2007). I aim to keep a reflexive log to ensure assumptions are considered and reflected upon with the supervisory team to be aware of any implications and assumptions that have or may be made.

Sample
A sample of student mental health nurses, and service users from two male personality disorder units will be invited to participate in the research. The care team will identify appropriate service users to participate and have the capacity to do so. Then those who are interested will be given an information sheet to consider the study. The researcher will visit the units and discuss the study with the care team and students. Students will be directed to the information sheets. Consent forms will be completed prior to the interviews. I will aim to recruit 10 participants in each group. The participants may be asked to engage in more than one interview to ensure the questions have been fully answered, which is included in the information sheet. The students will be in their 2nd or 3rd/ last year of a BSc or MSc in mental health nursing at a UK university.

Data analysis
The faculty research support team at the University of Central Lancashire will transcribe the interviews from spoken word to written transcriptions. The transcripts will be analysed by the researcher and research supervisors using thematic analysis (Braun & Clarke, 2006; Lacey & Luff, 2007). Braun and Clarke (2006) identify five key areas of thematic analysis; familiarisation, initial coding, searching for themes, reviewing themes, defining and naming themes, and producing the report. I will generate initial themes from the data and subsequently search for themes (Braun & Clarke, 2006). Computer software will be used to analyse the data collected, such as NVivo or MAXQDA. Credibility, usefulness and quality of results will be enhanced through careful documentation of stages and decisions in the analysis when data are converted into understandable themes (Moule et al., 2017).

Dissemination
I aim to work towards publication of articles and presentation of the study at academic conferences. Further research opportunities will be explored following the study, which will possibly lead to networking with other institutions and professionals.

The University of Central Lancashire is partially funding this project, I will be supported with study leave and resources. I will ensure equipment is available and in working order.

Ethical considerations
Approved by the NHS Research Ethics Committee, the Health Research Authority and the University of Central Lancashire.

Ethical implications of this study were important to consider fully. Ethical reflections have been completed to show consideration of the ethical areas of my study. I am a university lecturer in the UK and have previously worked in a secure unit (not the sites for this study) and I have therefore some potential biases that need to be considered. Reflexivity is vital to ensure any biases are stated (Finlay, 2003).

Involving mental health service users in research can raise ethical issues that need to be addressed (Rodriguez, 2012). I will ensure these issues are fully explored and clear strategies used to resolve them. An action plan will be in place if there are concerns with participants being in distress during the interviews and necessary support will be provided.

A potential ethical concern when using interviews is over-disclosure by the participants and the impact of over-disclosure. It is important that I am aware of how the participants are when they leave the interview (Moule et al., 2017). The interviews will be completed in a safe environment. I need to ensure confidentiality is maintained but also that the participants and others' safety is protected.

In addition to the above, it is a possibility that I may be informed of bad practice which presents ethical dilemmas (Moule et al., 2017). Any concerns must be discussed with my supervisor and formally dealt with and reported as necessary. If there is a need to report an illegal act this overrides the confidentiality agreement (Robson, 2011). As a nurse I have to abide by the Nursing and Midwifery Council code of conduct (Nursing and Midwifery Council, 2015) and have a duty to report such incidents. However there are limits to confidentiality. Through using information sheets it ensures the participants are fully informed of these issues, of the purpose of the study, their commitment and any risks (Marshall & Rossman, 2011). It is important that I ensure I am clear of any potential risks and what I would do if they occur; including issues with my safety.

APPENDIX 14: Letters

Letter to service users

School of Nursing
University of Central Lancashire
Preston
PR1 2HE
06.11.17

Dear service users,

I am inviting you to participate in an interview for a piece of research called- The lived experience of the time service users and students spend together on male personality disorder units: A phenomenological study.

You are being invited because you are a service user on the unit. The aim of this study is to explore your experiences of your time with students.

During the interview I will encourage you to talk about your opinions and your experiences. This is part of my research project for a Professional Doctorate at the University of Central Lancashire (UCLan).

Your decision to take part in this project **does not** in any way affect your care. The decision to take part is **entirely up to you** and you are free to withdraw at any stage during the discussion.

If you want to take part, please read the participant information sheet. I will be attending the unit so you can ask me any questions and let me know you are interested.

Thank you for taking the time to read this invitation.
Yours sincerely

Emma Jones
Researcher
School of Nursing
Brook building
UCLan
Preston
PR1 2HE
Email: ejones14@uclan.ac.uk

Letter to care team regarding service users

School of Nursing
University of Central Lancashire
Preston
PR1 2HE
06.11.17

Dear Sir or Madam,

I am inviting the service users in your care to participate in an interview for a research project called- **The lived experience of the time service users and students spend together on male personality disorder units: A phenomenological study**

The aim of this project is to explore their experiences of their time with student mental health nurses.

During the interview I will encourage participants to express their opinions about their experiences. This is part of my research project for a Professional Doctorate at the University of Central Lancashire (UCLan).
Their decision to take part in this project **does not** in any way affect their care. They will be free to withdraw at any stage.

I am writing to ask for you to identify service users you feel would be able to participate in the study and to ensure they have the capacity to participate. Please then signpost them to the information sheet available on the unit.
An information folder will be available on the unit which will include the information sheet, for them to review, they may ask you questions and they can ask me any questions they have before deciding to participate. They will be asked to sign a consent form. A copy will be given to you for their records.

Thank you for taking the time to read this letter. Please do not hesitate to contact me if you have any questions.

Yours sincerely

Emma Jones
Researcher
School of Nursing
Brook building
UCLan
Preston
PR1 2HE
Tel: 01772 895117
Email: ejones14@uclan.ac.uk

Letter to students

School of Nursing
University of Central Lancashire
Preston
PR1 2HE
06.11.17

Dear students,

I am inviting you to participate in an interview for a piece of research called- The lived experience of the time service users and students spend together on male personality disorder units: A phenomenological study.

You are being invited because you are a student mental health nurse on the unit. The aim of this study is to explore your experiences of your time with service users.

During the interview I will encourage you to talk about your opinions and your experiences. This is part of my research project for a Professional Doctorate at the University of Central Lancashire (UCLan).

Your decision to take part in this project **does not** in any way affect your studies. The decision to take part is **entirely up to you** and you are free to withdraw at any stage during the discussion.

If you want to take part, please read the participant information sheet. I will be attending the unit so you can ask me any questions and let me know you are interested.

Thank you for taking the time to read this invitation.
Yours sincerely

Emma Jones
Researcher
School of Nursing
Brook building
UCLan
Preston
PR1 2HE
Email: ejones14@uclan.ac.uk

Letter to University staff

School of Nursing
University of Central Lancashire
Preston
PR1 2HE
06.11.17

Dear Sir or Madam,

I am inviting the students at your university to participate in an interview for a research project called- **The lived experience of the time service users and students spend together on male personality disorder units: A phenomenological study.**

The aim of this project is to explore the students' lived experience of the time they spend with service users on their placements.

During the interview I will encourage participants to express their opinions about their lived experience. This is part of my research project for a Professional Doctorate at the University of Central Lancashire (UCLan).
Their decision to take part in this project **does not** in any way affect their course or placement. The decision to take part is **entirely up to them** and they are free to withdraw at any stage during the discussion.

Thank you for taking the time to read this letter.
Yours sincerely

Emma Jones
Researcher
School of Nursing
Brook building
UCLan
Preston
PR1 2HE
Tel: 01772 895117
Email: ejones14@uclan.ac.uk

APPENDIX 15: Participant information sheets

Service user participant information sheet

Information Sheet for Service Users

Research study title: The lived experience of the time service users and students spend together on male personality disorder units: A phenomenological study.

Name of researcher: Emma Jones

Researcher's contact details: Emma Jones, Professional Doctorate Research Student, University of Central Lancashire, Preston, PR12HE, ejones14@uclan.ac.uk

Director of studies: Dr Karen Wright, Research Supervisor, School of Nursing, University of Central Lancashire. KMWright1@uclan.ac.uk

You are invited to take part in a research study. Before you decide, we would like you to understand why the research is being done and what it would involve for you, so please read this information sheet. Talk to others about the study if you wish. This information sheet tells you about the purpose of this study and what will happen if you take part. Please do not hesitate to contact the researcher, Emma Jones, at the email above or discuss this with your care team if there is anything that is unclear or if you have any further questions.

Part one
What is the purpose of the research study?
The purpose of this study is to explore your experience of the time you have spent with student mental health nurses. The time service users spend with students is important, however we know very little about service user's experiences of this time. Hence, the findings from this study will assist us to gain an understanding of your experience and provide new information.

Why have I been invited?
You have been invited to take part because you are a service user who has had experience of spending time with students.

Do I have to take part?
No, participation in this research study is entirely voluntary and it will not affect your care in any way. It is up to you to decide to join the study by completing and signing the consent form. You are free to withdraw up until analysis, without giving a reason.

What will happen to me if I take part? What will I have to do?
If you decide to take part in the study, you will be asked to take part in an interview with Emma Jones, the researcher, to discuss your thoughts of the time you have spent with student mental health nurses. The interviews are anticipated to last between an hour and hour and a half, they may take less and you can have breaks at any point. You may be invited to participate in further follow up interviews to ensure understanding of your experiences. You can say as much or as little as you wish.

The interviews will be audio recorded using a digital recorder. Afterwards, the university faculty research support team will type the taped recording from spoken word into a written format. The transcript will be used for the analysis and this will be done by the researcher (Emma Jones) and research supervisors (Karen Wright and Mick Mckeown). As this study forms part of an academic qualification (Professional Doctorate in Health) the dissertation written will be the final report. The study write-up is expected to be completed by September 2021.

What are the possible disadvantages and risks of taking part?
The researcher will ask you to talk about your thoughts, perceptions and feelings which some people may find difficult. You are asked to only talk about aspects of your experience that you are comfortable to share, and will not be expected to discuss anything that you are not happy to be included anonymously in the research write-up.

What are the possible benefits of taking part?
Your participation will give you the opportunity to voice your opinions, reflect upon these and talk about your experiences. This subject area has not been explored before and by participating in this study you will have contributed to providing new information for this topic.

What will happen if I do not want to carry on with the study?
You can change your mind at any time up to and during the interview and withdraw from the study. You do not have to give a reason for this. If your data has already been analysed it will not be possible to withdraw this, however any quotations used will be anonymised so that they are non-identifiable.

What if there is a problem? Complaints
If you have any concerns please contact Emma (ejones14@uclan.ac.uk) in the first instance. You may also contact Karen, research supervisor (KMWright1@uclan.ac.uk). Concerns should be addressed to the University Officer for Ethics at OfficerForEthics@uclan.ac.uk. Information provided should include the study name or description (so that it can be identified), the student investigator and the substance of the complaint.

Will my taking part in the research study be kept confidential?
Yes, your contributions will be kept confidential by the researcher and research supervisors. There cannot be a promise of complete confidentiality, however, we will follow ethical and legal practice, as the researcher has a duty to keep your participation and information confidential within the usual limits of confidentiality (see below for details of the limits of confidentiality). Any personal information about you will be treated as confidential; your name will not appear anywhere in the research, your care team or the students you have spent time with will not be aware of what you say (see below for details of the limits of confidentiality). Any quotations used will be anonymised so that they are non-identifiable. Your care team will be aware you will be participating in the research, a copy of the consent form will be put in your notes. Please be aware our discussions will be confidential, unless you raise something during the interview which is of concern to risk to yourself or others, as referred to below. The researcher may need to inform your care team if you require any support, although this is not anticipated.

The confidentiality and anonymity of the other students, staff and any service users discussed will also need to be maintained, therefore if you mention other service users, students, or staff during the interview, please aim not to reveal their names (e.g. use initials or change names). However, should you inadvertently do so, these will not be typed up.

Limits of confidentiality
Please note that if, during the interview you reveal any risk to your own safety or the safety of other people, or if you discuss any information that raises concerns about anyone's clinical or professional practice, then the researcher will have to inform the appropriate persons within your care team, in accordance with the university procedures and policies. If this needs to happen, the researcher will inform you of this in advance.

Storage of information
Recordings and typed versions of the interviews and consent forms will be stored securely in a locked cabinet at the university and electronic files will be password protected. Your consent forms will be stored separately to the transcriptions with another name used. The anonymised transcripts will be accessible for other studies.

What will happen to the results of the research study?
The researcher will disseminate the findings to appropriate stakeholders via a presentation. The researcher aims to publish the research study in an appropriate journal so it is available outside of the service for other professionals and services.

Who has reviewed the research study?
This research study has been approved by; the NHS Research Ethics Committee, the Health Research Authority and the University of Central Lancashire.

What do I do if I decide I want to take part?
If, after reading this information sheet you decide that you would like to take part in the study, please inform your care team. You will complete and sign the consent form prior to beginning the interview. Your care team will assess your capacity and decide if it is appropriate for you to take part in the study.

Thank you for taking the time to read this information sheet.
Emma Jones
Professional Doctorate Student
University of Central Lancashire

Student participant information sheet

Information Sheet for Students

Research study title: The lived experience of the time service users and students spend together on male personality disorder units: A phenomenological study.

Name of researcher: Emma Jones

Researcher's contact details: Emma Jones, Professional Doctorate Research Student, University of Central Lancashire, Preston, PR12HE. Email: ejones14@uclan.ac.uk

Director of studies: Professor Karen Wright, Research Supervisor, School of Nursing, University of Central Lancashire. Email: KMWright1@uclan.ac.uk

You are invited to take part in a research study. Before you decide, we would like you to understand why the research is being done and what it would involve for you, so please read this information sheet. Talk to others about the study if you wish. This information sheet tells you about the purpose of this study and what will happen if you take part. Please do not hesitate to contact the researcher, Emma Jones, at the email above or discuss this with your mentor if there is anything that is unclear or if you have any further questions.

Part one

What is the purpose of the research study?

The purpose of this study is to explore your experiences of the time you spent with service users. The time students spend with service users is important, however we know very little about student's experiences of this time. Hence, the findings from this study will assist us to gain an understanding of your experience and provide new information.

Why have I been invited?

You have been invited to take part because you are a mental health nursing student who has had experience of spending time with service users.

Do I have to take part?

No, participation in this research study is entirely voluntary and it will not affect your course in any way. It is up to you to decide to join the study by completing and signing the consent form. You are free to withdraw up until analysis, without giving a reason.

What will happen to me if I take part? What will I have to do?

If you decide to take part in the study, you will be asked to take part in an interview with Emma Jones, the researcher, to discuss your experiences of the time you have spent with service users. The interviews are anticipated to last between an hour and hour and a half, they may take less and you can have breaks at any point. You may be invited to participate in further follow up interviews to ensure understanding of your experiences. You can say as much or as little as you wish.

The interviews will be audio recorded using a digital recorder. Afterwards, the university faculty support team will type the taped recording from spoken word into a written format. The transcript will be used for the analysis and this will be done by the researcher (Emma Jones) and research supervisors (Karen Wright and Mick Mckeown). As this study forms part of an academic qualification (Professional Doctorate in Health) the dissertation written will be the final report. The study write-up is expected to be completed by September 2021.

If you wish, you can receive a certificate of participation in the study and transcripts for you to reflect on as part of your continued personal and professional development.

What are the possible disadvantages and risks of taking part?
The researcher will ask you to talk about your thoughts, perceptions and feelings which some people may find difficult. You are asked to only talk about aspects of your experiences that you are comfortable to share, and will not be expected to discuss anything that you are not happy to be included anonymously in the research write-up.

What are the possible benefits of taking part?
Your participation will give you the opportunity to voice your opinions, reflect upon these and talk about your experiences. This subject area has not been explored before and by participating in this study you will have contributed to providing new information for this topic.

What will happen if I do not want to carry on with the study?
You can change your mind at any time up to and during the interview and withdraw from the study. You do not have to give a reason for this. If your data has already been analysed it will not be possible to withdraw this, however any quotations used will be anonymised so that they are non-identifiable.

What if there is a problem? Complaints
If you have any concerns please contact Emma (ejones14@uclan.ac.uk) in the first instance. You may also contact Karen, research supervisor (KMWright1@uclan.ac.uk). Concerns should be addressed to the University Officer for Ethics at OfficerForEthics@uclan.ac.uk. Information provided should include the study name or description (so that it can be identified), the student investigator and the substance of the complaint.

Will my taking part in the research study be kept confidential?
Yes, your contributions will be kept confidential by the researcher and research supervisors. There cannot be a promise of complete confidentiality, however, we will follow ethical and legal practice as the researcher has a duty to keep your participation and information confidential within the usual limits of confidentiality (see below for details of the limits of confidentiality). Any personal information about you will be treated as confidential; your name will not appear anywhere in the research, and placements and the university will not be aware of what you say (see below for details of the limits of confidentiality). Any quotations used will be anonymised so that they are non-identifiable. Your mentor/s will be aware you will be participating in the research. Please be aware our discussions will be confidential, unless you raise something during the interview which is of concern to risk to yourself or others, as referred to below. The researcher may need to inform your mentor if you require any support, although this is not anticipated.

The confidentiality and anonymity of the other students, staff and any service users discussed will also need to be maintained, therefore if you mention other students, staff or service users during the interview, please aim not to reveal their names (e.g. use initials or change names). However, should you inadvertently do so, these will not be transcribed.

Limits of confidentiality
Please note that if, during the interview you reveal any risk to your own safety or the safety of other people, or if you discuss any information that raises concerns about yours or others' clinical or professional practice, then the researcher will have to inform the appropriate persons within or outside the placement area, in accordance with the university procedures and policies. If this needs to happen, the researcher will inform you of this in advance.

Storage of information
Recordings and typed versions of the interviews and consent forms will be stored securely in a locked cabinet at the university and electronic files will be password protected. Your consent forms will be stored separately to the transcriptions with another name used. The anonymised transcripts will accessible for other studies.

What will happen to the results of the research study?
The researcher will disseminate the findings to appropriate stakeholders via a presentation. The researcher aims to publish the research study in an appropriate journal so it is available outside of the service for other professionals and services.

Who has reviewed the research study?
This research study has been approved by; the NHS Research Ethics Committee, the Health Research Authority and the University of Central Lancashire.

What do I do if I decide I want to take part?
If, after reading this information sheet you decide that you would like to take part in the study, please inform your mentor. You will complete and sign the consent form prior to beginning the interview.

Thank you for taking the time to read this information sheet.
Emma Jones
Professional Doctorate Student
University of Central Lancashire

APPENDIX 16: Consent forms

Consent form for service users

Title of study: The lived experience of the time service users and students spend together on male personality disorder units: A phenomenological study.

Name of researcher: Emma Jones

Please initial each item

1. I confirm that I have read and understand the information sheet dated 06.11.17 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
3. I understand that as part of this study there will be audio recording. ☐
4. I understand that I will not be named in the final report or in any publications. ☐
5. I agree to take part in the above study. ☐
6. I understand that relevant data collected during the study may be looked at by individuals from the University of Central Lancashire, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. ☐
7. I agree for the anonymised data/ transcripts to be kept for use in other studies ☐

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Name of participant	Date	Signature
---	---	---
Name of person taking consent	Date	Signature

When completed: 1. For participant; 1. For researcher records; 1. Care records

Consent form for students

Title of study: The lived experience of the time service users and students spend together on male personality disorder units: A phenomenological study.

Name of researcher: Emma Jones
Please initial each item

1. I confirm that I have read and understand the information sheet dated 06.11.17 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
3. I understand that as part of this study there will be audio recording. ☐
4. I understand that I will not be named in the final report or in any publications. ☐
5. I agree to take part in the above study. ☐
6. I understand that relevant data collected during the study may be looked at by individuals from the University of Central Lancashire, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. ☐
7. I agree for the anonymised data/ transcripts to be kept for use in other studies. ☐

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Name of participant	Date	Signature
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Name of person taking consent	Date	Signature

When completed: 1. For participant; 1. For researcher records

If you wish to receive transcripts for reflection as part of your continued personal and professional development and to receive a summary of the study, please leave your email.

Email address ----------

APPENDIX 17: Topic guides

Topic guide for service users

Introduction of researcher and thanks
How long it will take- approximately 60-90 minutes, can be less, can have breaks
If you need to leave
Confidentiality- anonymity
Digital recording and transcription
Refer to information sheet
Explanation re semi-structured nature of the interview
Consent forms

Questions:	**Prompts**
Tell me a bit about yourself	
Tell me about your time with students?	Tell me about spending time with students? Tell me about talking to students? What is it like spending time with students? Tell me about the first time with a student? Tell me about the last time with a student? Tell me a story about that/ another time? Tell me about a challenging time/ a good time? What does/ did that mean to you? Can you say/ tell me more about it/ that? Do you have a story about that/ to explain that? As you think about this, what comes to you? Can you describe that? What would you like to say about that? When you noticed- what did you see/ think/ what did that look like? Go back to that time, what was it like? What was happening? Can you tell me more about what you mean? What was that silence filled with? What do you mean about that word? Can you give me an example of that?
Anything else you would like to add/discuss?	Any other comments?
Summarise and clarify Thank you very much for taking part	Your thoughts on the discussions we've had today? Anything else to clarify?

Thank you

Topic guide for students

Introduction of researcher and thanks
How long it will take- approximately 60-90 minutes, can be less, can have breaks
If you need to leave
Confidentiality- anonymity
Digital recording and transcription
Refer to information sheet
Explanation re semi-structured nature of the interview
Consent forms

Questions:	**Prompts**
Tell me a bit about yourself	
Tell me about your time with service users?	Tell me about spending time with service users? Tell me about talking to service users? What is it like spending time with service users? Tell me about the first time with a service user? Tell me about the last time with a service user? Tell me a story about that/ another time? Tell me about a challenging time/ a good time? What does/ did that mean to you? Can you say/ tell me more about it/ that? Do you have a story about that/ to explain that? As you think about this, what comes to you? Can you describe that? What would you like to say about that? When you noticed- what did you see/ think/ what did that look like? Go back to that time, what was it like? What was happening? Can you tell me more about what you mean? What was that silence filled with? What do you mean about that word? Can you give me an example of that?
Anything else you would like to add/discuss?	Any other comments?
Summarise and clarify Thank you very much for taking part	Your thoughts on the discussions we've had today? Anything else to clarify?

Thank you

APPENDIX 18: IRAS ethical approval

NHS
Health Research Authority

Miss Emma Jones
Senior Lecturer
University of Central Lancashire
Brook building 309
University of Central Lancashire
PR12HE

Email: hra.approval@nhs.net

10 November 2017

Dear Miss Jones

Letter of HRA Approval

Study title:	**The lived experience of the time service users and students spend together on male personality disorder units: A phenomenological study**
IRAS project ID:	**181725**
REC reference:	**17/NW/0643**
Sponsor	**University of Central Lancashire**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from the HRA website.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through IRAS.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

procedure. If you wish to make your views known please use the feedback form available on the HRA website.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details on the HRA website.

Your IRAS project ID is **181725**. Please quote this on all correspondence.

Yours sincerely

Aliki Sifostratoudaki
Assessor

Email: hra.approval@nhs.net

Copy to: *Ms Denise Forshaw, University of Central Lancashire, Sponsor Contact*

APPENDIX 19: University of Central Lancashire ethical approval

22 December 2017

Karen Wright / Emma Jones
School of Nursing
University of Central Lancashire

Dear Karen / Emma

Re: STEMH Ethics Committee Application
Unique reference Number: STEMH 735

The STEMH ethics committee has granted approval of your proposal application 'The felt experience of the relationship between male service users with antisocial personality disorder and student mental health nurses in a secure service: A phenomenological study'. Approval is granted up to the end of project date*. It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Please also note that it is the responsibility of the applicant to ensure that the ethics committee that has already approved this application is either run under the auspices of the National Research Ethics Service or is a fully constituted ethics committee, including at least one member independent of the organisation or professional group.

Yours sincerely

Karen A. Rouse

Karen Rouse
Vice Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date
NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

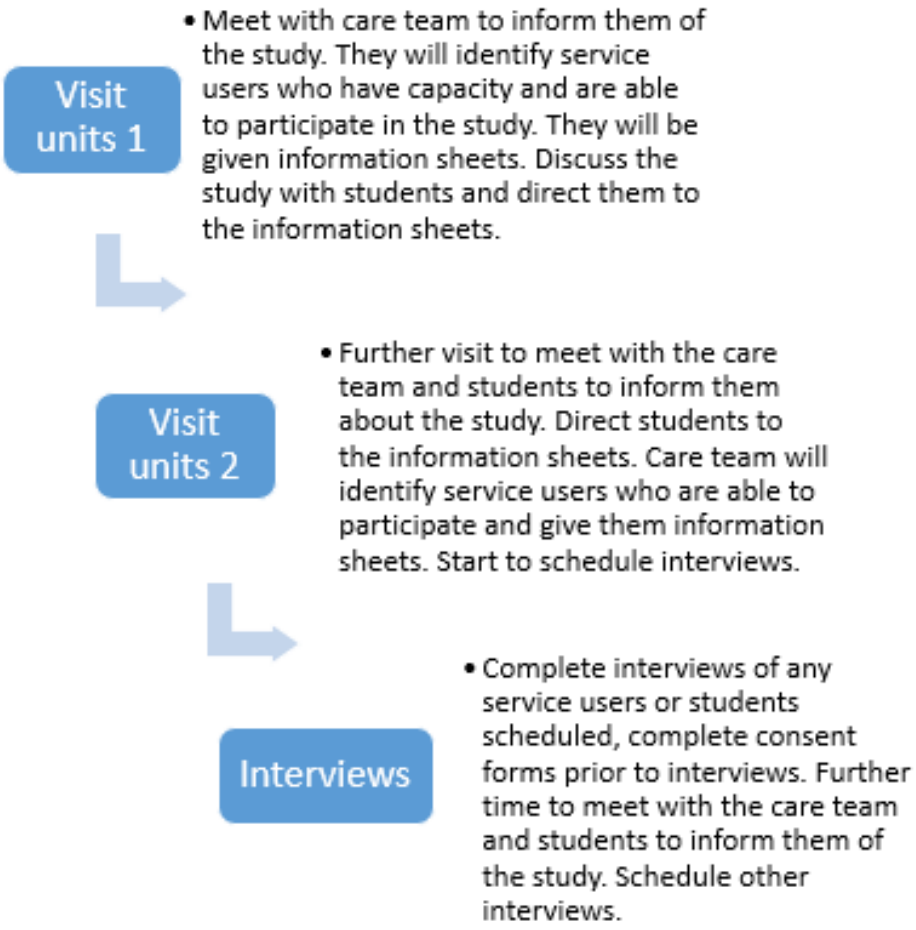
APPENDIX 20: Risk assessment

What	How to manage	Documentation
Psychological harm to the participants The researcher will ask the participants to talk about their thoughts, views and feelings, which some people may find difficult. There is a small potential for participants to become distressed during the interview.	The interviews may touch on sensitive areas, if disclosed, but there are no questions that seek to explore sensitive areas. It is not intended that the focus on the interviews will be difficult or sensitive areas, however it is dependent on the participant's responses. Clear information on the information sheet about what is expected. Time to consider participation in the study. Time to discuss participation with mentors/ key workers. Time to ask questions before hand. Signing of the consent form to confirm the participants have read the information sheet fully. Handover as necessary to staff/ mentors. Researcher will ensure on leaving the participants are okay. Participants can stop the interview at any point if needed. Interviews will take place in an appropriate environment. Participants are asked to only talk about aspects of their experiences that they are comfortable to share, and will not be expected to discuss anything that they are not happy to be included anonymously in the research write-up.	Consent form
Physical risk If the participants become distressed this may increase the risk for the researcher as physical or emotional harm.	The researcher will be known to the staff on the ward. Security and safety procedures will be followed. The researcher will ensure they make others aware of where they are, they will sit near the exit of a room and will report any concerns to the supervisory team or care team on the unit. The researcher will be completing the interviews in a secure unit with service users who may be sectioned under the Mental Health Act and may become distressed. Appropriate security measures will be followed as per the unit's policies, for example the researcher may need to wear a personal alarm.	Security and safety documentation
There is the potential for over disclosure	The researcher will ensure the participants are aware of this at the start of the interview. The researcher is an experienced professional and will ensure the participants are supported if this does occur and the staff will be accessible if any distress does occur. If the participants appear upset by anything, the researcher will steer the discussion away from sensitive areas. For the service users, the care team will be informed. For the student, the mentor may be informed if necessary.	Reporting of any distress to the staff team, who would record this in the patient notes.

There may be a risk of breach of confidentiality. Significant risk to any person or a disclosure of criminal activity	Any names or identifying information will not be written in the research write up and any identifiable information will be changed appropriately. If there is any disclosure of criminal activity or direct risk of harm to the participants or others, confidentiality must be broken. This is made clear in the information sheet for the participants. Support will be gained from the research supervisors where required and if the researcher is unclear if there is a complex situation. All interviews will commence with a discussion around confidentiality and the exceptions to that (risk/ disclosure/ legal). Because these are forensic areas, criminal activity may be disclosed. The researcher will ask the participant if such activity is known about already. If not the interview will be paused and a discussion will occur regarding disclosure.	Reporting of any breaches in confidentiality to the staff team who will follow their procedures and document appropriately.

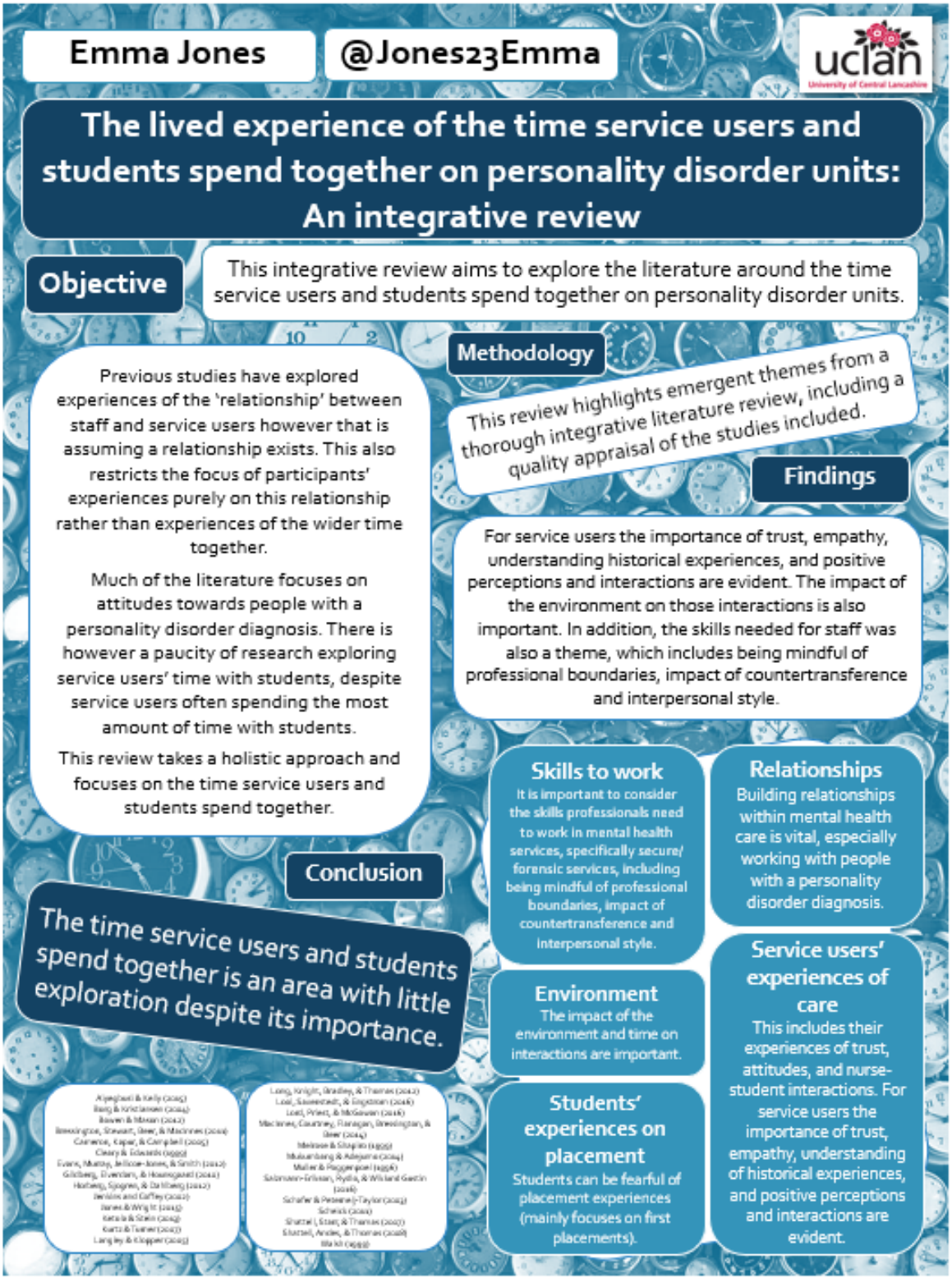
APPENDIX 21: Flow chart of proposal

Flowchart of Proposal



APPENDIX 22: Conference poster: Literature Review

Poster presentation at the yearly conference British and Irish Group for the Study of Personality Disorder 2018. Link to access poster- https://docs.google.com/presentation/d/1qrlJHBxkGv-PNdxlp8NADMYuNm7ijKS8/edit?usp=sharing&ouid=103172272412826427473&rtpof=true&sd=true



APPENDIX 23: Published integrative review article

Hyperlink to access article- https://pubmed.ncbi.nlm.nih.gov/33199063/

Nurse Education Today xxx (xxxx) xxx

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Review

An integrative review exploring the experiences of service users carrying a diagnosis of personality disorder and student mental health nurses and the time they share together

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ARTICLEINFO

Keywords:
Time
Service users
Students
Personality disorder
Experiences
Relationships
Nursing and midwifery council proficiencies

ABSTRACT

Objectives: This integrative review provides a collective understanding of the experiences of student mental health nurses and service users carrying a diagnosis of personality disorder and the time they share together.
Design: Published studies about the time service users and students share together were systematically selected in order to integrate their findings in a thematic analysis.
Data sources: Various databases were searched from 1984 until 2020. Specific search terms were used.
Review methods: 37 studies were included in the integrative review. The studies were from peer reviewed nursing, student, psychology and health related journals. A quality appraisal was completed using Walsh and Downe (2006) framework.
Findings: Four themes emerged from a thematic analysis of the integrative review. These were;

1. 'Psychosocial skills'
2. 'Relationships'
3. 'Environment'

With 'Impact of time' as an overarching theme.
Conclusion: A positive environment which considers time and focuses on seeing the person, as an individual can lead to the development of therapeutic relationships; a core element of the Nursing and Midwifery Council standards for nursing registration in the UK (Nursing and Midwifery Council, 2018). Students attempting to build such relationships need to be mindful of service users' and their own attachment experiences and the impact these can have on experiences of transference and countertransference, particularly for service users carrying a personality disorder diagnosis. It is important for students to be aware of the supportive impact of positive environments and how doing '*everyday stuff*' can make a person feel human despite residing in potentially dehumanizing places.

1. Background

The experience of the '*time*' students and service users share together in mental health services is an area that has not been specifically explored before. Other studies have explored experiences of the '*relationship*' (Aiyegbusi and Kelly, 2015; Hörberg et al., 2004; Jones, E & Wright, K., 2017; Walton and Blossom, 2013) but clearly assume that a relationship exists, and such studies also focus solely on the participants' experiences of the relationship rather than experiences of the wider time together. Students are both the present and future of nursing, and they often have greater contact with service users compared with registered nurses (Jones and Black, 2008; Mukumbang and Adejumo, 2014). They are new and fresh into nursing and may not have developed engrained views that some qualified practitioners have (Bowers et al., 2007). More importantly service users welcome interactions with students and find their presence facilitative (Morgan and Sanggaran, 1997; Mukumbang and Adejumo, 2014). The temporal nature of helping relationships and the passage of time in certain care settings has hitherto been remarked upon (Chandley, 2000) but not with respect to service users and student encounters. It is therefore important to consider experiences of the *time*

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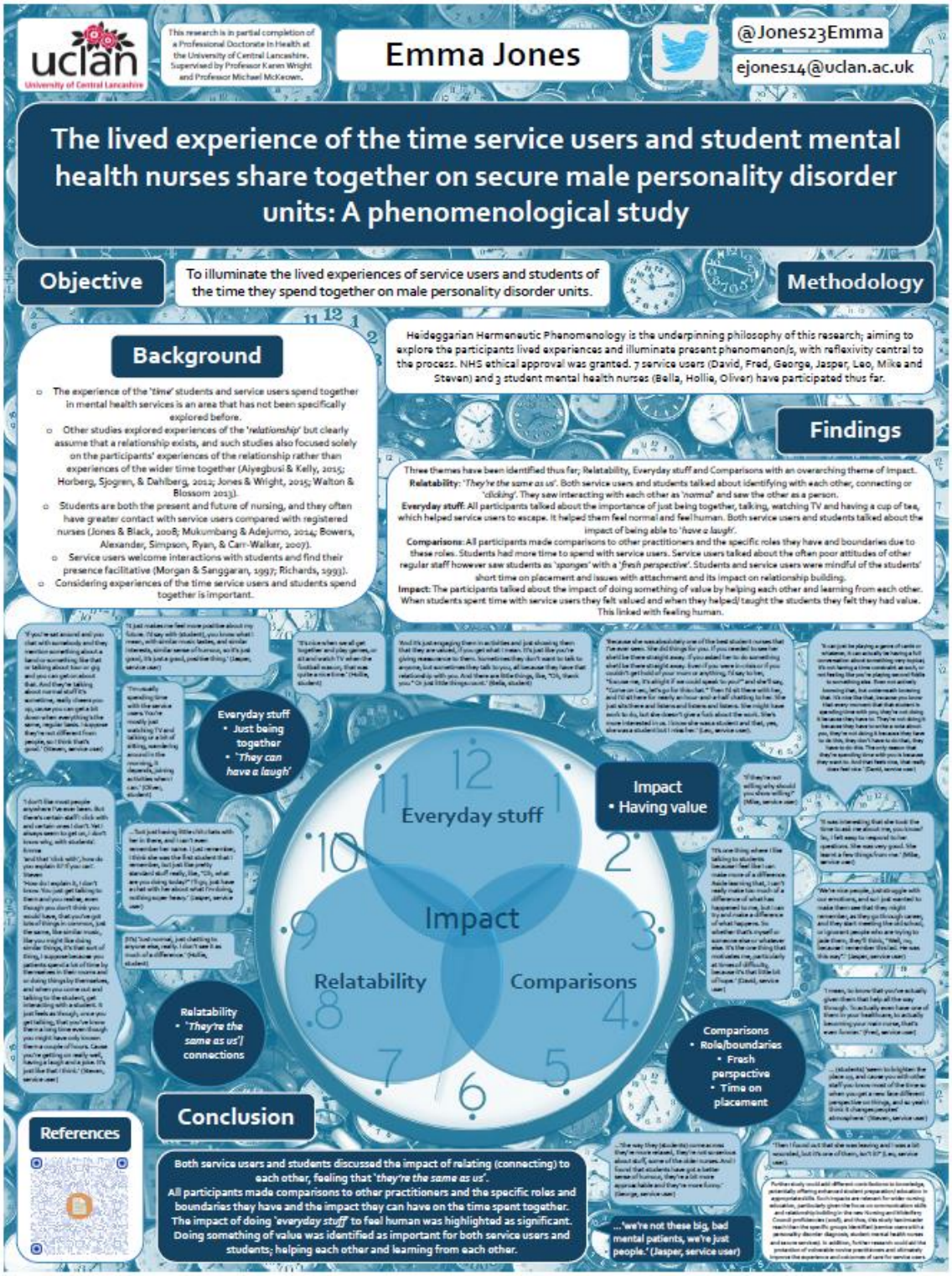
Available online 9 November 2020

APPENDIX 24: Conference poster: Early findings

Poster presentation at the yearly conference British and Irish Group for the Study of Personality Disorder 2021. Link to access poster- https://docs.google.com/presentation/d/1iZWMXA_GTC_a_EaTPBYKfyUFPy5rZuHZ/edit?usp=sharing&ouid=103172272412826427473&rtpof=true&sd=true



APPENDIX 25: Winner of qualitative poster prize BIGSPD conference 2021

Hi Emma,

Thank you for submitting your poster:

'The lived experience of the time service users and student mental health nurses share together on secure male personality disorder units: A phenomenological study'

We are very pleased to let you know your poster has won the prize for most qualitative poster.

Congratulations! The prize is a £50 Amazon gift voucher, we will send this to you in the coming days.

Oliver and Julia will make the announcement at the end of today.

Kind Regards

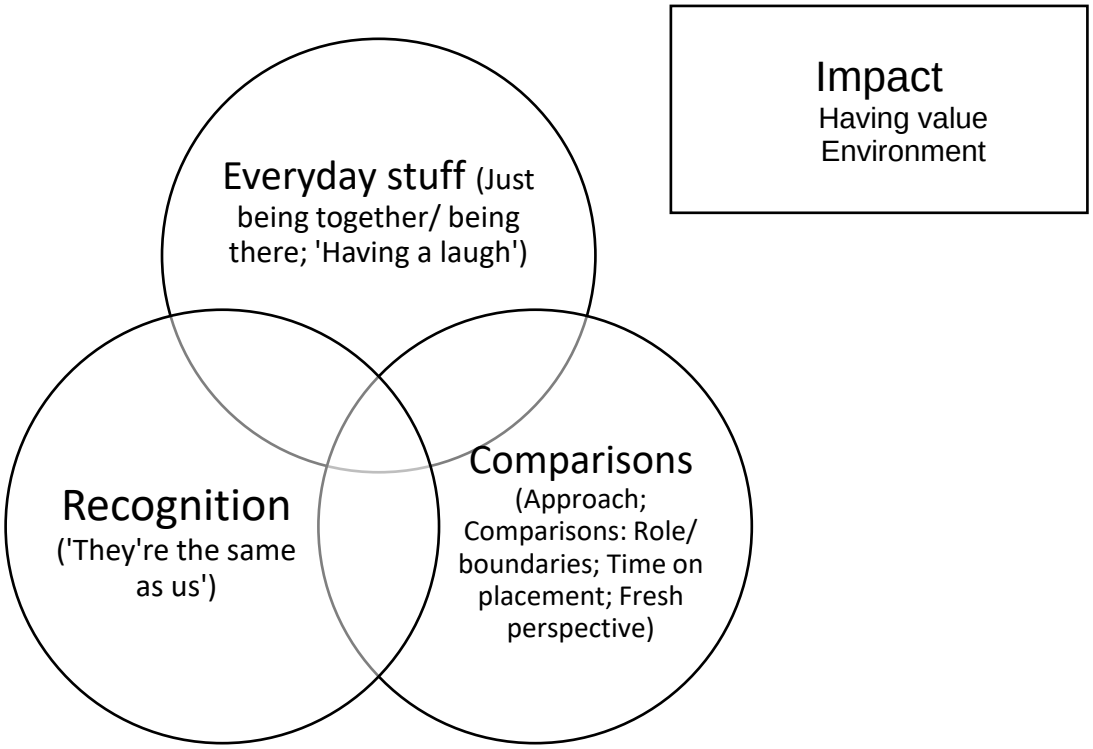
Lorraine

APPENDIX 26: Development of themes

To show the development of my thinking and themes I have displayed my thoughts here, merely to aid the reader in a clear fashion. Of course, this process was non-linear and fluid.

July 2020	January 2021	February 2021	Notes for discussion
1 Everyday stuff 1.1 'Just being around' 1.2 'Having a laugh'	1 Everyday stuff 1.1 'Just being around' 1.2 'Having a laugh' 1.3 'The way you speak to people is important'	1 Everyday stuff 1.1 '*Just being around'* 1.2 '*Having a laugh'* 1.3 '*The way you speak to people is important'*	**The bubble** Being-with The mundane
2 Recognition 2.1 They're the same as us	2 Identification and recognition ('more like us') balance 2.1 Recognition: They're the same as us and 'we're just people' 2.2 Identities: 'more like us' (differences, comparisons, 'not in the numbers') 2.3 Weathering the ride: 'Sponges' to holder of keys	2 Balance 2.1 Recognition: '*We're just people'* and they're the same as us 2.2 Identities: '*More like us'* 2.3 Weathering the ride: '*Sponges'* to holder of keys	**Balance** What makes us the same and different 2.1 Therapeuticness (leaping ahead) 2.2 Professionalism, roles etc. (leaping in) 2.3 Balance
3 Same and different 3.1 Role 3.2 Approach 3.3 'Sponges' 3.4 Time on placement	3 Impact 3.1 Temporality 3.2 Having value and feeling valued 3.3 The Landscape	3 Impact 3.1 Time 3.2 Having value and feeling valued: '*Damn well not useless now'* 3.3 The landscape	Things that **impact** on the everyday and people Stuff around Over arching
4 Impact 4.1 Having value and feeling valued 4.2 The Landscape	Move themes Change titles Check references to other themes Change introductions Check flow and links	Read findings again	

APPENDIX 27: Early data analysis thematic map



APPENDIX 28: Terms used by participants (theme 1.3 in findings chapter)

Specific words used	Patients	Students
Interact/ interactions	David, George, Steven	Bella, Hollie, Julie, Molly, Oliver
Engage	Mike	Hollie, Julie, Molly, Oliver
Relationship	David, George	Bella, Hollie, Julie, Molly, Oliver
Rapport	David	Bella, Julie, Molly
Trust	David, Leo	Julie, Molly
Therapeutic	David	Hollie
Click	Steven	
Just being around/ there	George	
Being with	David, Steven	
Being there (for the patients, being that support)		Hollie, Julie
Being under our care		Oliver
Being open		Julie
Being with a mate	Jasper	

APPENDIX 29: Excerpts from interviews to demonstrate style of engagement

Steven

e- Playing pool? What's that like?

s- It's really good because it's better than just wanting to do paper work and stuff like that. And they have a lot of that to do. I think when they can find time to you know just do general stuff, even if it's just a chat, watch TV or even if they play a game it's pretty good as well.

e- When you're watching TV, how's that for you, when you're with the students?

s- It's good, cause in this place, you can get a bit boring. The same thing. If you're sat around and you chat with somebody and they mention something about a band or something like that or talking about tour or gig and you can get on about that. And they're talking about normal stuff it's sometime, really cheers you up, cause you can get a bit down when everything's the same, regular basis. I suppose they're not different from people, so I think that's good.

e- What sort of normal stuff do you tend to talk about stuff with them?

s- Music, sport, it surprises me when, I like rugby and stuff like that and I've always been surprised the amount nowadays girls especially that go to rugby matches and football matches and even ice hocky.

e- I love ice hocky.

s- They could be training to be OT or nurse or even a doctor, sometime because sometimes you're in your own world you don't expect them to be interested in stuff like that, so its quite good when you realise they enjoy the same things. I think it really lifts people's mood to have students around.

e- Why do you think that is? Is there a reason for you?

s- I think with me myself its cause I can on quite easy doing the same old thing the same company.

e- Different company? Different conversations like you said?

s- Yeah.

e- Can you think of a time when you were with a students when it was particularly good, what was good about it?

s- I think it was just enjoying the company of somebody different. Especially with me because I've been out on leave with the same, or even just because I've been on low secure it's different to medium secure and high secure and sometimes you can't. go for a walk round the grounds and stuff like that. I think that's really good.

e- What do you normally do during that time?

s- Just go for a walk. You know the bird the wildlife, stuff like that. I'm repeating myself a few times but just basically.

e- I think it's interesting you're repeating yourself because it must be important. What about a time that really stands out for you with a student, can you think of any? Or a story about being with a student?

s- I can't think.

e- I'm putting you on the spot aren't I (laugh), all these difficult questions, trying to make you wrack your brains remembering stuff.

s- Oh I know, one time when there was a couple of female students and we went to [theme park]. And a lot of the normal staff wouldn't go on the big scary rides with me they don't like it. But yet, oh I'll go on it, so it was great, so we went on just about everything , about 5/6 years ago, I always go on everything. I like being scared if you know what I mean. And that was good, they were just, I like that, I like that. It was really good… I think what surprised me about this girl in particular, she had done bungy jumps and I've done one of them years ago, I did a parashoot jump as well and she was actually going to, that was her next plan.

David

e- What does it feel like when you spend that time with the students?

d- It's really nice, really, really nice. Just the time that we spend, it's something that is really nice. You feel valued, if that makes sense. And, also, the nicest thing with students is that if a nurse asks them to do something and it's not urgent, which normally it isn't, it's not like, you know, 'Who put the cover on because this member of staff needs the toilet or the phone call for them,' or something mundane like that. 'Oh, by the way, you've got to help do this and help do that.' When the nurses ask the student to do something, it gets added to the list but you don't feel like you've been checked off the top. I've sat there with a nurse talking and they've come in and gone, 'Oh, do you mind doing this or this with the paperwork on the *** system thing,' and they'll just turn around and they'll go, 'Yes, sure okay.' And then I've stopped talking, no-one's expecting them to go straightaway and they've just looked at me and gone, 'Carry on.' And I actually went to one of them not long ago and I went, 'can I?' and he went, 'Yes, I'll look it up in a minute. It's not urgent.' She went, 'It's urgent, but it's not urgent, urgent, we can continue talking and then when the conversation has finished I can go and do it.'

e- How does that feel for you?

d- Really good, really good. It's strange, two nurses in the lounge like we've had, we've been lucky with two nurses at the same time, which was quite good. Some people would see that as a hindrance, but far from it. When we had those two students, when one of them was in the lounge there would be a lot more patients in there than there would be normally. The room was a lot more nice, the TV wasn't the focal point, it was more turned down, it was a lot quieter, it was just somewhere nice and it was quite enjoyable. It was really enjoyable.

e- What do you think was the enjoyable bit about it?

d- Company. Knowing you can have a reasonable conversation, to go and try and talk about a news story with somebody who believes that everyone is an alien can be quite difficult at times. You understand their own world but you're kind of like, 'I want a good conversation.' And when they sit down it's like, 'Yay.' It's real good because one, not *** but the other student we have, ***, she stopped at the same time, as students do with the placement and things. But she's done quite a few bank shifts afterwards and that's really helped, because it might seem daft, but we still treat her like the student nurse and we still talk to her like a student nurse and things like that. It keeps the relationship the same because it's like, 'Hang on a

second, she’s technically a healthcare today, but we’re still treating her like she’s a student nurse in a good way.’ It’s kind of like, ‘Yes, this is strange.’

Hollie

e- So, the last time that you spent time with a service user?

h- When would that be? Honestly, I think it’s normally either Scrabble and cards, or sitting in front of the TV when I’m on nights. A lot of patients are up and about. No, quite a lot of the time they’re all quite cheery at the moment, which is lovely to see, just sit and have a joke and a laugh with them, play cards.

e- What’s that like, having a joke with them?

h- Just like anyone else, yes. Most of them have a really good sense of humour. I don’t even know how to explain that. It’s just normal, as if you’re sitting in the pub with your friends, obviously without the alcohol. I keep realising I refer to it as ‘friends’ a lot.

e- You said that, but then you also said that it’s different than friendship as well?

h- It is different than friendship, but it’s a very fine line. It’s not friendship but you still interact with them the same way that you would with your friends, but maybe a more moderated version of it is the best way to explain it.

Molly

e- When you're with the service users and you’re talking to them, what's that like for you? How do you find that?

m- Sometimes it can be quite difficult. Maybe you don't know the service user very well, but you got to start from somewhere and. It does feel good talking to service users because then you get to know them. You get to know them and because sometimes you just kind of read up about the person. And you think ooo, and you start to make presumptions, not intentionally. It's just kind of, I think, human nature. Just you don’t intend to make any judgments or anything beforehand, so I think. Talking to them. And reading up on maybe their past and. Previous diagnosis things I've read and then talking to them getting to know them for them, not what you found on the computer. Yeah, I think yeah, it's it's really good experience going to talk service users I can’t stress enough. Yeah, so important to go and sit with them while about them, not just learning about them from their care plans or their HCR-20s or whatever.

e- Aw that’s lovely, it's really nice to hear. So what sort of things do you end up talking about?

m- It could be really trivial stuff like I said, like television and music. We've spoken about animals. Like even things they have in common . So and like a lot of the patients where I am have tattoos and I have tattoos, it's just conversations about that. And then sometimes it is the more serious stuff , so maybe they said something that could be considered inappropriate. So I know there was one incident where a patient was talking to me and was being racially abusive about other staff and it was having a conversation of. Well, it's not appropriate to be speaking about the staff that way that They’re here to care for you, it's not appropriate for you to talk about the colour of the skin, because that's not something they can help is not something that should be abused for. It's a mixed bag with what we talk about. 'cause Yes you do get the just general chit chat, enormous banter with the patients because it's nice when you can have that, but you also get the more serious. Stuff like when they're talking about their mental health well when an incident occurs when you trying to deescalate the situation.

APPENDIX 30: Excerpts from reflective diary

27.07.2016 One of my first entries

Feeling of being overwhelmed with all the work to do, especially the literature review and ethics. Also worried about learning about phenomenology and trying to get my head around it. Very difficult subject, more worry over the difficult language- reading should help. Also mindful I'll need to write about epistemology which I struggle to understand. I will look at previous modules (4025, 4026) and see if I can attend for a refresher on it- (booked 4094).
Looking forward to completing it! Keep thinking about all the work. The main struggle will be recruitment, need to identify a service. Students should be okay, the main concern is patients, particularly due to capacity and consent and also getting the MDT on board and identifying the patients *who can take part.*
Ethics will take a long time, I did enjoy this bit with my Masters but IRAS will be A LOT of work. I'm hoping that once I'm cracking on with the lit review and methodology and ethics and if recruitment goes okay I should then be okay.
I do know that I am a perfectionist so will put a lot of pressure on myself to read EVERYTHING to make sure I'm not missing anything, which may cause added stress. I am mindful of workload, and know I'll have to give up my weekends. It will be difficult managing exercise, work and prof doc, as well as sleep and family and friends. I will have to be strict with work and extra stuff I take on! I defo need to keep exercising as my outlet and coping mechanism. I need to do that to be able to keep going.
The first writing session was really helpful to get myself sorted what needs doing, I need to also make time deadlines etc. to help keep me focused. Good I've been trained on refworks and cinahl, do need to look at end note though.

03.04.2017-06.04.2017 Hermeneutic course

After day one, I want to give up, too much, too big, feel stupid.
After the course, many light-blub moments, really interesting, many questions to think about. Need to change my questions. Exciting, feeling more authentic now. Feels like I will get more depth more detail, more experiences, lived.
Reflections: it is difficult to complete the literature search. We are restricted by language.
How can you search for the time students and patients spend together?
Can't call it relationship as that is my preconceived idea, my idea of a phenomenon but might not be the phenomenon. I worry about silence, no talking, not answering, if they'll understand the questions etc. Feel better now I've changed the questions.
Lots to read and learn.

19.02.2018 First visit to site

Visit to XX. It went really well they were very helpful. Was shown around the unit. I met some of the patients which was nice, felt nice to be able to talk to them, reassured me for doing the interviews. I spoke to one about video games. Imagine there may be some researchers who are not personable. I can go next Monday to interview the students, might be able to interview a few patients too potentially. They've two students at the moment and may get some more too.
The unit was really nice, very quiet, lots of resources, not many patients around probably because it was lunchtime. It had nice communal rooms, the patients had personal bedrooms which was nice to see.
Spoke to the modern matron XX who was nice and XX the ward manager who showed me round and introduced me to patients. They are going to give me a room and alarm. Really helpful.

12.03.2018 Interviews

I was very nervous last night. Got up early as stayed in hotel. Had broken sleep. Worried it will go okay. Tired.
Will explain silence in introduction to help me feel better. Make notes of stuff I need to ask. Might be short, that's okay. Need to write reflections after each one and type up. Need to save recording on surface pro after each one too to check I have it. Will test dictaphones before use. Can just see how it goes. Good to have been at the unit before, makes me feel better at least I've met some patients before. Need to make sure I don't lead the questions but I need to be myself as well. Authentic- need it to be a chat.
On the unit, In the MDT room tested dictaphones, got all paperwork. Few interested, one more, one changed their minds. Staff outside room watching but non-intrusively. Nervous, talked to staff about study, stuttered a bit. Need to keep an eye on time.
Good to get interviewing.

12.03.2018 First patient interview David

Wow so talkative. Loads of info to transcribe. Easy to interview. Did worry about the time. Staff come in and asked if we were okay as had taken a while. Feel bad on the staff having to let me in and out etc. and keep an eye on me. He said loads. Hope I asked good questions and didn't lead, don't think I did. Did just say yes, yeah, laughed to confirm I was listening, nodded my head a lot. Can listen on my way home. It's so long- a lot to transcribe. Good place to interview in the MDT room. Had good 'rapport' chatty, laughed, discussed veganism- which helped him open up I feel. Very knowledgeable about his BPD diagnosis. Actually spoke about that which I didn't expect. Initial notes: Time- feel valued, just sit with you, not 100 things to do. It's fun, nice, he liked educating students. Predisposed judgement if new, lambs, can talk to them, hard with support workers. Activities- TV, pool- nice, fun, laugh. Prejudice. Main bits- valued, time, no looking at the clock (clock watching).

07.08.2018 First student interview Hollie

First student at XX. Unable to interview patients at either site (as pregnant). Listened to recording of George interview on what to check questions and intro bits as I made notes on the topic guide but didn't bring them. Be good to do some student interviews before mat leave. Timescales of students on placements and changes in environment implications etc. looking forward to doing students interviews to see if similar themes.
Got everything ready, here early, waiting in nice area. Nervous waiting.
Interview- had met her before during visit which was nice. Enjoyed it- interesting. Individualised care, diagnosis came up, normal stuff, chatting, scrabble- nice environment, long stay placement. As a student only on placement for so long- time. Friendly- friends discussions. Discussed boundaries- professional, humour, TR, engagement, recovery.

22.06.2019 Reflections following birth of Arthur

First time back looking over my prof doc. Arthur 6 months now, feel like I can start doing some again. Could potentially do some interviews before I'm due back, that would be helpful as will struggle once back at work. Plan to go back part time, have a full day or two a week on prof doc. I will have to review my lit review again before finishing thesis. Getting more students could be an issue as depends on placement allocation, they should be on placement oct/nov though. Need to discuss with mick and karen. Feels good to get a plan going makes it feel doable. I've done nearly 30000 words already and a lot of chapters.

04.04.2020 Notes during analysis

NVIVO hadn't saved some of the theming I did yesterday on David's, when it crashed, very frustrating. I wish I could see what I did. Luckily, I do remember some as made some notes but not all. Highlights that it is helpful to manually theme as well as use NVIVO. Having to theme it again I'm wondering whether I've themed it exactly the same or missed bits I themed last time or something I didn't yesterday. It will be different because it's a different lens I'm looking at it through. I've themed Bella's so that will impact on me reading David's. This will be the same for all the analysis and why it's a hermeneutic circle, going back over and over and deeper based on what I've done before. All the parts influence the whole and the whole influences the parts.

I found the theming I thought I had lost so compared what I had themed, it was basically the same which was interesting, and possibly reassuring. Some slight differences in what I themed a couple of parts which showed the interlinking nature of the themes.

Had another chat with chris, this is my informal peer review as Peoples (2021) talks about. We spoke about my findings and perhaps because of my previous job where I did formulations and explored a person's history to make sense of what things were going on for them, I always look towards a person's fore-structures and try to understanding their thrownness. This may mean that I do not see the darker side of things, and see things in a positive light, I do always try to see the positive in things, and am definitely a glass half full person. This may impact on my interpretation, which I need to be mindful of. However 'we need to be true to ourselves to we can be true to our participants; how we are with others is fundamentally moral' (Dibley et al., 2020). We must also be moral in how we listen to stories. Darker side of things did not reveal themselves to me, it is however important to be aware of them.

I also always remember a patient saying to me on my first placement of my nurse training, you will find something in common with everyone. Also something a mentor then said later in my training- do lots of hobbies so you've things to talk about with people. That's definitely something coming across as important to build common interests.

A colleague told me of something his daughter said decades ago about his job as a mental health nurse which really touched me, she was 8 or 9 at the time 'My daddy is a mental health nurse, he takes people for long walks in the sun and tells them jokes to stop them being sad'. Really highlighting the essence of mental health nursing, doing activities and using humour to help people, which the students did, though made me think that the specified roles and systems nurses are in prevents them from this, as I've found reading other research.

27.07.20 Reflections from supervision

Good supervision session. Feel positive, can crack on writing my findings chapter now. Good discussions, enjoying the discussions more and more, which is a demonstration of the knowledge I've gained and personal development. They said I'd done a lot of work, and that I was showing doctorate level study. Feeling more like it's doable now.

28.10.2020 Reflections from reading

On reflection I think I would have slightly re-worded my prompt questions, got more examples, stories for the experience not just thoughts. That has come from reading Peoples (2021). As you read a page if you read it again you are changed. I am not the same person, or think in the same way as I did when I started the doctorate nor when I did the interviews.

I love the quote from Smythe (2011) as you read familiar work, lines jump off the page that previous were passed over, fresh questions come, you mark sections of a book that previously was passed over.

Peoples (2021) state you develop as you read the transcripts and interpret, you learn, and develop understanding. Leo was good at discussing experiences and stories. I always asked what did it mean to you, but I should have asked can you give me an example of that, or have you got an experience or story you can share with me about that more than I did.

Humour is coming through clearly as important in building connections between people, all bar one talk about its importance. It is certainly something I used in the interviews to help the participants feel at ease. I also used it a lot when I was working as a nurse in secure services, and just always something I've used in general. It came through only slightly in the literature review. And now I'm finding there's not loads written about use of humour in secure services or with patients carrying a personality disorder diagnosis. Will be an interesting area to explore in the future.

02.01.2021 Reflections during sabbatical

This is the year I submit my thesis. Now freaking out a little. I've got my plan for doing weekends and evenings and spoke to Chris about it. I need a draft of my discussion I'll feel loads better then. This is the last hurdle, feels like the hardest bit. It felt like it's gone okay up until now except ethics, the odd issues with accessing units or getting participants. Have generally really enjoyed it.

Some notes on my thoughts about gaps and recommendations-
Gap- impact of students on patients' quality of life, humanness, role, purpose, value. By teaching students, patients have value. Impact of patients helping students settle in, not just practice assessors and teams. Importance of humanness in dehumanising settings. Crucial everydayness, having a laugh, just being around- should be a focus in nurse education. Role differences; how can these be changed so staff can have valuable shared time with patients as students do.

Students make such a difference for patients. Different role but the same as them, same interests, time to share them, not the complications of reporting or paperwork etc./ decisions/ power. Learning, there because they want to be, not paid, like volunteers. Students help patients work towards recovery. Of course, other side is if their inexperienced or have a poor approach it can cause distress, but generally they have an overwhelmingly positive impact. Give the patients a role in teaching the students. Patients help students settle in.

Does it have to be a student that makes a difference for patients? It is the time, that they are not paid and also that they are learners, you do not get all of those things with any other group of people. Why are students valued so much by patients?

1. *They have time (to just be around)*
2. *They are not paid (there because they want to be)*
3. *They are learners (so patients can teach them, not so serious can have a laugh, not the power dynamics)*

These are the factors that make students special and unique to patients and why they are so valued. Students of any profession? Nursing students are perceived as more 'general'- will just be there, watch tele, do normal stuff. Psychology students are finding out histories, OT specific activities at certain times, social work- are not specifically on wards to just be around. Volunteers or peer support workers aren't learners, could they be? Maybe post doc stuff to explore.

How can other staff be more like students? Should they be? It's good to have a balance. They are paid. They could take on a learning role, patients could have teaching roles. Get more time to spend with patients, just being there.

24.01.2021 Further reflections during sabbatical

Have delayed my submission which is another relief so I can really enjoy my sabbatical and do the best I can, read and really explore my discussion chapter in depth. Amazing to have full outline of all my discussion chapter themes now, some as good drafts. Just to work on them. Feel like I'm over the mountain now, like Everest, and can see the end. I've got a thesis, it's just developing it. I've basically a very very rough draft of my thesis. It's all there, just adding and developing now. Huge point to have got to despite Covid and everything else.

08.03.2021 Reflections in last week of sabbatical

It's been a period of deep reflection for me on this part of my sabbatical. I've been so lucky to have this time, which I have treasured. I still feel I've so much to do and read but have a draft of nearly whole thesis, which I'm really proud of. I've been reading heavily about philosophy, phenomenology and hermeneutics and thus questioning my being and existence, which feels enlightening while also difficult.

I've now got a full rough draft of all my thesis, which is amazing! And really pleased with it. Such powerful findings about the hugely positive impact patients and students have on each other. 3.2 is a lovely theme in the findings chapter so many heartening quotes. It's exciting pulling it all together. Really happy with the conclusions I'm writing, feel such important findings to get out there. Lovely to see how their experiences resonate with Heideggarian concepts and writing about these. I'm enjoying my reading and feeling enjoyably perplexed rather than confusingly perplexed. Nice to feel the difference, very empowering. Been nice to talk through things with Chris, Jean and Gill, always feel excited and gather more interest. I've also been enjoying supervision sessions more and more with Karen and Mick and been having such interesting discussions. Really getting there now. I think it will be difficult to stop and finish it. I just want to keep reading, part of my issue of being a perfectionist which I need to be mindful of and manage. As others state hermeneutic studies are not finished but there is a time to stop, that what I've done is good enough, at this time, to submit a thesis. This is just the beginning of my journey.

Development of 'therapeuticness'

I remember doing a teaching session years ago and came out with therapeuticism and therapeuticness by accident to try and explain the whole picture of being therapeutic or managing therapeutic things alongside safety. It helped explain things to the students. I'd not used the terms again and not thought about them until trying to explain what was included in the bubble and leaping ahead and it was the right type of word that captured all of those things. Therapeuticness resonated with the way Heidegger used terms to explain things that there wasn't the language to explain, and hence was my choice.

Doing a google search therapeuticness (140 hits), interestingly a student actually tweeted that we had used it in a session. Other ways google had found the term used was in relation to music or art. Some that were related to my subject area were the below, though minimally used or defined-
Used in Jauhar et al. (2014)-
'Apart from this, variations in the degree of 'therapeuticness' among different control interventions almost certainly needs to be considered' they do not define it or make it clear their interpretation of the term.

Mentioned by a participant in Dixon and O'Connor (2010).
Carey, Mansell, and Tai (2015) book refers to it- 'The self-evaluation may be a significant clue as to the way in which therapeutic strategies and techniques, in general, achieve their therapeuticness.'
Other hits picked up where therapeutic was used rather than the full term.

Therapeuticism (90 hits) had been used, in relation to rave music and I also found an article about countertransference, so there are others who have attempted to use such words to explain things that English language struggles to do fully (Loiacono, 2013). However Loiacono do not define the term specifically.

Development of metaphors used

The development of metaphors used through the thesis came from myself and the participants. For example, bubble was a concept I used to capture the space students and patients experienced when they shared time together. Weathering the ride was from a quote of David's explaining that some staff can 'weather the ride' and not become absorbed in the one. Holder of keys was my concept developed from experiences of the participants about the staff who had become part of the one. 'Sponges' was Fred's term to describe students as soaking up all their experiences and learning.

July 2021 Reflections on Hermeneutic course

I came on to the course with my experiences with me, my situation managing being a mum, a student, working, while engaging in counselling to help me manage and the submission date close. Through the month it was overwhelming, intense, emotional, I felt up and down, finding it difficult to accept where I am at and being okay that my understanding and writings are good enough for me at this time. It was inspirational and exciting and felt a sense of community with others though online. Such a precious and invaluable experience, helping me and my thesis to develop.

I presented my study and cried at the end, such a huge wave of emotion, vulnerability, feelings came out in tears, it was very freeing and authentic. It's part of the journey. Wisely advised to own my tears. I received amazing and supportive feedback, and insightful and thoughtful questions which took my thinking deeper.

I loved the reading while overwhelming, I felt how much I and my thinking had grown since the first course, though still more to grow, always.

HP feels to me, happy, warm, giggly, like I'm at home in myself. It helps me make sense of things. It also makes me feel vulnerable and overwhelmed and perplexed, and sometimes stupid and annoyed, all truly precious experiences.

Some crafted stories I wrote during the course to help with my interpretations

Molly
One of the patients wrote poetry and one day he asked if he could read me one of his poems, he looked excited to share it. We went into the little relaxation room on the ward and he read it. It was about his friend who had taken his own life by taking an overdose, so was a very personal subject. It felt really good because he chose to share it with me. It means so much when patients open up to you and trust you, I felt very fortunate.

Oliver
When I was on placement I saw a patient I'd known for years in other services when he was very unwell and he used to call me Shrek. I walked on the ward and he said 'Oliver'. And I just thought 'aw you remembered me'. It was a nice feeling, I just felt like I'd done something positive.

Steven
I don't like most people but there's certain staff I just click with. And with students you just seem to get on with them. You just get talking to them and realise, even though you don't think you would have, you've got loads of things in common, like music. So it just feels like once you get talking, that you've known them for a really long time, even though you might have only known them for a couple of hours.

David
My anxiety would get extreme where I'd be sitting in a corner and I felt like I couldn't move, I couldn't breathe. Some of the patients would affectionately say 'oh he's like a naught boy in the corner', but this student nurse came and sat down next to me to see how I was doing and it was nice, because I knew every moment, she was with me, it was because she wanted to be. She wasn't there because she had to write a note about me, or have to do this or that. The only reason she was there was because she wanted to be, and that feels nice, that really does feel nice.

Leo
I was sat with this student, she was one of the best students we've had, she did things for you if you needed straight away. She'd speak to you and say 'come on Leo, let's go for this chat'. So I'd be sat there for an hour and a half chatting, she just listened, she had work to do but she just listened. I miss her. One day she saw it in my face that I wasn't well, she could tell, so she made be a brew and we went for a chat. So I was sat there having a nice cup of tea and we were just chatting. We always used to take the piss out of each other, she had me in stitches, I had her in stitches, and then everyone else joined in. Then I found out she was l leaving and I was wounded, it was sad because I might not see her again, but one day, touch wood, I'll see her somewhere, I'll bump into her and say 'What's happening'?

APPENDIX 31: Visual presentation of study

Here I include a visual presentation of the study for you to access, please see the notes to each slide.
https://docs.google.com/presentation/d/1jd736LNTnz2eLiV0TxJdB8-53pH1ML5t/edit?usp=sharing&ouid=103172272412826427473&rtpof=true&sd=true