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Research Article

A Hermeneutic Phenomenological Exploration of Patients' and Student Nurses' Experiences of the Time They Share Together on Personality Disorder Forensic Units

Emma S. Jones, Karen M. Wright, and Mick McKeown

School of Nursing, University of Central Lancashire, Preston, UK

Correspondence should be addressed to Emma S. Jones; ejones14@uclan.ac.uk

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This hermeneutic phenomenological study illustrates the value of key aspects of interpretative hermeneutics for illuminating the time shared between patients and students in forensic unit for men carrying a personality disorder diagnosis through interviews. The participants were being-with in their own time and space, sharing ordinary activities and common interests, and having a laugh, ultimately making enduring connections. This was despite experiences of thrownness into the world, ward landscapes, or the bearing of diagnostic labels. Students experienced a balance between therapeuticness (leaping-ahead) and professionalism (leaping-in). They were immune to the relational vacuum of the ward office and were viewed as "sponges", reflecting their availability to patients, as opposed to other staff occupying more distant, identity defining set roles. On transition to fully fledged staff roles, students can become holders of keys, but can weather the ride by treasuring the everyday mundane, being-with and connecting with patients. This temporality of student-patient's relationships encompasses mutual recognition of shared humanness. This hermeneutic phenomenological study uniquely explores the time shared between patients and students in forensic settings. Learnings from their experiences as illuminated using philosophical notions aid our understanding of this time to ensure focus on human connection.

1. Background

Across the globe, individuals studying to become registered mental health nurses across a variety of courses spend a substantial amount of their time allocated to clinical placements, including forensic units. These include low, medium, and high secure/forensic services (each increasing in physical, procedural, and relational security) as well as step down services and community specialist forensic teams. Forensic services have different security levels, risk assessments, and related management strategies compared to local acute mental health units [1, 2]. Patients are admitted to forensic units due to needing additional support levels of physical and relational security not available mainstream services [2, 3]. Not all people detained in forensic units have been through the criminal justice system but the majority in high and medium security units will have been. Students on such placements share time with and support patients, carrying various diagnoses, including personality disorder. "Patients" will be used throughout for consistency and reflecting the terminology used by the participants in this study. There is no term that suits everyone, and each has limitations, hence the decision to be led by the participants.

Throughout we have chosen not to abbreviate personality disorder to "PD" as it is a further demonstration of othering often experienced for people with the diagnosis. Personality disorder is a diagnosis attracting particular criticism due to associated stigma, exclusion, and trauma/retraumatisation [4–7]. Conversely, having a diagnosis can enable access to appropriate services, helpful treatment, or welfare benefits [6, 8, 9] or help explain otherwise inexplicable feelings or responses [4, 10]. However, many argue that formulation is a more useful tool than simple diagnosis [11, 12], though this can also be open to criticism

[13]. Formulation is a process of attempting to understand the person, their past experiences, and influences that impact on their present [12], hence the links to Heidegger's term thrownness. Mental distress, however categorised, can be seen as an understandable response to adverse experiences such as trauma [14–16]. Moving on from outdated views of personality disorders being incurable [17], trauma-informed approaches support compassionate ways of working to support individuals developing their abilities to reduce threat systems [18], focusing on safety as a core target of therapeutic relationships [18].

This article offers a unique contribution by exploring the experiences of patients and students who share time together in forensic units. Students represent the present and future of nursing, often having greater patient contact than registered nurses [19, 20], and this is appreciated by patients [19–22]. 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 UK) [23]. Student mental health nurses in the UK complete the minimum of a bachelor's degree and also the professional qualification of registered nurse by meeting the professional standards set by the Nursing and Midwifery Council [24]. Such courses explore medical, trauma-informed, and recovery-oriented approaches to care.

Previous research focuses on attitudes and therapeutic relationships [25], rather than the temporality of shared contact. Patients in forensic services with personality disorder diagnoses can be the most stigmatised group in mental health care and exploration of their experiences lacking [26, 27], these must be shared.

2. Philosophical Approach

This research is grounded in hermeneutic phenomenology, with the aim to "illuminate the lived experiences of the time patients and student mental health nurses share together on medium forensic personality disorder units for men." The study is the first author's doctoral research, supervised by second and third authors [28]. The data that support the findings of this study are available from the corresponding author upon reasonable request. As interpretive beings, we are always already there [29], and we constantly construct meaning through engagement with the world [30, 31]. Hence, the paradigm is interpretivism, aligning with the interpretive nature of nursing [32].

2.1. Reflexivity and Researcher Situatedness. Reflexivity was central to this hermeneutic study. It was a constant process, "a hermeneutic circle in itself" [30]. Neglecting reflexivity fails to acknowledge Dasein's embeddedness in the world [33]. Heidegger raised "the question of the meaning of being" [29]. Dasein is the notion of the existence of being. It means "being-there", being present, or "being-in-the-world", which is interlinked/joined [34]. There is no separating Dasein and the world [30]. Dasein exists because we ask, and we already possess an understanding of being [35]. Dasein is interconnected with the world and being-in-the-world temporally [29, 35]. As described by Heidegger [29], "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'".

Mental health nurses lean to more qualitative research methodologies [36]. My (first author) way of thinking guided my research choice [30], or as Smythe [37] states the methodology chooses you. Nurses form interpersonal relationships with patients in an attempt to gain a sense of their world and use themselves in their role [38, 39], and they accept the uncertainty and individuality of the patients they work with, akin to a hermeneutic phenomenological approach [36, 40]. Ontological hermeneutics, in particular, merits being at the heart of mental health nursing which aims to understand the very being of people [41, 42].

Our historical and cultural situatedness of our social environment is important to hermeneutic understanding [43]. Hence, I (first author) have supported people carrying a personality disorder diagnosis and spent time with patients as a student and nurse, and then since supported students. The second and third authors have also supported patients in their role as mental health nurses, each observing the importance of therapeutic relationships for people carrying a personality disorder. Given our preunderstandings, reduction is impossible [29], necessitating an interpretive approach.

2.2. Ethical Considerations. Ethical approval was granted. Conducting research in forensic settings presents unique ethical considerations, including containment and restrictions [44–46]. It was additionally essential to acknowledge the vulnerability of students [47] and therefore ensure support for all participants following the interviews should they have needed and clear participation information and written consent forms. Although support from the care team or practice assessors was available following the interviews, this was not needed.

2.3. Methods. Sampling in hermeneutics is always purposive as it is essential the participants have had the experience of interest [30]. Seven patients (David, Fred, George, Jasper, Leo, Mike, and Steven) and five student mental health nurses (Bella, Hollie, Julie, Molly, and Oliver) participated in unstructured hermeneutic interviews across two medium forensic units: one independent and one NHS. Both units identified as specialist personality disorder units with input from multidisciplinary teams including nursing, psychology, social work, psychiatry, and occupational therapy. All students were in their final year of the BSc in mental health nursing. They were on placement at the time of interviewing, and their placement length was variable. Pseudonyms are used to enrich the findings and emphasise human situatedness of the research [30, 43].

2.4. Analysis. This study draws upon Heideggerian notions to illuminate experiences, without asserting absolute truth. The analysis was an iterative process, transcripts were read

and re-read, recordings listened to, considered, and then reflected upon and subsequent themes were developed. The first author lead on the analysis, with input from the second and third author, including the consistent use of regular supervisory meetings to discuss analysis. Conclusions in hermeneutic phenomenological research are not final or fixed, new interpretations can emerge over time [48], we are never experts in hermeneutic phenomenology, and we are always becoming [30, 49]. Researchers must wait patiently (or dwell) and tolerate the uncertainty and woolly nature of analysis [50]. Hermeneutic research gives wonder and openness and is unbounded, which can feel unnerving, messy, and unstructured [51, 52].

3. Findings

Here the findings are presented from patients and students, discussed together, aligned with exploration of the participants' time, and shared together. Key Heideggerian notions resonating with the findings are explored in the discussion. Exploration of the impact of patients and student mental health nurses sharing time together in forensic units is published in [54] (In Press).

This pictorial representation depicts the findings visually; the student and the patient are at the centre and their shared time in a bubble. They experience "everyday" talk, and 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 (see Figure 1).

3.1. Just Being Around. The students and patients mutually influenced and supported each other, learning and connecting through shared time and everyday activities, such as "just being around" (George), "having a laugh" (David, George, Hollie, Jasper, Julie, Leo, Molly, Oliver (student), and Steven), and bonding over common interests:

> [We talk about] really trivial stuff. . . like television and music. We've spoken about animals. Like things they have in common. A lot of the patients where I am have tattoos and I have tattoos, it's just conversations about that. (Molly, student)

Both patients and students emphasised the importance of doing "normal stuff" (Steven) which included watching television, engaging in various activities, and just talking. By just being together; being there; and doing everyday stuff the students appeared to help the patients feel human, feel "normal" (Jasper) by escaping reality and coping in a stressful yet boring place. For the patients it was "just nice" (David and George) being together doing everyday stuff despite being in a forensic unit. For the students, it was nice to just chat to patients and watch television with them to get to know them.

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.

Sharing time together was something that felt "normal" (Hollie, Oliver (student), and Steven), like having a laugh which showed the connections they had as humans together. Humour stood out as an essential aspect of Leo's experiences, as he reflected on funny experiences:

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

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. 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)

3.2. "We're Just People". The students and patients bonded or "click[ed]" (Steven) with each other through connections they made with their common interests and recognised each other as "just people" (Fred and Jasper). This was important for the patients who rejected their label:

> "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, patient)

Similarly, Jasper said that they are not "these big, bad patients, we're just people" that may struggle with their emotions. The students saw the patients as people they had common interests with and empathised with their experiences and circumstances. Hollie spoke of talking to patients "like anyone else" and not treating them differently. 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".

Nevertheless, the students were also mindful of the environment and potential risks with forensic services. Oliver referred to certain nursing roles being paternalistic because of the "nature of forensic service[s]." In relation to this, he considered the balance of professionalism and having a laugh specifically.

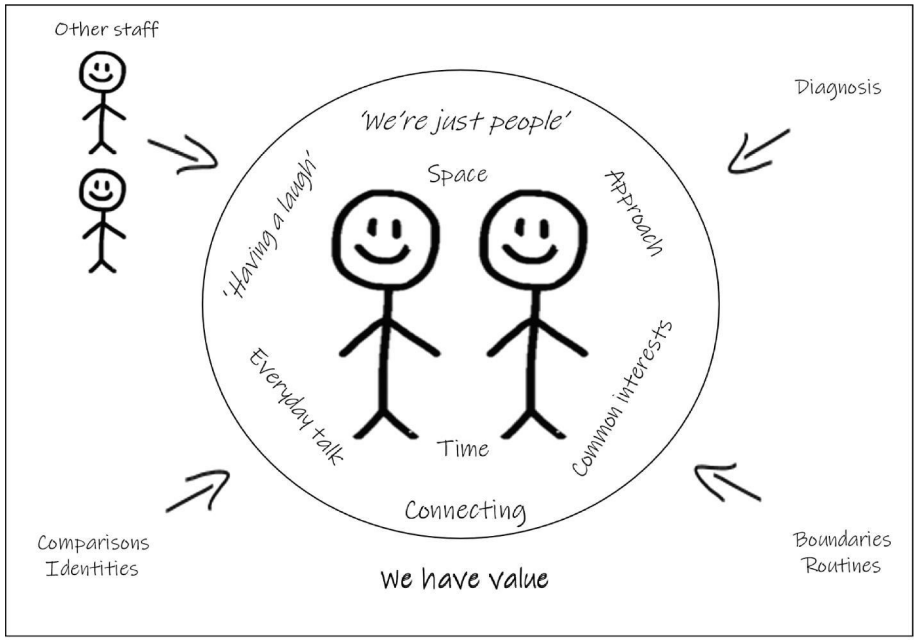

Figure 1: Pictorial representation of the findings.

"I think [a laugh and a joke is] 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..." (Oliver, student)

As compared to nurses, due to roles that involved them being in the office, students were seen as available by the patients as they had more time to spend with them. The participants identified that students had more time than nurses who were seen as "always busy doing stuff" (George) like paperwork in the office.

"I think that is the thing I'll miss when I qualify... 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, student)

3.3. Sponges. Patients identified students by various terms depicting that they were new, and 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, patient)

David, spoke of students as "baby lambs", without prejudice, but as they are exposed to the prejudice of others, become "sheep" or jaded (Jasper).

"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, patient)

Patient participants viewed the students as having a more positive attitude as compared to some regular staff due to them being viewed as learners. Jasper found it "nice to have a fresh face on the ward" and Fred said how the students were "willing to learn." Steven similarly referred to the impact the students had on the environment by being new, that they "brighten[ed] the place up" and enabled conversations. The patient participants felt students were more "like us" (George), as compared to "regular" staff (David, George, Jasper, and Steven), due to associated roles, time, and boundaries:

... "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, and that's nice. We like that spending a bit more time with us and stuff..." (George, patient)

4. Discussion

4.1. Being-With. Heidegger's notion of Dasein 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 [55]. 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 [29]:

> . . . "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." [29]

Heidegger's phenomenology is the phenomenology of everydayness, the showing and interpretation of Dasein "in its average everydayness" [29] and its encounters in the world [30, 56]. We always inhabit a shared world [57], and the way we exist in the world is always structured and influenced by others [58]. We are, by nature, social beings who share a world, time, and space with others, some near and some far [33]. On the ontological level, just as Dasein is never without a world so too it is never without others [29]. "Dasein is essentially for the sake of others" (p. 123/160); others matter to us [29]. Our relation to others is understood under the notion of "care" (solicitude), where in being-with we can leap in for the other. 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", and it leaps forth and liberates [29].

Students and patients share time and space on the forensic unit, socialising about and in the everyday. The students and patients spoke of being-with each other in their own time and space, where they shared an experience of togetherness, enabling them to feel they were "just people" (Fred and Jasper) and had value, which had a lasting impact. They connected with each other creating a bubble (a shared time and space between students and patients). Steven described a click he experienced with students when talking about common interests. This click or the connections patients and students made formed their bubble, despite their experience of thrownness into the world, the landscape, and assessment. People diagnosed with a personality disorder have often experienced trauma when young, which can impact on their perception of themselves, others, and the world around them [4]. We are thrown or delivered over into the world and into life and circumstances, and we exist in the ways made available by this thrownness [59, 60]. Hence, "we are subject to things about which we have little if any say" [60].

The patients and students referred to the value of being together, "just being around" (George) each other whether that was watching television together, playing pool, talking, playing cards, or simply just sat together. Of course, it is important to acknowledge the potential for students' negative feelings during interactions, and authentic meetings contain both positive and negative feelings [61]. Overwhelmingly, the participants reflected on positive interactions. There was something precious for them in just sitting together [62], being present, experiencing things together, being-in-the-world, being-with [63]. 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 dehumanising setting of the forensic unit [2]. They experienced this temporally and spatially in that it was their own time and space, not in the physical or measurable sense (see Steven's quote in "Just being around").

Bergson distinguished between objective time (measured) and lived time (our inner subjective experience) [64]. Lived time, often overlooked, is felt and acted [64]. Heidegger [65] and, more recently, Crowther et al. [66] discuss kairos as an existential temporal experience that is rich in significant meaning, rarely spoken about yet touches those present. It involves shared connectedness [66], as the participants experienced. Van Manen [67] describes lived time (temporality) as felt experience, an ontological phenomenon. It is a moment of life altering possibilities [66], as the students opened for the patients.

In their bubble, there was a meeting of two lifeworlds [68, 69]. Welch [70] and Stockmann [71] describe such bringing together of lifeworlds as presence, embodying past experiences. Rask and Brunt [68] describe it as two people meeting in a "common sphere" that they both experience (p. 170), resonating with the bubble metaphor. This shared "sphere" or bubble aligns with Merleau-Ponty's [72] description of the "between" in interpersonal relationships, or as Gendlin [73] describes a "crossing" or "dipping" (p. 547). Such metaphors can be used to explore therapeutic encounters, providing rich imagery for making sense of experiences [74, 75]. "Metaphor is for most people a device of the poetic imagination and the rhetorical flourish—a matter of extraordinary rather than ordinary language" [76]. They are often used in mental health nursing [74, 75, 77, 78] and are indebted to the phenomenological tradition [76].

Connecting with patients is something done in everydayness and often unnoticed, despite its importance [79]. Mental health nursing is embedded in the everyday world [80], the focus of [29] Being and Time. Arguably, nursing aligns with Heidegger's phenomenology, and being-with is thus a crucial phenomenon which lies at the very core of relational elements of nursing and caring [81–83]. However, Deacon et al. [84] argue it is difficult to articulate the being-with process in nursing and the skills invovled, hence the role of being-with has been overlooked in previous mental health research. This is despite Schmid [85] positing that mental illness represents a fundamental disturbance of being-with, particularly for patients with a diagnosis of personality disorder, who may find difficulties in connecting with others [86].

An essential element to the participants' connectedness was humour. "Having a laugh", a joke, or "banter" was of great value to participants, helping them feel normal in the abnormal place of the forensic unit, a key aspect of the use of humour [87]. We, as Dasein, are always situated and experiencing human connectedness [88]. Being-with is Heidegger's analysis of connectedness, and it is Dasein's openness to fellow humans. In their bubble, they shared a common humanity, identifying with each other on the same level [89, 90], 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."

It is essential for students to see the person in front of them, not the diagnostic label they carry [91–93], to negate associated stigma [94]. It is also important to acknowledge a persons' thrownness into the world [29, 30], our

enculturation into a shared community [95]. Hence, the importance of 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 [12].

Patients carrying a personality disorder diagnosis are likely to have experienced adverse childhood experiences (ACEs) [96, 97]. Moreover, patients in forensic settings may originate from the most deprived societies with high experience of abuse, neglect, and insecure attachments [98]. Thus, their thrownness is into a traumatic world. Importantly, as Julie disclosed, the students may have also experienced trauma [99]. Lack of understanding of the dynamics of personal trauma may impact on the nurses' ability to interact in a meaningful and safe way with patients [61, 100].

Our past shapes who we are and influences our present and future selves [30, 101]. Heidegger [29] emphasised 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 [102]. In recognising the person as a person while understanding their past experiences, such empathy and appreciation of thrownness can help reduce othering practices [103]. The patients and students recognised their shared humanity despite unique experiences of thrownness [29] and individual realities [104].

Being-with, shared laughter, and connecting over common interests fostered therapeutic relationships. These relationships, or whatever term is used, are composed of connectedness [105]. In the time patients and students shared, they were being-with, connecting over common interests, forming their bubble 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 (Figure 2).

4.2. Leaping-In and Leaping-Ahead. On the one hand, leaping-in [29] is signified with fear, legal accountability, and risk aversion and on the other empowering, ordinary, and mundane humane relating (leaping-ahead). There has been limited exploration of such a balance for students, except for specific considerations of humour [106], empathy [107], or self-disclosure [108]. Students do not hold the label of professional [109]; however, there is an expectation of them to behave in a certain manner [106, 110] and closeness can be determined by professionalism expectations [111]. For often new and unconfident nurses, the balance can be daunting [112].

This balance is shown in the balance of therapeuticness (Figure 2), which signifies the balance between managing risk and safety linked to the custodial environment while being therapeutic and supporting recovery/discovery. The term "therapeuticness" encompasses the experience of care and therapeutic practices, being-with, the mundane every day, recognition, use of self, and so forth, while custody and risk encompass restrictive identities and roles, professionalism, boundaries, power constructs, and so forth. Therapeuticness involves a holistic approach that is therapeutic, an all-encompassing supportive and humane 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 [81, 113], or opposing forces [114] and many view custody and care as binary opposition [46], there is in reality complexity and interaction between the two. They are more like a seesaw [115] and flexible. For example, ensuring appropriate boundaries is essential for consistency, which is vital when supporting patients carrying a personality disorder diagnosis [25, 116]. 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 (as identified by David) in achieving this balance.

Leaping-in, phenomenologically, means to take over or to take away care from the other [29, 30, 117], to dominate, or disempower [81]. It shows itself in the focus on medical professionalism that often deters staff from authentic and empathic connections [118]. Such approaches restrict and restrain the body while the self is ignored [118]. Participants in Gilburt et al.'s study [119] reflected that staff wielding of power and control was due to fear of accountability, against a political and policy backdrop of criticism and scrutiny [120, 121] heightening focus on professionalism and risk aversion [106, 122]. Such political demands increase the tensions experienced [123, 124]. Due to such concerns around accountability, services and staff become risk averse, now a defining feature of mental health settings [125]. Coffey et al. [126] 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 [103]. Staff experience oppressive expectations to complete paperwork with threat of managerial disapproval [125]. Though, despite the importance of engagement, lack of engagement does not meet the same disapproval as incomplete paperwork. A focus on such aspects of professionalism is unfulfilling for staff and patients, while therapeuticness is most fulfilling, clearly evident for study participants and their sense of recognition and humanness, despite set roles, identities, and the landscape.

Opposing paternalism and risk aversion, leaping-ahead empowers, and it enables [29, 30].

> . . ."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 existential potentiality-for-being, not in order to take away his 'care' but rather to give it back to him. . ." [29]

It frees others to move towards their possibilities [29, 127]. It is a collaborative mutual partnership, valuing shared knowledge and promoting growth [117, 128].

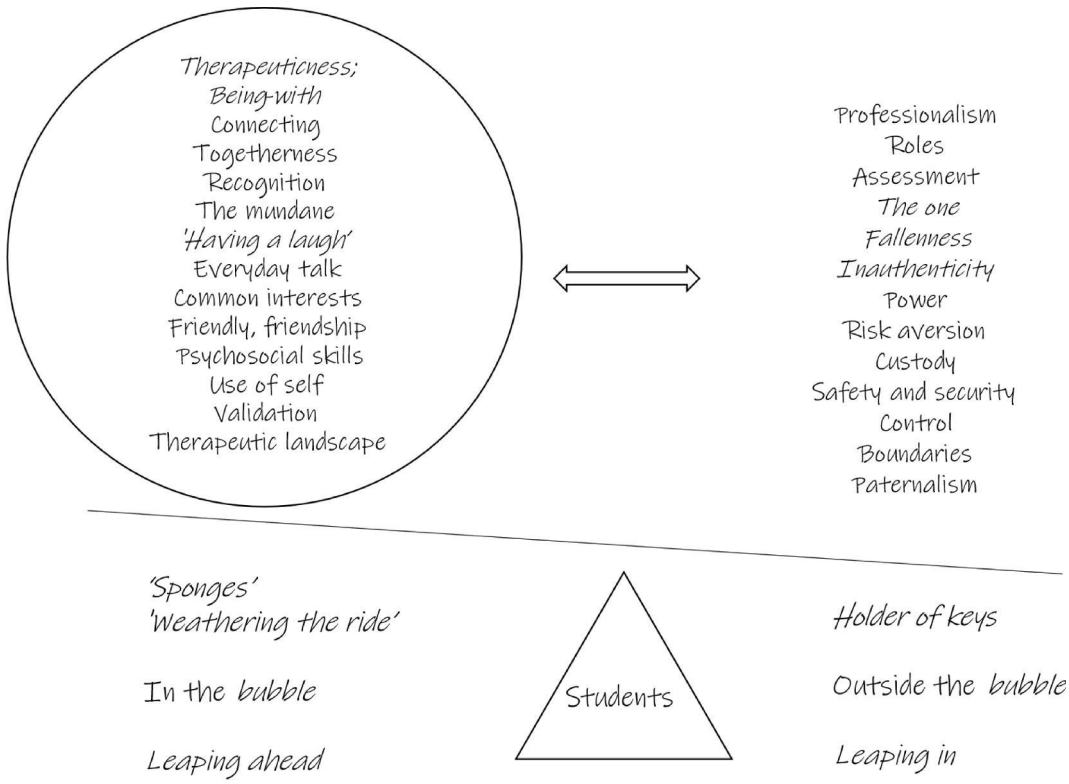

Figure 2: Balance of therapeuticness.

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 [118, 129]. Humanity is demonstrated with mutual understanding and connections which ensure patient and staff relationships are more equal [124], as found in this study.

Generally, students were perceived as leaping-ahead; they were "always there" (Fred) and available compared to other ward staff, who were identified as not available and "always busy" (George), for example, doing paperwork. They were physically present but not available due to such roles. Nurses are not seen as readily available to patients, with lack of time being a major obstacle [130, 131], with nurses too busy to talk, despite its importance [105, 118, 130, 132, 133]. Students are, of course, expected to complete paperwork, such as assessments, care plans, and formulations as part of their learning experience [24]. However, they do not have the same scope of practice, roles, and responsibilities as qualified nurses, hence less "paperwork" and more time with patients, as noticed by participants in this study. Their expected education outcomes on such placements as forensic units can include, for example, engaging in the day-to-day routines of the ward, connecting with and supporting patients, engaging in assessment and care planning, leading meetings, and working with the multidisciplinary team [24]. Such is agreed upon by the student and their practice assessor as aligned with their year of study and opportunities in the placement area.

4.3. Holder of Keys. Students were viewed positively as "sponges" (Fred), soaking up learning. 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 (leaping-ahead).

Although students may be inexperienced or novice (Benner, 1984/2001), this is outweighed by them being "sponges" (Fred) and learners without ingrained or "jaded" attitudes (Jasper). Conversely, Benner [134] argued that novice nurses have problems seeing the patient individually and are more focused on practical tasks as compared to the expert nurse. In contrast to Benner's [134] assumptions, this study found that 'regular' nurses or 'experts' were holder of keys, seen as having a less desirable approach and less time than students to spend with patients. The students were identified positively as "sponges" but could become enculturated in the landscape to holder of keys (the one; [29]) as fully fledged nurses. In this regard, they assume decision-making responsibilities (leaping-in), must maintain professionalism, and due to this become increasingly, spatially, and temporally distant from patients. The keys signified power, a physical representation of custodial role. Thus, material objects like keys, or physical objects like doors

[135], take symbolic form in the practice of territorialisation, wherein boundaries are set [89, 136]. "Real power lies with the one who holds a ward key" [137]. Such objects do not implicitly hold meaning, and this must be conferred by human beings [30].

As human beings, we are always being-with others and subject to cultural norms, as part of the one, as Heidegger [29] described Das Man. In our everyday lives, we do what "one" does according to culturally accepted norms [138]. Students are "sponges" that can be influenced by others and conform to become the one in the forensic landscape. Students can experience fallenness to become the one when they become holder of keys. Heidegger [29] wrote about being caught up in the world and ignoring our Dasein, which he calls "fallenness," where we are rendered inauthentic [139]. When inauthentic, we are conforming and adopting what others do without challenging why. By doing this every day, we experience a state of fallenness. By the individual taking more agency over their life and questioning what they do, they are making their own decisions and being authentic. Heidegger makes it clear inauthenticity is a state of coping and 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 [29].

There is a transition from learners with time to share with patients, valued because they were unpaid, to being paid, busy, and no longer learners. The patients spoke of this transition from student to nurse as "baby lambs" (David) (in a positive sense) becoming "sheep" (David) (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. Patients can view students as unwritten sheets, without prejudice [21].

When the transition to regular staff occurs, students appeared as fallen [29] through becoming accepted into the wider workforce culture (the one). Their state of fallenness is indicative of enculturation [117], becoming inauthentic as holder of keys. Conversely, some staff may feel authentic as holder of keys. Heidegger [29] was careful to posit, 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." [29]

The one articulates the referential totality; in other words, conforming as the one helps us make sense of cultural norms and function in society [56, 81]. 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 [127]. 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 [95]. Conversely, in taking risks and embracing possibility offers opportunity for a meaningful existence [140], which is what sets us apart from everything else as humans; we create space for new things [141], 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 [29], students balanced therapeuticness over professionalism, embracing possibility and taking risks. In confronting situations, we open ourselves up to the best version of ourselves [142]. 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 [101].

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 [101]. So, although students may fall to become holder of keys (the one), they are coping in the world and can "weather the ride" (David) and resist mindless conformity. However, as patient participants depict, there are nurses and support workers who mindlessly conform or become cognitively dissonant [144]. They become thoroughly conditioned into roles of regular staff, absorbed by cultural traditions and practices of healthcare, and cannot see this [140]. They "become lost in an anonymous, formless, and inauthentic 'they-ness'" [95]. Thomson [95] 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.

4.4. "Weather[ing] the Ride": Managing the Balance. Of course, as Thomson [95] reflects, 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 bubbles. Encouragingly, students can be creative and innovative within the landscape, balancing therapeuticness and professionalism, challenging norms and behaviour of the one. Reflective practice, supervision, patient involvement, and feedback challenge mindless conformity [89, 117]. Encouraging students to reflect on their practice is essential in cultivating critical and analytical thinking [145].

In this study, student participants recognised patients as people, "like anyone else" (Hollie). Students' humanising views are heartening as they can help reclaim the humanity of those designated personality disordered [146], a turn congruent with trauma-informed understandings of care [18] and relational practice [11]. Patients reciprocally saw the students as "like us" (Steven) 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 forensic service care and patients' satisfaction and ultimately quality of life. We must negotiate the balance between therapeuticness and control.

5. Strengths and Limitations

"Imperfection is a gift" [30]

Qualitative research aims to explore and illuminate phenomena, not make generalisable findings. By reducing a person to measurable units disregards their own context of possibilities and their complex, colourful, and rich lives [30]. Nevertheless, this is one study in medium forensic services for men (across two sites in the North of England), it may not be representative of other areas, and thus, further research would bring added insights into this minimally researched area. Incorporation of preunderstandings (Heidegger, 1927/2019) and prejudices (Gadamer, 1967/1976) is a strength of hermeneutic research. This ontological project was concerned with understanding lived experiences and bringing commonalities to light [147]. The project maintained research rigor through reflective logs, focused supervision, and robust data collection and analysis.

6. Recommendations

(1) Call to all in practice to foster and value just being-with, spend time having a laugh, or just talking to build connections.

(2) Further research on the experience of humour between patients and students in forensic settings.

(3) Exploration of nurses' and patients' experiences of sharing time in forensic personality disorder units. Joint and individual interviews could be considered.

(4) Specific exploration of experiences of the balance of therapeuticness and professionalism for students, other staff, and patients is warranted. Also, exploration of the experiences of the transition from student to nurse and the impact on time with patients and the concept of holder of keys.

7. Conclusion

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: a special shared time and space, despite experiences of thrownness into the world and landscape, or the bearing of diagnostic labels. Together, the participants engaged in the mundane every day, sharing activities, connecting over common interests, and having a laugh. The time students and patients shared together powerfully impacted 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. Students were viewed as "sponges," as available unpaid learners, elements not fully present for other staff due to set roles. Students can become holder of keys on becoming staff and, however, can "weather the ride" by focusing on the everyday mundane, being-with and connecting with patients to create bubbles.

This article 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, and be with patients. This article 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.

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)

Data Availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Ethical Approval

This study was approved by the United Kingdom National Health Service Health Research Authority (REC reference: 17/NW/0643).

Consent

Written consent was given by all participants.

Disclosure

This study was the first author's doctoral research, supervised by second and third authors [28].

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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References

[1] A. McGregor Kettles, P. Woods, and R. Byrt, "Introduction," in *The National Forensic Nurses' Research and Development Group*, Quay, London, UK, 2008.

[2] P. Reavey, S. D. Brown, A. Kanyeredzi, L. McGrath, and I. Tucker, "Agents and spectres: life-space on a medium secure forensic psychiatric unit," *Social Science and Medicine*, vol. 220, pp. 273–282, 2019.

[3] National Health Service, *Your Guide to Relational Security: See, Think, Act*, National Health Service, London, UK, 2010.

[4] W. Bolton, K. Lovell, L. Morgan, and H. Wood, "Meeting the challenge: making a difference," 2014, https://www.newhamscp.org.uk/wp-content/uploads/2016/11/Meeting-the-Challenge-Making-a-Difference.pdf.

[5] L. Johnston, M. Boyle, J. Cromby et al., "The power threat meaning framework: towards the identification of patterns in emotional distress, unusual experiences and troubles or troubling behaviour, as an alternative to functional psychiatric diagnosis: the British Psychological Society," 2018, https://www.madinamerica.com/wp-content/uploads/2020/12/The-Power-Threat-Meaning-Framework.pdf.

[6] L. Sheridan Rains, A. Echave, J. Rees et al., "Service user experiences of community services for complex emotional needs: a qualitative thematic synthesis," *PLoS One*, vol. 16, no. 4, p. e0248316, 2021.

[7] P. Tyrer, R. Mulder, Y.-R. Kim, and M. J. Crawford, "The development of the ICD-11 classification of personality disorders: an amalgam of science, pragmatism, and politics," *Annual Review of Clinical Psychology*, vol. 15, no. 1, pp. 481–502, 2019.

[8] National Institute for Health and Care Excellence, "Borderline personality disorder: recognition and management," 2009, https://www.nice.org.uk/guidance/cg78.

[9] National Institute for Health and Care Excellence, "Antisocial personality disorder: prevention and management," 2013, https://www.nice.org.uk/guidance/cg77.

[10] S. Gillard, K. Turner, and M. Neffgen, "Understanding recovery in the context of lived experience of personality disorders: a collaborative, qualitative research study," *BMC Psychiatry*, vol. 15, no. 1, p. 183, 2015.

[11] R. Haigh and N. Benefield, "Towards a unified model of human development," *Mental Health Review Journal*, vol. 24, no. 2, pp. 124–132, 2019.

[12] K. Houghton and E. Jones, "To formulate or not to formulate? A case study," *British Journal of Mental Health Nursing*, vol. 5, no. 6, pp. 274–281, 2016.

[13] W. Aves, "A pathological 'diagnosis-seeker' speaks out," *Asylum: The Radical Mental Health Magazine*, vol. 29, no. 4, pp. 8-9, 2022.

[14] M. Boullier and M. Blair, "Adverse childhood experiences," *Paediatrics and Child Health*, vol. 28, no. 3, pp. 132–137, 2018.

[15] M. DeLisi, J. Alcala, A. Kusow et al., "Adverse childhood experiences, commitment offense, and race/ethnicity: are the effects crime-race-and ethnicity-specific?" *International Journal of Environmental Research and Public Health*, vol. 14, no. 3, p. 331, 2017.

[16] A. Sweeney, S. Clement, B. Filson, and A. Kennedy, "Trauma-informed mental healthcare in the UK: what is it and how can we further its development?" *Mental Health Review Journal*, vol. 21, no. 3, pp. 174–192, 2016.

[17] J. Paris, "The natural history of personality disorders: recovery and residual symptoms," *Canadian Journal of Psychiatry*, vol. 60, no. 7, pp. 301-302, 2015.

[18] A. Sweeney, B. Filson, A. Kennedy, L. Collinson, and S. Gillard, "A paradigm shift: relationships in trauma-informed mental health services," *BJPsych Advances*, vol. 24, no. 5, pp. 319–333, 2018.

[19] K. Jones and D. Black, "Involving mental health service users in student education," *Nursing Times*, vol. 104, no. 29, pp. 32-33, 2008.

[20] F. C. Mukumbang and O. Adejumo, "Patients' experiences of being nursed by student nurses at a teaching hospital," *Curationis*, vol. 37, no. 1, p. 1230, 2014.

[21] N. Andersson, M. Ekebergh, and U. Hörberg, "Patient experiences of being cared for by nursing students in a psychiatric education unit," *Nordic Journal of Nursing Research*, vol. 40, no. 3, pp. 142–150, 2020.

[22] J. Speers and J. Lathlean, "Service user involvement in giving mental health students feedback on placement: a participatory action research study," *Nurse Education Today*, vol. 35, no. 9, pp. e84–e89, 2015.

[23] B. Palmer, R. Hutchings, and C. Leone, "Laying foundations: attitudes and access to mental health nurse education," 2020, https://www.nhsconfed.org/publications/laying-foundations.

[24] Nursing and Midwifery Council, "Standards of proficiency for registered nurses," 2018, https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/.

[25] E. Jones, K. M. Wright, and M. McKeown, "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," *Nurse Education Today*, vol. 98, 2021.

[26] C. G. Long, C. Knight, L. Bradley, and M. Thomas, "Effective therapeutic milieus in secure services for women: the service user perspective," *Journal of Mental Health*, vol. 21, no. 6, pp. 567–578, 2012.

[27] A. Scholes, O. Price, and K. Berry, "Women service users' experiences of inpatient mental health services and staff experiences of providing care to women within inpatient mental health services: a systematic review of qualitative evidence," *International Journal of Nursing Studies*, vol. 118, 2021.

[28] E. Jones, "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," Doctoral thesis, University of Central Lancashire, Preston, UK, 2022.

[29] M. Heidegger, "Being and time (J. Macquarrie & E. Robinson, Trans.)," *Martino Fine Books*, 1927.

[30] L. Dibley, S. Dickerson, M. Duffy, and R. Vandermause, *Doing Hermeneutic Phenomenological Research: A Practical Guide*, Sage, Newcastle upon Tyne, UK, 2020.

[31] M. van Manen, "Beyond assumptions: shifting the limits of action research," *Theory Into Practice*, vol. 29, no. 3, pp. 152–157, 1990.

[32] P. Benner, C. Tanner, and C. Chesla, *Expertise in Nursing Practice Care: Clinical Judgment and Ethics*, Springer, Cham, 2009.

[33] S. Crowther and G. Thomson, "From description to interpretive leap: using philosophical notions to unpack and surface meaning in hermeneutic phenomenology research," *International Journal of Qualitative Methods*, vol. 19, p. 160940692096926, 2020.

[34] T. Carman, *Heidegger's Analytic: Interpretation, Discourse and Authenticity in Being and Time*, Cambridge University Press, Cambridg, UK, 2003.
[35] D. R. Cerbone, *Heidegger: A Guide for the Perplexed*, Continuum, London, UK, 2008.
[36] J. Cutcliffe and P. Goward, "Mental health nurses and qualitative research methods: a mutual attraction?" *Journal of Advanced Nursing*, vol. 31, no. 3, pp. 590–598, 2000.
[37] E. Smythe, "Discerning which qualitative approach fits best," *New Zealand College of Midwives Journal*, vol. 46, 2012.
[38] D. Freshwater, *Therapeutic Nursing: Improving Patient Care through Self-Awareness and Reflection*, Sage, London, UK, 2002.
[39] J. Travelbee, *Interpersonal Aspects of Nursing*, FA Davis Company, Philadelphia, PA, USA, 1969.
[40] A. C. Morck, "Right there, in the midst of it: impacts of the therapeutic relationship on mental health nurses," *Journal of Applied Hermeneutics*, 2016.
[41] K. Chang and S. Horrocks, "Is there a place for ontological hermeneutics in mental-health nursing research? A review of a hermeneutic study," *International Journal of Nursing Practice*, vol. 14, no. 5, pp. 383–390, 2008.
[42] A. L. Holm and E. Severinsson, "A hermeneutic approach to the characteristics of mental health nursing practice," *Journal of Psychiatric and Mental Health Nursing*, vol. 18, no. 10, pp. 843–850, 2011.
[43] S. Crowther and G. Thomson, "Introduction: situating hermeneutic phenomenology as research method in health, social care and education," in *Hermeneutic Phenomenology in Health and Social Care Research*, S. Crowther and G. Thomson, Eds., pp. 1–20, Routledge, London, UK, 2023.
[44] G. Adshead, "Care or custody? Ethical dilemmas in forensic psychiatry," *Journal of Medical Ethics*, vol. 26, no. 5, pp. 302–304, 2000.
[45] W. Austin, E. Goble, and J. Kelecevic, "The ethics of forensic psychiatry: moving beyond principles to a relational ethics approach," *Journal of Forensic Psychiatry and Psychology*, vol. 20, no. 6, pp. 835–850, 2009.
[46] U. Hörberg and K. Dahlberg, "Caring potentials in the shadows of power, correction, and discipline-Forensic psychiatric care in the light of the work of Michel Foucault," *International Journal of Qualitative Studies on Health and Well-Being*, vol. 10, no. 1, p. 28703, Article ID 28703, 2015.
[47] L. Bowers, J. Alexander, A. Simpson, C. Ryan, and P. Carr-Walker, "Student psychiatric nurses' approval of containment measures: relationship to perception of aggression and attitudes to personality disorder," *International Journal of Nursing Studies*, vol. 44, no. 3, pp. 349–356, 2007.
[48] H. G. Gadamer, *Philosophical Hermeneutics*, D. E. Linge, Ed., University of California, California, CA, USA, 1976.
[49] E. Smythe and D. Spence, "Nurturing a spirit of attuning-to," in *Hermeneutic Phenomenology in Health and Social Care Research*, S. Crowther and G. Thomson, Eds., pp. 21–36, Routledge, Oxon, UK, 2023.
[50] K. Dahlberg, "Lifeworld phenomenology for caring and health care," in *Qualitative Research in Midwifery and Childbirth*, G. Thomson, F. Dykes, and S. Downe, Eds., Routledge, London, UK, 2011.
[51] B. E. Neubauer, C. T. Witkop, and L. Varpio, "How phenomenology can help us learn from the experiences of others," *Perspectives on Medical Education*, vol. 8, no. 2, pp. 90–97, 2019.
[52] G. Thomson and S. Crowther, "Attuning to trustworthiness and final reflections," in *Hermeneutic Phenomenology in Health and Social Care Research*, S. Crowther and G. Thomson, Eds., pp. 213–217, Routledge, Oxon, 2023.
[53] D. Greene, "An investigation of patient experiences of treatment in the cranial field of osteopathy," Thesis, Unitec Institute of Technology, New Zealand, 2009.
[54] E. Jones, K. Wright, and M. McKeown, "The impact of patients and student mental health nurses sharing time together in forensic units," *Journal of Forensic Nursing*, 2024, In press.
[55] C. Molloy, S. Bankins, A. Kriz, and L. Barnes, "Making sense of an interconnected world: how innovation champions drive social innovation in the not-for-profit context," *Journal of Product Innovation Management*, vol. 37, no. 4, pp. 274–296, 2020.
[56] H. Dreyfus, "Heidegger: being and time," *Lecture*, 2007, https://www.youtube.com/watch?app=desktop&v=IaIWz_87Kz0.
[57] E. Smythe and D. Spence, "Heideggerian phenomenological hermeneutics: working with the data," *Nursing Philosophy: An International Journal for Healthcare Professionals*, vol. 21, no. 4, p. e12308, 2020.
[58] H. Dreyfus and M. A. Wrathall, *A Companion to Heidegger*, John Wiley and Sons, Hoboken, NJ, USA, 2008.
[59] W. Blattner, *Heidegger's Being and Time: A Reader's Guide*, Bloomsbury, London, UK, 2006.
[60] M. Wrathall, *How to Read Heidegger*, Granta Publications, London, UK, 2005.
[61] E. Missouridou, "Secondary posttraumatic stress and nurses' emotional responses to patient's trauma," *Journal of Trauma Nursing*, vol. 24, no. 2, pp. 110–115, 2017.
[62] M. Salzmann-Erikson, C. Rydlo, and L. Wiklund Gustin, "Getting to know the person behind the illness-the significance of interacting with patients hospitalised in forensic psychiatric settings," *Journal of Clinical Nursing*, vol. 25, no. 9-10, pp. 1426–1434, 2016.
[63] C. Taylor, "Being in the world," 2010, https://youtu.be/dIFsZ9uTrpE.
[64] V. Leonard, "Henri bergson," 2020, https://plato.stanford.edu/entries/bergson/.
[65] M. Heidegger, *The Metaphysical Foundations of Logic*, Indiana University Press, Indianapolis. Indiana, 1984.
[66] S. Crowther, E. Smythe, and D. Spence, "Kairos time at the moment of birth," *Midwifery*, vol. 31, no. 4, pp. 451–457, 2015.
[67] M. v. Manen, "Phenomenology of practice," *Phenomenology and Practice*, vol. 1, pp. 11–30, 2007.
[68] M. Rask and D. Brunt, "Verbal and social interactions in the nurse–patient relationship in forensic psychiatric nursing care: a model and its philosophical and theoretical foundation," *Nursing Inquiry*, vol. 14, no. 2, pp. 169–176, 2007.
[69] M. van Manen, *Phenomenology of Practice: Meaning and Method in Phenomenological Research and Writing*, Left Coast Press, California, CA, USA, 2014.
[70] D. Welch, "A Heideggerian phenomenological study of nurses' experience of presence," Thesis, Victoria University of Technology, Melbourne, Australia, 2001.
[71] C. Stockmann, "Presence in the nurse–client relationship: an integrative review," *International Journal for Human Caring*, vol. 22, no. 2, pp. 49–64, 2018.
[72] M. Merleau-Ponty, *Phenomenology of Perception*, Routeledge, New York, NY, USA, 1945.

[73] E. T. Gendlin, "Crossing and dipping: some terms for approaching the interface between natural understanding and logical formulation," *Minds and Machines*, vol. 5, no. 4, pp. 547–560, 1995.
[74] J. Turner, "CAT, metaphor and pictures: an exploration of the views of CAT therapists into the use of metaphor and pictorial metaphor," *Reformulation: The Newsletter for the Association for Cognitive Analytic Therapy*, vol. 36, pp. 37–41, 2011.
[75] J. Turner, "Metaphors and therapeutic encounters in mental health nursing," *Mental Health Nursing*, vol. 34, no. 3, 2014.
[76] G. Lakoff and M. Johnson, *Metaphors We Live by*, University of Chicago press, IL, USA, 2008.
[77] J. Turner and R. Ralley, "Cognitive neuroscience, metaphor and pictures: part 1," *Mental Health Nursing*, vol. 39, no. 5, pp. 16–19, 2019.
[78] J. Turner and R. Ralley, "Cognitive neuroscience, metaphor and pictures: part 2," *Mental Health Nursing*, vol. 39, no. 6, pp. 16–19, 2019.
[79] K. R. Delaney and M. E. Johnson, "Metasynthesis of research on the role of psychiatric inpatient nurses:what is important to staff?" *Journal of the American Psychiatric Nurses Association*, vol. 20, no. 2, pp. 125–137, 2014.
[80] P. Awty, A. Welch, and L. Kuhn, "A naturalistic inquiry of registered nurses' perspectives and expectations of psychodynamic therapeutic care in acute psychiatric inpatient facilities," *Archives of Psychiatric Nursing*, vol. 24, no. 2, pp. 104–113, 2010.
[81] J. Gullick, J. Wu, C. Reid, A. C. Tembo, S. Shishehgar, and L. Conlon, "Heideggerian structures of Being-with in the nurse-patient relationship: modelling phenomenological analysis through qualitative meta-synthesis," *Medicine, Healthcare and Philosophy*, vol. 23, no. 4, pp. 645–664, 2020.
[82] A. Horgan, M. O Donovan, F. Manning et al., "Meet me where I am': mental health service users' perspectives on the desirable qualities of a mental health nurse," *International Journal of Mental Health Nursing*, vol. 30, no. 1, pp. 136–147, 2020.
[83] L. O'Reilly and C. Cara, "Being with the person cared for in a rehabilitation context: a profound, therapeutic, and transformative human relationship," *Recherche en Soins Infirmiers*, vol. 4, pp. 46–66, 2010.
[84] M. Deacon, T. Warne, and S. McAndrew, "Closeness, chaos and crisis: the attractions of working in acute mental health care," *Journal of Psychiatric and Mental Health Nursing*, vol. 13, no. 6, pp. 750–757, 2006.
[85] S. Jelscha, "Disordered existentiality: mental illness and Heidegger's philosophy of Dasein," *Phenomenology and the Cognitive Sciences*, vol. 17, no. 3, pp. 485–502, 2018.
[86] O. Sagan, "The loneliness of personality disorder: a phenomenological study," *Mental Health and Social Inclusion*, vol. 21, no. 4, pp. 213–221, 2017.
[87] E. Jones, K. Wright, and M. McKeown, "Humour in forensic services: enabling connections between patients and students," *British Journal of Mental Health Nursing*.
[88] D. Moran, *Introduction to Phenomenology*, Routledge, London, UK, 2000.
[89] A. Bennett and P. Hanna, "Exploring the experiences of male forensic inpatients' relationships with staff within low, medium and high security mental health settings," *Issues in Mental Health Nursing*, vol. 42, no. 10, pp. 929–941, 2021.
[90] N. R. Cook, B. N. Phillips, and D. Sadler, "The Tidal Model as experienced by patients and nurses in a regional forensic unit," *Journal of Psychiatric and Mental Health Nursing*, vol. 12, no. 5, pp. 536–540, 2005.
[91] L. Hammarström, M. Häggström, S. A. Devik, and O. Hellzen, "Controlling emotions: nurses' lived experiences caring for patients in forensic psychiatry," *International Journal of Qualitative Studies on Health and Well-Being*, vol. 14, no. 1, pp. 1682911-1682912, 2019.
[92] E. S. Jones and K. M. Wright, "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," *International Journal of Offender Therapy and Comparative Criminology*, vol. 61, no. 5, pp. 526–543, 2017.
[93] H. Spandler and T. Stickley, "No hope without compassion: the importance of compassion in recovery-focused mental health services," *Journal of Mental Health*, vol. 20, no. 6, pp. 555–566, 2011.
[94] L. A. Marshall and E. A. Adams, "Building from the ground up: exploring forensic mental health staff's relationships with patients," *Journal of Forensic Psychiatry and Psychology*, vol. 29, no. 5, pp. 744–761, 2018.
[95] G. Thomson, "Abandonment of being' in childbirth," in *Qualitative Research in Midwifery and Childbirth*, G. Thomson, F. Dykes, and S. Downe, Eds., pp. 133–152, Routledge, Oxon, UK, 2011.
[96] M. Bush, "Addressing adversity: prioritising adversity and trauma-informed care for children and young people in England," 2018, https://youngminds.org.uk/media/2142/ym-addressing-adversity-book-web.pdf.
[97] J. Ramsden, "Are you calling me a liar? Clinical interviewing more for trust than knowledge with high-risk men with antisocial personality disorder," *International Journal of Forensic Mental Health*, vol. 17, no. 4, pp. 351–361, 2018.
[98] G. Mezey, H. Youngman, I. Kretzschmar, and S. White, "Stigma and discrimination in mentally disordered offender patients–A comparison with a non-forensic population," *Journal of Forensic Psychiatry and Psychology*, vol. 27, no. 4, pp. 517–529, 2016.
[99] P. Ramluggun, M. Lacy, M. Cadle, and M. Anjoyeb, "Managing the demands of the preregistration mental health nursing programme: the views of students with mental health conditions," *International Journal of Mental Health Nursing*, vol. 27, no. 6, pp. 1793–1804, 2018.
[100] E. Missouridou, E. C. Fradelos, E. Kritsiotakis, P. Mangoulia, E. Segredou, and I. V. Papathanasiou, "Containment and therapeutic relationships in acute psychiatric care spaces: the symbolic dimensions of doors," *BMC Psychiatry*, vol. 22, no. 1, p. 2, 2022.
[101] H. Dreyfus, "Being in the world," 2010, https://youtu.be/dIFsZ9uTrpE.
[102] H. Pickard, "Responsibility without blame: empathy and the effective treatment of personality disorder," *Philosophy, Psychiatry, and Psychology*, vol. 18, no. 3, pp. 209–224, 2011.
[103] C. Peternelj-Taylor, "An exploration of othering in forensic psychiatric and correctional nursing," *Canadian Journal of Nursing Research Archive*, vol. 36, no. 4, pp. 130–146, 2004.
[104] K. Jaspers, *General Psychopathology*, J. H. Hoenig, Ed., Manchester University Press, Manchester, UK, 1962.
[105] A. Mirhaghi, S. Sharafi, A. Bazzi, and F. Hasanzadeh, "Therapeutic relationship: is it still heart of nursing?" *Nursing Reports*, vol. 7, no. 1, pp. 4–9, 2017.
[106] D. Flynn, "Personal and social influences on the use of humour in the interactions of student nurses in UK clinical

settings," *British Journal of Nursing*, vol. 29, no. 5, pp. 303–307, 2020.
[107] A. K. Heggestad, P. Nortvedt, B. Christiansen, and A. S. Konow-Lund, "Undergraduate nursing students' ability to empathize: a qualitative study," *Nursing Ethics*, vol. 25, no. 6, pp. 786–795, 2016.
[108] R. Ashmore and D. Banks, "Mental health nursing students' rationales for self-disclosure: 1," *British Journal of Nursing*, vol. 12, no. 20, pp. 1220–1227, 2003.
[109] T. Stickley, G. Stacey, K. Pollock, A. Smith, J. Betinis, and S. Fairbank, "The practice assessment of student nurses by people who use mental health services," *Nurse Education Today*, vol. 30, no. 1, pp. 20–25, 2010.
[110] Nursing and Midwifery Council, "The code for nurses and midwives: nursing and midwifery Council," 2018, https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf.
[111] A. Scanlon, "Psychiatric nurses perceptions of the constituents of the therapeutic relationship: a grounded theory study," *Journal of Psychiatric and Mental Health Nursing*, vol. 13, no. 3, pp. 319–329, 2006.
[112] F. K. Sun, A. Long, Y. S. Tseng, H. M. Huang, J. H. You, and C. Y. Chiang, "Undergraduate student nurses' lived experiences of anxiety during their first clinical practicum: a phenomenological study," *Nurse Education Today*, vol. 37, pp. 21–26, 2016.
[113] P. A. Inglis, "Therapeutic characteristics of nursing staff in a medium secure setting," *Journal of Learning Disabilities and Offending Behaviour*, vol. 1, no. 2, pp. 30–46, 2010.
[114] I. E. P. Menzies, "A case-study in the functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital," *Human Relations*, vol. 13, no. 2, pp. 95–121, 1960.
[115] S. Jackson and C. Stevenson, "What do people need psychiatric and mental health nurses for?" *Journal of Advanced Nursing*, vol. 31, no. 2, pp. 378–388, 2008.
[116] Consensus Statement, "Shining lights in dark corners of people's lives: the consensus statement for people with complex mental health difficulties who are diagnosed with a personality disorder," 2018, https://www.mind.org.uk/media-a/4408/consensus-statement-final.pdf.
[117] S. Riahi, G. Thomson, and J. Duxbury, "A hermeneutic phenomenological exploration of 'last resort'in the use of restraint," *International Journal of Mental Health Nursing*, vol. 29, no. 6, pp. 1218–1229, 2020.
[118] J. Cheetham, S. Holttum, N. Springham, and K. Butt, "'I can see it and I can feel it, but I can't put my finger on it': a Foucauldian discourse analysis of experiences of relating on psychiatric inpatient units," *Psychology and Psychotherapy: Theory, Research and Practice*, vol. 91, no. 3, pp. 317–331, 2018.
[119] H. Gilburt, D. Rose, and M. Slade, "The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK," *BMC Health Services Research*, vol. 8, no. 1, pp. 92–12, 2008.
[120] L. Darzi, *The Lord Darzi Review of Health and Care*, Institute for Public Policy Research, London, UK, 2018.
[121] R. Francis, "Report of the mid staffordshire NHS foundation trust public inquiry," 2013, https://webarchive.nationalarchives.gov.uk/20150407084231/.
[122] M. A. Kingston and S. Greenwood, "Therapeutic relationships: making space to practice in chaotic institutional environments," *Journal of Psychiatric and Mental Health Nursing*, vol. 27, no. 6, pp. 689–698, 2020.
[123] N. Benefield and R. Haigh, "Personality disorder: breakdown in the relational field," in *Working Effectively with Personality Disorder: Contemporary and Critical Approaches to Clinical and Organizational Practice*, J. Ramsden, S. Prince, and J. Blazdell, Eds., Pavilion, West Sussex, UK, 2020.
[124] C. Oeye, A. K. Bjelland, A. Skorpen, and N. Anderssen, "User participation when using milieu therapy in a psychiatric hospital in Norway: a mission impossible?" *Nursing Inquiry*, vol. 16, no. 4, pp. 287–296, 2009.
[125] H. L. Brooks, K. Lovell, P. Bee, C. Sanders, and A. Rogers, "Is it time to abandon care planning in mental health services? A qualitative study exploring the views of professionals, service users and carers," *Health Expectations*, vol. 21, no. 3, pp. 597–605, 2018.
[126] M. Coffey, R. Cohen, A. Faulkner, B. Hannigan, A. Simpson, and S. Barlow, "Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning," *Health Expectations*, vol. 20, no. 3, pp. 471–483, 2017.
[127] M. Miles, Y. Chapman, K. Francis, and B. Taylor, "Exploring Heideggerian hermeneutic phenomenology: a perfect fit for midwifery research," *Women and Birth*, vol. 26, no. 4, pp. 273–276, 2013.
[128] A. McCloughen, D. Gillies, and L. O'Brien, "Collaboration between mental health consumers and nurses: shared understandings, dissimilar experiences," *International Journal of Mental Health Nursing*, vol. 20, no. 1, pp. 47–55, 2011.
[129] S. Browning and R. Waite, "The gift of listening: JUST listening strategies," *Nursing Forum*, vol. 45, no. 3, pp. 150–158, 2010.
[130] N. A. Cutler, J. Sim, E. Halcomb, L. Moxham, and M. Stephens, "Nurses' influence on consumers' experience of safety in acute mental health units: a qualitative study," *Journal of Clinical Nursing*, vol. 29, no. 21-22, pp. 4379–4386, 2020.
[131] A. R. Moreno-Poyato, P. Montesó-Curto, P. Delgado-Hito et al., "The therapeutic relationship in inpatient psychiatric care: a narrative review of the perspective of nurses and patients," *Archives of Psychiatric Nursing*, vol. 30, no. 6, pp. 782–787, 2016.
[132] R. C. Stenhouse, "'They all said you could come and speak to us': patients' expectations and experiences of help on an acute psychiatric inpatient ward," *Journal of Psychiatric and Mental Health Nursing*, vol. 18, no. 1, pp. 74–80, 2011.
[133] J. Terry and M. Coffey, "Too busy to talk: examining service user involvement in nursing work," *Issues in Mental Health Nursing*, vol. 40, no. 11, pp. 957–965, 2019.
[134] P. Benner, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, Prentice-Hall, Hoboken, NJ, USA, 1984.
[135] E. Missouridou, P. Mangoulia, V. Pavlou et al., "Wounded healers during the COVID-19 syndemic: compassion fatigue and compassion satisfaction among nursing care providers in Greece," *Perspectives in Psychiatric Care*, vol. 58, no. 4, pp. 1421–1432, 2022.
[136] S. D. Brown and P. Reavey, "Vital spaces and mental health," *Medical Humanities*, vol. 45, no. 2, pp. 131–140, 2019.
[137] F. A. Gildberg, K. J. Paaske, V. L. Rasmussen, R. D. Nissen, S. K. Bradley, and L. Hounsgaard, "Humor: power conveying social structures inside forensic mental health nursing," *Journal of Forensic Nursing*, vol. 12, no. 3, pp. 120–128, 2016.

[138] L. Kay, S. Downe, G. Thomson, and K. Finlayson, "Engaging with birth stories in pregnancy: a hermeneutic phenomenological study of women's experiences across two generations," *BMC Pregnancy and Childbirth*, vol. 17, no. 1, pp. 283–312, 2017.
[139] S. Mulhall, *Routledge Philosophy Guidebook to Heidegger and Being and Time*, Routledge, London, UK, 2005.
[140] T. Carman, "Being in the world," 2010, https://youtu.be/dIFsZ9uTrpE.
[141] M. Wrathall, "Being in the world," 2010, https://youtu.be/dIFsZ9uTrpE.
[142] S. Kelly, "Being in the world," 2010, https://youtu.be/dIFsZ9uTrpE.
[143] K. M. Wright and D. Schroeder, "Turning the tables: the vulnerability of nurses treating anorexia nervosa patients," *Cambridge Quarterly of Healthcare Ethics*, vol. 25, no. 2, pp. 219–227, 2016.
[144] J. D. Jacob, "The rhetoric of therapy in forensic psychiatric nursing," *Journal of Forensic Nursing*, vol. 8, no. 4, pp. 178–187, 2012.
[145] E. Missouridou, A. Zartaloudi, C. Dafogianni et al., "Locked versus open ward environments and restrictive measures in acute psychiatry in Greece: nursing students' attitudes and experiences," *Perspectives in Psychiatric Care*, vol. 57, no. 3, pp. 1365–1375, 2021.
[146] K. M. Wright, K. Haigh, and M. McKeown, "Reclaiming the humanity in personality disorder," *International Journal of Mental Health Nursing*, vol. 16, no. 4, pp. 236–246, 2007.
[147] S. Crowther, "Sacred joy at birth: a hermeneutic phenomenology study," Thesis, Auckland University of Technology, Auckland, New Zealand, 2014.