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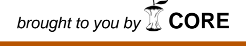

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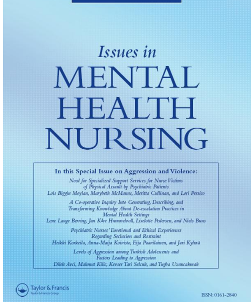

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Being recognised as a whole person: A qualitative study of inpatient experience in mental health

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ABSTRACT

Few studies address the many challenges that are faced by staff and patients in the inpatient mental health context. In particular, there is a lack of research that explores first-hand patient experiences in order to establish what treatment practices best assist patient recovery and what are the barriers to these practices. This qualitative study, which utilises a user-involved research framework, collaborates with a co-researcher patient group throughout the study. Fourteen patients, all of whom had been in inpatient treatment for at least three weeks, were recruited to the study. Study participants were interviewed in-depth in the period September 2016 to March 2017. Data underwent a thematic analysis that was inspired by interpretative phenomenological analysis. A core theme of the findings was the importance of being recognised as a whole person, and the patient–professional relationship was regarded as a fundamental factor in fostering recovery, with two underlying themes: (i) a need to have one's self-identity recognised and supported, and (ii) an experience of ambivalence between needing closeness and distance. This study suggests ways nurses can give priority to interpersonal interactions and relationships with hospitalised patients over task-oriented duties, highlighting the need for nurses to balance patient competing needs for both closeness and distance.

Introduction

People with mental health disorders (mental health patients) may be offered hospitalisation as a treatment strategy when they are in severe distress. Inpatient treatment may include medication, individual therapy, group therapy and milieu therapy as integral parts of the intervention strategy. There is only a limited empirical understanding of the mechanisms and processes by which inpatient treatment aids recovery of hospitalised mental health patients in distress (Smith & Spitzmueller, 2016; Thomas, Shattell, & Martin, 2002). Existing studies of established principles of inpatient care, such as genuine respect, collaboration, and promoting patient autonomy, tend to be implemented to only a limited extent (Oeye, Bjelland, Skorpen, & Anderssen, 2009; Oute, 2018; Stomski, Morrison, Whitely, & Brennan, 2017; Waldemar, Arnfred, Petersen, & Korsbek, 2016).

Background

Between different countries, major variations in health care offered to patients with mental disorders prevail. The present study was carried out in Norway. In Norway, inpatient treatment is one of several treatment strategies offered to patients with mental health disorders, in particular those with high levels of distress. Psychotherapy, which is used in either the individual or group context, often forms part of the inpatient treatment programme of mental health patients. The effectiveness and working mechanisms of psychotherapy have been thoroughly researched for a variety of important disorders (APA, 2013; Lambert, 2013; Wampold & Imel, 2015). There has also been extensive research into the use of medication, another important treatment intervention in the mental health context, albeit with inconsistent results (Cipriani et al., 2018; Leucht et al., 2017).

In the mental health context, therapeutic relationships have been researched in numerous studies since Peplau's (1952) statement that this interpersonal relationship is at the heart of nursing. For example, Shattell, Starr, and Thomas (2007) reported that people with mental health problems want nurses to really know them and to incorporate time, understanding, and skill in their care. Wiechula

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The fifth and sixth authors were service user co-researchers conducting interviews and advising on the analysis and presentation of results. The fourth author was not part of the core research team. His contribution was scientific advice in designing and conducting the study and manuscript preparation. The second, third and last authors were involved in analysis and manuscript preparation. The first author contributed in all phases of the study.

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et al. (2016) reported an umbrella review of the nurse–patient relationship, and detail six key areas that seem important for good patient–nurse relationships— values, expectations, knowledge and skills, communication, context and the impact of the relationship. In a review and synthesis of qualitative studies on mental health nurses' interaction with patients, Cleary, Hunt, Horsfall, and Deacon (2012) emphasised that nurse communication involves interpersonal approaches and modalities that amplify highly developed communication and personal skills. However, this interpersonal relationship does not exist in a vacuum. A study of barriers to the nurse–patient relationship reported that it was influenced by individual and organisational conditions, and that therapeutic relationship was not necessarily prioritised by these contexts (Pazargadi, Fereidooni Moghadam, Fallahi Khoshknab, Alijani Renani, & Molazem, 2015).

Nurse-patient interaction is frequently the main form of therapeutic contact with professionals that is experienced by mental health patients and it is, thus, often regarded informally as the most important feature of inpatient treatment. However, the effectiveness and mechanism of nurse-patient interaction in the treatment of mental health patients is poorly understood. This lack of understanding might be due by the inherent complexities of nurse-patient interactions, as well as the relative lack of control, such that nurse-patient interaction is often overlooked in narrowly focussed research of conventional design. However, a full understanding of the importance of inpatient treatment in the mental health context is critical and, thus, inpatient treatment should receive the same level of scrutiny as the use of psychotherapy and medication.

A number of studies report the social reality of inpatient treatment in mental health. Thomas et al. (2002) reported that hospitalised mental health patients had a continued desire for a deeper connection with healthcare professionals and they called for the implementation of more insight-oriented treatment strategies. Patients felt they were not gaining an understanding of their patterns of behaviour during hospitalisation. An observational study by Oeye et al. (2009) found that hospitalised mental health patients often were understood as harmed children and that they was deprived of formal authority and autonomy (Oeye et al., 2009). A narrative literature review of the perspectives of both nurses and hospitalised mental health patients found that nurses were not readily available or accessible to patients (Moreno-Poyato et al., 2016). Moreover, a literature review of recovery-oriented practice in mental health found that inpatient settings were characterised by a lack of collaboration, communication and engagement between hospitalised patients and staff, diverting from the values and principles of recovery (Waldemar et al., 2016).

To understand if and how inpatient treatment can help improve the health of a specific group of patients, one needs to properly understand what 'improved health' means for that patient group. The medical model, for which psychiatric disorders are understood as illnesses in the same sense as somatic disorders, defines outcomes as being related to symptom alleviation (Wampold & Imel, 2015). Following this, it is helpful to understand what is needed to support symptom reduction. The humanistic tradition, however, understands 'positive outcomes' more as processes related to the values and day-to-day functions of the patient, often using the term *recovery*. Recovery has been described as 'a deeply personal, unique process of changing one's attitudes, values, feeling, goals, skills and/or roles. A way of living a satisfying, hopeful and contributing life even with the limitations caused by illness' (Anthony, 1993, p. 15).

Leamy, Bird, Le Boutillier, Williams, and Slade (2011) state that more studies are needed into how mental healthcare providers can best support patient recovery. Factors that aid patient recovery have been explored from the perspective of nursing professionals in a number of studies (Alsaker & Ulfseth, 2017; Cleary et al., 2012; Spiers & Wood, 2010). Research that is undertaken from a professional perspective has an implicit understanding of whether good outcomes might or might not align with the perspective of the hospitalised patient. Thus, to develop a comprehensive understanding of helpful processes, it is also necessary to explore the patient perspective (Leamy et al., 2011; Wood & Alsawy, 2016); indeed, there has been a recent increased interest in studying the patient perspective (Molin, Graneheim, & Lindgren, 2016; Wood & Alsawy, 2016). Wood and Alsawy (2016) found that collaborative and inclusive care, positive relationships, and a safe and therapeutic hospital environment are key to providing high inpatient care. Borge and Fagermoen (2008) interviewed patients during their hospitalisation and found that, in order to improve their feeling of self-worth, mental health patients seek a combination of professionalism and kind-heartedness from healthcare professionals. This field of research is in its infancy, and more detailed empirical knowledge of how 'good intentions' can be translated into helpful practices and careful professional reflection is needed urgently in order to further develop nursing practices within patient-centred mental health care.

Methods

Aim

This study aims to provide a deeper understanding of the lived experience of recovery in the context of inpatient treatment in mental health by exploring the following research question: What do hospitalised patients perceive as aiding their recovery during inpatient treatment in the mental health context?

Design

We used a qualitative and serial research design to explore the research question, using in-depth interviews to collect data in this hermeneutic-phenomenological study (Binder, Holgersen, & Moltu, 2012). We developed a set of objectives and procedures within a framework of user-involved research, with service users cooperating throughout the

Table 1. Participant characteristics.

Participant	Gender	Age	Living arrangements	Employment	Hospitalised
1	Female	20s	With family	Employed	5 or less times
2	Male	30s	Alone	Disability pension	5 or more times
3	Female	40s	With family	Employed	5 or less times
4	Male	40s	Alone	Disability pension	5 or more times
5	Male	70s	With family	Retired	5 or less times
6	Male	50s	Alone	Disability pension	5 or more times
7	Male	40s	With family	Employed	5 or less times
8	Female	20s	Alone	Disability pension	5 or more times
9	Female	40s	Alone	Unemployed	5 or less times
10	Male	30s	Alone	Unemployed	5 or less times
11	Female	60s	Alone	Employed	5 or less times
12	Female	50s	With family	Employed	5 or more times
13	Female	50s	Alone	Disability pension	5 or more times
14	Male	50s	Alone	Employed	5 or more times

research process, taking the role of co-researchers (Moltu, Stefansen, Svisdahl, & Veseth, 2012; Veseth, Binder, Borg, & Davidson, 2017). This fostered a collaborative process whereby service user insights and perspectives informed all phases of the study. According to Davidson et al. (2010), it is necessary to collaborate with service users when exploring recovery to ensure that research questions are informed both by lived experiences and the researcher perspective. The present study is a part of a larger qualitative serial study in which participants were interviewed twice: the first interview was conducted during hospitalisation and the second interview was conducted three months after discharge. In the present study, we report the findings from the first interview only.

Sample

For our study sample, we recruited 14 patients who were hospitalised at one of three mental health units; this is a large enough study group to expect consistent results (Hill, 2012; Malterud, Siersma, & Guassora, 2016). The inclusion criterion was that patients had received inpatient psychiatric treatment for at least 3 weeks, and the exclusion criterion was that patients were diagnosed with active psychosis. Three participants were receiving inpatient treatment for the first time, while the remaining participants had also received inpatient treatment on previous occasions. Table 1 details the participant characteristics.

We recruited six service users, all of whom had first-hand experience of being a patient in inpatient treatment, to form a co-researcher group. The co-researcher group met for four times a year for two-day seminars throughout the whole project, who lasted for 4 years, to collaborate on all phases of the study. The co-researcher group collaborated with three experienced researchers: two specialists in clinical psychology and one physical therapist. Additionally, a PhD student and experienced nurse had the role of project leader. The fourth author (LD) provided scientific advice in designing and conducting the study, including participation in dissemination of results.

Data collection

The researchers and co-researchers collaborated to develop an interview format of open questions. The interviewers (the project leader and two co-researchers) received training in proper interview techniques, and pilot interviews were performed prior to data collection (Kvale & Brinkmann, 2009; Malterud, 2017). The interviews were conducted from September 2016 to March 2017 and each interview lasted between 50 and 180 min. All interviews began with an open-ended question: What is it like for you to be in here? The aim of the interview was to facilitate an interaction that permitted the participant to explore his/her own experience, in his/her own words. All interviews were audio recorded and transcribed verbatim.

Ethical considerations

All participants received written and verbal information regarding the study, including a clear statement that participation was voluntary and that they could withdraw from the study at any time without negative consequences. People with mental health problems are respected as potentially vulnerable and marginalised. Therefore, we aimed to conduct the study with care for their safe participation: The interview locations were flexible to participants' choices, either at the hospital unit, or in a meeting room outside the hospital area. Furthermore, participants could choose if they wanted to be interviewed alone by the project leader, or with one of the co-researchers present. Ten chose to be interviewed with a co-researcher present. The interviewers had no formal connection to the units from which the participants were recruited. All identifying information was anonymised during transcription to protect confidentiality. The Regional Committee for Medical and Health Research Ethics approved the study (REK VEST: 2016/30).

Data analysis

We performed a theme-based analysis according to the principles of interpretative phenomenological analysis (IPA; Smith, 2004; Smith, Flowers, & Larkin, 2009). IPA involves six analytical steps: (i) reading and re-reading, (ii) initial note taking, (iii) developing emergent themes, (iv) searching for connections across emergent themes, (v) moving to the next case, and (vi) looking for patterns across cases (Smith et al., 2009). The project leader conducted stage (i) of the analysis and organised a team-based interpretive process that aimed to develop consensual themes. Members of the co-researcher group attended two-day seminars to reflect on and share their analyses and opinions on the data material; there were two such seminars, one at the beginning of the analysis, and one at the end. These seminars led to a deeper understanding of the themes, by focussing attention on co-researcher experiences and viewpoints. The seminars also provided a forum for questions and group discussion of emergent themes. Seminar discussions were audio recorded and reviewed for later data analysis. Table 2 presents an example of the data analysis.

Table 2. Sample of data analysis from four of the participants talking about what they need from the staff.

Transcript	Descriptive, conceptual and linguistic comments	Emergent themes	Themes across cases	Final Themes
I1: ehh. Yes … that kind of thing. There are some kinds of people like that … and its very … nice if it is someone at your own age. That you can make contact with, and talk a little bit with … So … some people here are my age that I can talk a bit with, and that is very positive. That someone is at the same level as me.	Needs someone of her own age to feel connected to; someone at the 'same level'.	Same age; make contact; same level	Support the normal	Needing to have one's identity recognised and supported
I3: Yes, that they are honest … and that they do no … That they can talk about themselves … and not finished stories. Because I do not always want to talk about me. Then. It was one that I asked what he was doing. I asked what he was training for … and he talked a lot about himself. I think that was good.	Does not always want to talk about herself. She liked that he was talking about himself; that was good. A normal conversation?	Normal conversation	Identification	
I7: I think it's important that they are at work. Everyone may have a bad day or so, but that they have surplus. In addition, and … They would be a more heterogenic group. Here it is … there are many ladies working here and that's nice, but could have been more heterogeneous … maybe it would have done something with the environment in general.	Wants them to be present. Why is this a bad day? Too homogenous? Many ladies, are they different to him? Can they not understand him?	Identification		
I10: ehh … It is the oldest who are the worst, the ones who have been working the longest and have got into a routine. Like the younger ones, they are quite nice and want to join and do things with us. Especially the students, they are more engaged than those who have worked here a long time.	He does not like the "old ladies". The young are nice, especially the students. Why are experienced staff not more engaged?	Distance in terms of age and interests		

Data validity and reliability

Researchers must be aware of their own preconceptions and engagement in their field of study, especially when performing qualitative research, since they will be brought close to the conversations that form the study data. It is a challenge to be simultaneously close to the practice field and be conscious of one's own position and background (Alvesson & Sköldberg, 2000; Finlay, 2003). Without systematic reflexivity, this close researcher participation risks introducing bias to the analysis; however, with systematic reflexivity, close researcher participation can bring deeper understanding. This study employed systematic reflexivity by incorporating co-researchers into the analysis, thereby helping to strengthen the analysis processes (Veseth et al., 2017). In addition to the project leader (nurse), one of the qualitative researchers (EN) and the co-researcher coordinator (ÅS) also read the entire transcribed material in detail. Finally, the project leader developed a reflexive practice by writing a reflexive diary and by discussing the project frequently with the co-researcher group.

Results

A core theme in our results was the importance of being perceived as a 'whole person'. The patient–professional relationship was the most important aspect of the inpatient experience, with patients finding it easier to be both physical and emotionally close to themselves and others when they felt that professionals recognised them as whole people. A good patient–professional relationship seemed to be a prerequisite for a patient to continue to a good recovery in the inpatient setting. Two broad themes emerged: (i) a need to have one's self-identity recognised and supported, and (ii) an experience of ambivalence between needing closeness and distance. These broad themes demonstrate the complexity of being a person in inpatient mental health treatment.

Needing to have one's self-identity recognised and supported

Previous experiences influenced how participants regarded themselves in relation to their inpatient surroundings. Several participants described themselves as worthless and they did not want to bother others. One female participant, who had been admitted on several previous occasions, said:

> *It is about not being allowed to, I am not allowed to … I have to agree with anyone who is stronger than me. So that I am not in the way, so that I don't irritate anyone, so that I don't make even more trouble in the system… You became, sort of, a thing that was just there …* (Participant 13)

Being regarded as 'who you are' was described by all participants as being particularly important. Several participants mentioned episodes when staff did something out of the ordinary for them; such episodes were remembered and described as representing particularly good care and treatment. Participants considered professionals who talked about their own daily lives, without becoming too personal,

as helping them to feel like a whole person. One female participant expressed this in the following words:

> *Well, they were just so nice to talk to. They were so friendly, and the atmosphere was good too. On all shifts someone came and chatted with me during the shift and all, and I remember one lady down there. She came into my room and woke me up in the morning, with coffee and one of those almond cookies, and she said that when she grew up her grandmother had always brought her a little something to eat in bed. Yes, and she brought me a little something too.* (Participant 11)

This participant experienced being regarded as an equal, being recognised as a whole person; this made her feel good and gave her a memorable experience. For many people this would have been a small gesture, but it meant a lot to this participant who was receiving inpatient treatment, away from her everyday life. Another female participant described her need to be seen not as a 'piece of paper with letters on' but as a real person with a name:

> *I do feel that I am a human being, I have a name, I am allowed to say, I am allowed to say … I can speak and be heard without being brushed off with "Can't you just be quiet?" [laughs a little]. But that you are invited to speak "You know what, if this gets difficult now you must come out here, and we'll have a chat".* (Participant 13)

This quote is an example of a common and meaningful inpatient experience, of being regarded as a person rather than as a diagnosis or treated as a child. These experiences were viewed by all participants as having fundamental importance to their treatment, helping then to challenge their negative beliefs and experiences of self at a time when they were feeling particularly vulnerable. Many participants described such experiences, as illustrated by this statement from Participant 1:

> *No, well, I do want to say … I am pretty normal, you know… [laughs a little] It's like… I don't have any handicap or … I am a normal person and your equal so to speak … There is no difference between you and me, really … No … So… [laughs a little].* (Participant 1)

Other participants had experienced being excluded or turned away, such as the description by this female participant:

> *… For I have experienced being sort of kicked out, or being dismissed fairly quickly after having been really ill, both because the diagnosis was wrong, and that it was in a way, … that you were met with a sort of disgust and rejection and … let… in a way been taunted …* (Participant 8)

These two quotes exemplify how participants perceived that healthcare staff treated them in a manner that made them feel regarded with contempt. They did not feel recognised as a person in their own right and they experienced the professional healthcare staff as being disrespectful and patronising towards them.

The participants did not only desire recognition of their full personhood, they highlighted the importance of staff engagement, wanting to sense that staff wanted to be at work. In summary, it was important that staff should communicate their own desire to help the participants directly to the participants. Furthermore, the participants also wanted to be treated by professionals who were willing to express their humanity and to be honest. As one female participant said:

> *So, I want someone to 'play ping pong ball' with, I don't want someone who just chatters along. I ask because I also want some opposing views. Eh… for then I may make a better, independent decision on this or that.* (Participant 12)

Experiencing ambivalence between needing closeness and needing distance

For inpatient treatment to best support recovery, all participants expressed a need to be emotional and physical close to someone in the treatment context while, at the same time, emphasising the value of being able to maintain a both emotional and physical distance from others (professionals and patients). What was most important to participants seemed to vary from day to day and from situation to situation. All participants talked about certain professionals who they felt were more able to help them in their recovery; individuals in whom they developed greater trust and in whom they felt more at ease. It was difficult to clarify what characterised such people, except that they always conveyed a feeling of significance to the participants. Participants frequently described having experienced professionals who did not appear to enjoy their work, or who were being overly 'professionally distant', so that these professionals did not seem to really care about the people they were treating. One female participant described both types of professionals:

> *… There are certain persons that you become closer to than others. And there was one in particular who was really nice to talk to… Not that she was nicer than all the others, or that some of the others weren't nice to talk to. But she was just special. I don't know what it was about her, but … she was so nice to talk to … but at times you feel as if you're somewhat talking to the wall. They have just heard it all so many times before, it is sort of. You can tell that … They are at work. So, the empathy is, in a way, learned. They are very capable, but she seemed real. In a way…* (Participant 3)

Several participants talked about healthcare professionals who had an important unspoken quality about them. They found it difficult to explain what this unspoken quality was, but all participants stated that these professionals conveyed a genuine interest in the patients, and that they had the ability to make their patients feel important. In particular, it was possible for professionals to convey a valuable message of worth to the patients through expressions with their eyes.

Many participants had experienced demanding relationships with the staff at the inpatient unit. Some described reacting by distancing themselves or protecting themselves by withdrawing to their room and being less present on the ward. One participant stated:

> *You know that today you have been given this or that contact, don't have much of a relation. My solution: I'll just be gone a lot. I don't want to talk with him because I don't trust him. I can't handle, I can't handle involving just anyone in everything. Eh … but if there is someone with whom you have a good relation, then you can also show much more of your vulnerability. I think*

> *so. It feels very safe the days that I'm able to show my own vulnerability.* (Participant 12)

This quote exemplifies the importance of good patient-professional relationships to the feeling of safety during hospitalisation. Meeting professionals that they could identify with, or who they felt had a strong basis for understanding them, was considered important for achieving emotional closeness to staff.

Other participants expressed how staff experience and knowledge were important to building trusting patient–professional relationships. It was important to feel understood and recognised by professionals, and participants experienced this most frequently when engaging with staff who had worked at the inpatient unit for a long time. This was described by a female participant:

> *Yes, and understanding and maybe, get things and see things, without you having to tell them. For of course you notice a difference in those who have worked here for a long time, and those who have not, right. […]. Lots of them are quite good of course, but they don't know enough. Plain and simple. They don't have enough life experience to understand, I think.* (Participant 9)

Knowledgeable professionals were important to many participants, and this led to increased trust in staff who had a formal education; this enabled closer patient–professional relationships. On the other hand, some participants experienced knowledgeable professionals as maintaining an unnecessary distance and, therefore, posing potential obstacles to developing close patient–professional relationships. This female participant described such experiences:

> *I also feel a bit smaller when I'm with some people, with education, as they can, they have placed me into a system … but … In a way the temporary personnel are in a way a bit like that … a bit like the woman at the training ward, that they are a bit on the outside … that they in a way are someone else. I feel much calmer, more like myself, more like a human being, with them at times.* (Participant 8)

Here we see an example of the participant feeling calmer, more like a whole person, when she is with professionals who have minimal training. She considers that she can teach the less skilled staff something, and this gives her a feeling of equality and of being a whole person.

The participants described how they needed to feel safe in order to develop close emotional relationships with others. Furthermore, several participants expressed how they felt that they were not taken seriously when they were introduced constantly to new staff; constant staff changes were a barrier to the trust that is needed to expose their vulnerability. Some participants expressed that they felt that some professionals did not take the same responsibility for them as a patients because of these constant changes.

Closeness was also about being close in a physical sense, with some participants describing ambivalence in. Sometimes they needed physical closeness, and other times they needed distance. A female participant described it like this:

> *You can't just stay in your room if you don't want to be with people. You just can't do that. But it is difficult not to be polite and chat and such. I don't really want to chat …* (Participant 3)

Thus, closeness was also about a need for physical contact. For example, the feeling of vulnerability when someone observes that you feel bad without reaching out a hand. This female participant's quote illustrates the point:

> *Children are not the only ones who need human contact, we're all human beings, and mentally ill people are often isolated and need a lot of body contact. They do not get it anywhere else … you may think … what's wrong with me since they not even want to touch me? …* (Participant 8)

In the context of the need for physical contact, participants felt that staff should first enquire if patients would like to be embraced rather than hug them uninvited since that would risk increasing their feeling of vulnerability. Overall, physical contact was very important to participants and a lack of physical contact, or a lack of offer of physical contact, made them feel that they were not worthy of being comforted.

Discussion

In this study, we explored the experiences of hospitalised mental health patients, focussing on their inpatient recovery. Our major finding is the importance of being welcomed as a whole person during hospitalisation, with two main themes: (i) a need to have one's identity recognised and supported, and (ii) contradictory needs for closeness and distance. We describe our major finding with a rather simple description, one that most professionals would say they already hold as a professional value, and we describe the two constituent themes as means of achieving a feeling of welcome in practice. As illustrated by Waldemar et al. (2016) review, the mental health field does not seem to be properly embracing the needs identified by these themes.

According to Davidson and Johnson (2013), recovery from mental illness occurs through an ongoing exchange between patients and their social context. Furthermore, recovery-oriented care requires that healthcare providers support the patient's own efforts towards their recovery (Davidson et al., 2016), recognising that patient autonomy is core to recovery. Patients with serious mental illnesses may strive to experience a sense of self-agency and they feel that regaining self-agency offers them an important step in recovery. Time and patience are needed to regain self-agency, and hospitalised mental health patients may need significant help from nurses in this regard. We find that constructive patient-professional relationships are fundamental for a feeling of safety and an acceptance of nursing support. Under our theme of ambivalence, participants highlighted the time it took to build a good relationship with their nurse and that they needed a nurse whom they met regularly and who was not replaced, a nurse who had time to spend with them and who recognised them as a whole person. Topor and Denhov (2012) found that time is an important factor in the development of such patient-professional relationships, and that when autonomy was granted to both professionals and patients, the patients had a strong sense of being a whole person rather than merely a hospitalised patient. Moreno-Poyato et al. (2016) performed a

comprehensive literature review, revealing that nurses reported administrative burdens and short-term work placements as being important barriers to building safe patient-professional relationships. They also reported research that establishes that nurses feel that the expectations of hospitalised patients are unrealistic in the context of their working conditions, with downstream impact on their own job satisfaction. Our findings address the importance of properly organising healthcare services to enable nurses to provide the professional support that is needed by their patients.

This study highlights the complexity of inpatient treatment in the mental health context. Sometimes hospitalised patients need to be emotional and/or physical close to someone while at other times they need to be distant, and it is difficult for the nurse or even the patient to identify the current needs. This complexity and ambivalence can cause staff to feel insecure in how they approach their patients. Our findings illustrate that poor patient–professional relationships cause withdrawal and impair recovery in hospitalised mental health patients. Our findings are supported by several previous studies that highlight the importance of patient–nurse relationships, emphasising the need for nurses to foster an authentic interpersonal engagement with their hospitalised patients (Delaney, Shattell, & Johnson, 2017; Molin et al., 2016; Wyder, Bland, Blythe, Matarasso, & Crompton, 2015).

We find that interpersonal relationships between nurses and hospitalised patients are fundamental to inpatient recovery, with hospitalised patients being apprehensive due to their often traumatic histories and experiences. A recently published discourse analysis from a core psychiatric nursing text offers a dominant discourse whereby hospitalised patients are portrayed much like children, with the nurse being the maternal adult archetype (Oute, 2018). We also reveal how hospitalised mental health patients express a need to be fully recognised as adults, supporting Oeye et al's. (2009) findings suggesting that patients were treated as children during admission. Davidson et al. (2016) highlight how staff's respect of patients' adult autonomy helps maximise the degree to which they can exercise this autonomy while being hospitalised. This is echoed in our results, as participants underscore the need to make autonomous choices of how they spend their time, who they spend time with and what activities they choose to be involved in when hospitalised.

A qualitative meta-synthesis by Stomski et al. (2017) found that healthcare providers rarely recognise that patients should have full control over decisions, and that patient participation is frequently characterised by tokenism. Myers (2016) recently identified a systemic lack of respect for the autonomy of hospitalised patients and a lack of true engagement in their care and treatment as a barrier to recovery. Fostering more inclusive approaches will require additional nurse training. Furthermore, appropriate training curricula updates are required to foster user participation, with the aim of changing the traditional attitude that 'professionals know best' for hospitalised patients; this will require that nurses are willing to share 'power' with their patients. Open dialogue has been fostered as a means of treating hospitalised patients as equals (Seikkula, 2011), focussing on strengthening personal resources and normalising individual situations rather than focussing on regressive behaviour. Rosen and Stoklosa (2016) found that open dialogue can be used as an effective form of inpatient treatment in patient-centred care.

We show that hospitalised patients want nurses who focus on interpersonal relationships, who possess therapeutic interventional skills, and who have professional attributes. A literature review by Sharac et al. (2010) found that nurses spend only a limited amount of time in direct contact with patients. Furthermore, a medical model for mental health services emphasised a culture in which nurses spend most of their time performing routine task-oriented duties such as administering medication, keeping the unit safe, providing custodial care, completing large amounts of paperwork and other administrative duties (Sharac et al., 2010). Myers (2016) confirms the vital role of nurses who provide inpatient care, and that these nurses are well-placed to deliver a wide array of recovery-oriented services. Myers highlights that transforming the mental health system from a medical model to a recovery model would create an opportunity for nurses to return to their professional roots and deliver person-centred holistic care, with a focus on therapeutic relationships.

In conclusion, patient descriptions of inpatient treatment provide a rich, unique learning basis for nurses, enabling them to further understand and reflect on their interactions with vulnerable patients. Nurses should be trained to foster patient participation in clinical contexts, to strengthen the personal resources of hospitalised patients, and to normalise the situation. Participatory research methods that bridge the gap between theory and practice should be developed further, and programmes and policies based on user-involved research should be implemented.

Limitations

This study was conducted by interviewing hospitalised patients from three mental health units who volunteered to participate, suggesting a potential bias in the study population. While the study findings are context-specific due to fact that the study population does not fully represent all hospitalised mental health patients, they are supported by the findings of similar studies in the field. Therefore, there may be a degree of generalisability, particularly to different mental health inpatient units where nurse day-to-day practice is aimed at a therapeutic effect beyond than providing containment and safety. Studies, such as this one, that involve high levels of service-user participation are both costly and time-consuming, making them difficult to replicate in wider contexts.

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