



ORIGINAL ARTICLE

Empathic processes during nurse–consumer conflict situations in psychiatric inpatient units: A qualitative study

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ABSTRACT: *Empathy is a central component of nurse–consumer relationships. In the present study, we investigated how empathy is developed and maintained when there is conflict between nurses and consumers, and the ways in which empathy can be used to achieve positive outcomes. Through semistructured interviews, mental health nurses (n = 13) and consumers in recovery (n = 7) reflected on a specific conflict situation where they had experienced empathy, as well as how empathy contributed more generally to working with nurses/consumers. Thematic analysis was used to analyse the data, utilizing a framework that conceptualizes empathy experiences as involving antecedents, processes, and outcomes. The central theme identified was ‘my role as a nurse – the role of my nurse’. Within this theme, nurses focussed on how their role in managing risk and safety determined empathy experienced towards consumers; consumers saw the importance of nurse empathy both in conflict situations and for their general hospitalization experience. Empathy involved nurses trying to understand the consumer’s perspective and feeling for the consumer, and was perceived by consumers to involve nurses ‘being there’. Empathic relationships built on trust and rapport could withstand a conflict situation, with empathy a core component in consumer satisfaction regarding conflict resolution and care. Empathy allows the maintenance of therapeutic relationships during conflict, and influences the satisfaction of nurses and consumers, even in problematic situations. Nurse education and mentoring should focus on nurse self-reflection and building empathy skills in managing conflict.*

KEY WORDS: *acute care, conflict, empathy, nurse–consumer relationship, perspective taking.*

INTRODUCTION

Relationships between clinicians and consumers significantly influence therapeutic outcomes (Hewitt & Coffey 2005; Lambert & Barley 2001). Indeed, therapeutic relationships contribute to recovery, independent of

treatment and consumer characteristics (Forchuk *et al.* 1998; Martin *et al.* 2000; Zuroff & Blatt 2006). Vital to an effective nurse–consumer relationship is empathy (Bee *et al.* 2008; Orlando 1990; Peplau 1991; Rask & Aberg 2002; Reynolds & Scott 1999; Travelbee 1963), which is described as ‘the essence of all nurse–client communication’ (Kunyk & Olson 2001; p. 317). Empathy leads to consumer trust, non-defensiveness and willingness to disclose, and nurses gain a better understanding of consumers’ experiences (Reynolds & Scott 1999; Reynolds *et al.* 2000). In contrast, relationships characterized by superficial or irregular contact, distance, and inequality, and where ‘nurses were not perceived by the clients as accepting the client’s reality’

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Accepted October 06 2016.

(Forchuk *et al.* 1998; p.41) do not progress to a functional working relationship.

Research has largely ignored factors that influence nurses' ability to develop and maintain, and for consumers to experience, empathy in acute psychiatric settings (Coatsworth-Puspoky *et al.* 2006). One factor that affects empathy relationships is discord. The purpose of the present study was to explore how empathic processes operate when there is conflict between mental health nurses and consumers, and how empathic understanding can be accomplished to facilitate conflict resolution and positive consumer outcomes.

BACKGROUND

While definitional clarity eludes the empathy concept (Davis 1994; Davis *et al.* 2004; Kunyk & Olson 2001), the term is generally used to describe two main areas. The first is referred to as perspective taking or cognitive empathy, and involves taking another person's perspective (Dal Santo *et al.* 2014; Gerace *et al.* 2013). The second involves emotional reactions to another person's experiences, which are considered outcomes of perspective taking (Lamothe *et al.* 2014). It encompasses the terms emotional empathy, empathic concern, compassion, sympathy, and personal distress (Batson 2011).

Psychology studies reveal that strategies used to take another perspective include placing oneself imaginatively in the other person's situation, relating new events to one's own past experiences, and shifting between one's own interpretation of events and that of the other person (Epley *et al.* 2004; Gerace *et al.* 2013). Empathic emotion also motivates empathizers to help others (Batson 2011; Travelbee 1964). However, nurses might encounter difficulties in perspective taking and regulating emotional responses. Consumers' perspectives are difficult to understand, particularly during acute illness (Barker 2004; Dearing & Steadman 2009). Professional and emotional distance is also advocated in helping disciplines (Mercer & Reynolds 2002; Morse *et al.* 1992).

The centrality of conflict to mental health nursing is exemplified in acute care settings, where a large proportion of consumers are involuntarily hospitalized (Foster *et al.* 2007). Nurses might apply restrictive, coercive, and unwanted measures to manage risk, while attempting to maintain therapeutic relationships (Dziopa & Ahern 2009; Lorem *et al.* 2015; Muir-Cochrane *et al.* 2012). The nursing role in acute inpatient settings involves managing a control–freedom tension, including

preventing conflicts, such as violence, but not 'suppressing inevitable human conflict' (Cleary *et al.* 2012; p.74).

Conflicts include aggression, self-harm, absconding, substance use, medication refusal, and breaking unit rules (Bowers *et al.* 2003, 2014). Reviews indicate the prevalence of violence (Spector *et al.* 2014) and self-harm (James *et al.* 2012) in acute inpatient units, and individual studies highlight challenges in reducing absconding (Gerace *et al.* 2015b). Conflict might also result from, or lead to, containment strategies, including seclusion and restraint (Bowers 2014). Other examples include consumers wanting to engage in activities outside specified times, refusing food or drink, and disagreements regarding treatment (Bowers 2006; Bowers *et al.* 2003).

While Bowers *et al.* (2003) consider conflict 'a neutral term that is not intended to allocate responsibility to either group' (p. 403), conflict behaviours within the literature are largely consumer actions, with nurses tasked in managing the risk of these behaviours (Cutcliffe & Stevenson 2008). This reflects a tension between risk management in the context of increased illness severity and involuntary hospitalization (Foster *et al.* 2007; McKenna *et al.* 2014; Sly *et al.* 2009), and fostering recovery-oriented principles and nurse–consumer partnerships (Kelly *et al.* 2002).

Conflict is inversely related to empathy (Mohr *et al.* 2007), and can lead to anger and less motivation to help (Forsyth 2007). In challenging situations, nurses are expected to be health professionals and fellow human beings, and both distant and close (Hem & Heggen 2003). Nurses might feel burdened by consumers' emotional demands and their own emotional responses and personal distress. This can lead them to relate on a more professional and less personal level, or to avoid interaction (Gleichgerrcht & Decety 2013; Jackson & Stevenson 2000; Michaelsen 2011; Stotland *et al.* 1978).

Despite conflict and anger, nurses and other health professionals maintain empathy (Cleary 2003; Halpern 2007; Lorem *et al.* 2015), and studies suggest this is central to positive outcomes. Positive outcomes include consumer well-being, discharge, and recovery (Cleary *et al.* 2012). In examining the potential role of empathy in conflict resolution in medical settings, Halpern (2007) found that 'there is virtually no literature in medicine about *how* physicians can empathize with their patients during conflicts that evoke their own anger or other negative emotions' (p. 696). The same can be said for mental health nursing. Studies that have been conducted often conceptualize empathy in differing or narrow ways (e.g.

as either cognitive or affective) (Reynolds *et al.* 2000), focus on nursing care more generally and address empathy or conflict indirectly (Jackson & Stevenson 2000), use small samples or individual case studies (Hem & Heggen 2003), and consider empathy only from the health professional's perspective (Rask & Aberg 2002). While studies in psychology provide information on the outcomes of empathy, they do not address the enacting and receiving of empathy in the clinical setting. In order to understand how nurses empathize (or not) with their consumers during conflict situations in acute psychiatric settings, a model developed by Davis (1994), which synthesizes previous work, was used as the theoretical framework for the study.

Davis (1994) organized an empathy episode into four constructs 'having to do with the responses of one individual to the experiences of another' (p.12). The model is linear, with proximal constructs demonstrating the strongest relations to one another. The four model components are: (i) antecedents, including dispositional tendencies, type of situation, and empathizer–target similarity; (ii) processes in which an empathizer might engage, the most cognitively complex being perspective taking; (iii) intrapersonal outcomes, which are a result of empathic processes, and include experiencing the same or similar affect to the target (parallel outcomes), experiencing affect that is a response to the target (reactive outcomes; e.g. sympathy, compassion, personal distress), and non-affective outcomes, including accurate inferences of the target's perspective, and attributions for their behaviour; and (iv) interpersonal outcomes, including helping and inhibition of aggression. The model provides a framework to conceptualize empathy, but allows investigation of ways in which components are experienced in specific situations (Davis *et al.* 2004; Gerace *et al.* 2013).

METHODS

Design

This was a qualitative study examining nurse and consumer experiences of empathy during conflict situations. Qualitative approaches are suitable for exploring issues about which we have yet to develop a clear understanding, and where the interest is in people's subjective views and experiences (Creswell 2007); they have been used successfully to investigate experienced or received empathy in difficult situations (e.g. Kerem *et al.* 2001; Håkansson & Montgomery 2003). Purposeful sampling was used to recruit nurses and consumers

throughout Adelaide, South Australia, Australia, to participate in semistructured interviews. Nurses were required to have ≥ 1 year of experience working in an acute psychiatric setting. Participants in the consumer group were required to have experienced an acute psychiatric inpatient admission, but not be in current receipt of inpatient care. Study information sheets were distributed to nurses through health service email distribution lists, and to consumers through the email distribution list, newsletter, and website of a non-government mental health organization providing services to consumers and carers. Interested persons volunteered to participate by contacting the researchers by email or telephone. All interested persons who contacted the researchers and scheduled a time to participate were included in the sample. Study ethical approval was granted by the Southern Adelaide Clinical Human Research Ethics Committee.

Thirteen female nurses and seven consumers (three female) were interviewed. The mean ages of the participant groups were 49 years (nurses, standard deviation (SD) = 10.86) and 44.57 years (consumers, SD = 11.53). Nurses were experienced in working in mental health (median = 13, range = 1.5–41 years) and acute care settings (median = 10, range = 1–25 years). All nurses were registered, with 10 reporting a specific mental health nursing qualification. Consumer participants had a median of two previous acute care psychiatric admissions (range = 2–60).

Data collection

Participants received definitions of conflict (Bowers *et al.* 2003) and empathy (Gerace *et al.* 2013), were asked to think of a time when they experienced empathy towards a consumer (nurses), or felt a nurse demonstrated empathy towards them (consumers) in a conflict situation, and were questioned regarding this experience and empathy in general.

Nurses were presented with the two definitions and asked to recall a conflict experience. Interview questions about the specific situation were asked followed by the general questions regarding empathy in mental health care.

Consumer participants were questioned about their definitions of empathy and then provided with the study definition. This was to ensure researchers and consumers had similar understanding of the area, with consumer definitions potentially including aspects not covered in psychological/nursing definitions. Following this, consumers were asked general questions regarding

empathy during inpatient hospitalization. They were then presented with the conflict definition and asked to select a specific situation for discussion.

The antecedents, processes and outcomes framework by Davis (1994) was used to guide participants through discussion of their empathy experiences. Questions were designed based on previous research (Gerace *et al.* 2013; Van Boven & Loewenstein 2003), and included questions, such as 'Can you describe the situation and what occurred?', 'What did you do to understand the consumer or take their point of view?' (nurse), 'What did the nurse do to show empathy?' (consumer), 'Do you remember what you were thinking and feeling?', and 'What did you think the other person was thinking and feeling?', 'How did you respond?', and 'What happened after your interaction with the other person?'.

General questions addressed empathy's contribution to working with nurses/consumers and building and maintaining relationships, behaviours that demonstrate (or not) empathy, challenges in being empathic, personal and professional influences on empathic responding (nurses), and in what ways empathy helps consumers.

The average length of interviews was 50 min for nurses and 42 min for consumers.

Analysis

Interviews were recorded, transcribed, and analysed using thematic analysis. A deductive or 'top-down' approach, where analysis is more theory driven than inductive or 'bottom-up' methods (Braun & Clarke 2006; p.83), was chosen; the Davis (1994) model was used as the underlying theoretical framework.

The method described by Braun and Clarke (2006) guided analysis. The first author read all transcripts, with co-authors reading a subset of transcripts. Transcripts were read multiple times, with preliminary notes and interpretations made. Once this had occurred attempts at extracting initial codes and categories were undertaken. These stages were conducted using printed transcripts, Microsoft Word documents, and Excel spreadsheets (Microsoft, Redmond, WA, USA). This also allowed re-occurrences of codes to be grouped together, and for the generation of connected codes and initial themes.

The authors discussed generated themes, and the first author examined these themes to explore ways in which they reflected and deviated from Davis's (1994) model. Given the framework is a broad model, this allowed flexibility. All authors were involved in the development of these themes.

In the Results, nurses and consumers are denoted by 'N' or 'C' and their participant number.

RESULTS

Nurses believed that one of their main skills in managing conflict, and in their practice generally, was empathic communication and relating to consumers: 'I see nursing as empathic. I feel that's one of the major tools of our job' (N7). Themes were generally consistent with Davis's (1994) model of the empathy experience as involving antecedents, processes, intrapersonal and interpersonal outcomes. The central theme was 'my role as a nurse – the role of my nurse'. This theme could be considered an antecedent to the empathy process, as it influenced the ways in which nurses took consumers' perspectives (a process in the model), emotions felt towards consumers (intrapersonal outcomes), and specific nurse behaviours (interpersonal outcomes). There was also another antecedent theme, which involved what nurses and consumers brought to the situation; in particular, the nurse's capacity for self-reflection and awareness, and the consumer being a person outside of the inpatient unit.

The processes component was reflected in a theme that involved the nurse trying to understand the consumer's perspective. The theme relating to intrapersonal outcomes in the model involved feelings towards the consumer. Often nurses used perspective taking to regulate their emotional reactions.

While Davis (1994) focussed more generally on interpersonal outcomes (e.g. helping), three specific outcomes were apparent. A theme titled 'being there' involved specific behaviours that indicated to consumers that their nurses empathized and wanted to help. In addition, trust and rapport developed from an empathic relationship, and through trust and rapport, an empathic relationship could withstand conflict. Finally, empathy influenced consumer satisfaction with the resolution of conflict situations. Figure 1 integrates the themes into Davis's linear model of empathy.

Antecedents of the empathy experience

My role as a nurse – the role of my nurse

The central theme involved 'my role as a nurse – the role of my nurse'. Both participant groups believed empathy was a central tool to achieve positive outcomes (e.g. reduction of risk, consumer well-being) in conflict situations. However, they differed in their focus on the nurse's professional responsibilities during

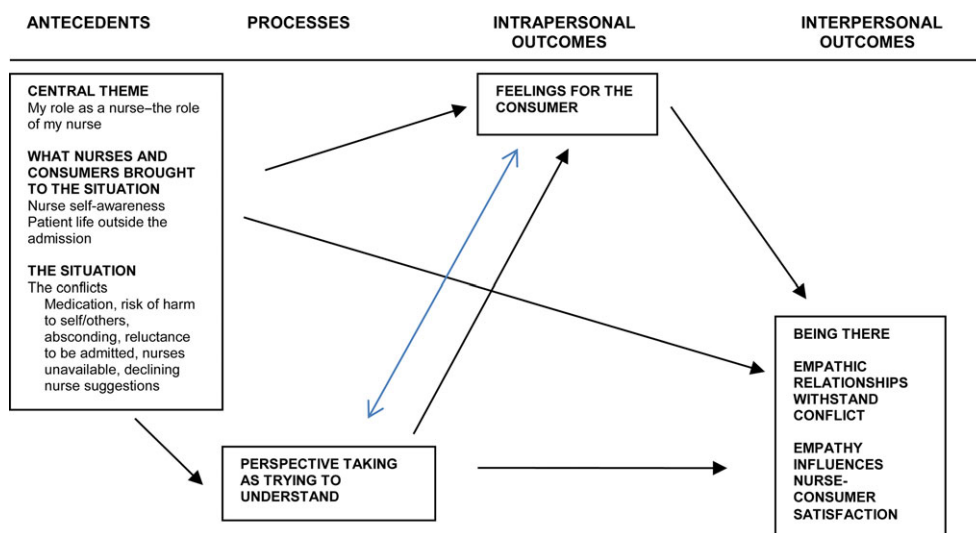


FIG. 1: Themes of the analysis using Davis’s (1994) linear antecedents, processes, intrapersonal outcomes, interpersonal outcomes framework. An additional double-headed arrow not present in the original model is included to indicate the use of perspective taking to regulate nurse emotions towards the consumer.

these situations. Nurses approached conflict or emotionally-charged situations mindful of their role as the consumer’s health-care provider, and aware that this entailed responsibility to maintain consumer and staff safety: ‘I’m there as a professional...to help them, so I stay in that role, that’s my job’ (N2). The most common situation described by nurses involved consumers not wanting to take medication ($n = 5$). In two cases, restraint and seclusion were used to administer the medication. Absconding was described by one nurse, and this also involved restraint. Three nurses described self-harm or harm to others, with a consumer trying to strangle themselves, a consumer becoming aggressive after treatment, and a consumer who was causing unit disruption. Two nurses described consumers who did not want to be admitted to the unit.

Nurses balanced what was required in their professional role and the empathy they were experiencing for the consumer and their situation. This balance was prevalent in narratives involving medication:

(Forcing the medication)...might’ve left him feeling more confused and trapped... (but) on the other hand, I thought, this boy needs his medication severely. (N7)

A nurse working with a client reluctant to be admitted reflected:

It got to the point where it...was about risk...so I really had to manage the part of me that wanted to do more what he wanted to do. (N5)

Consumers reflected on the nurse’s role more widely than maintaining safety, and the part empathy played in defusing conflict situations: ‘(Empathy built) trust (and that) was...everything to bring me down (from paranoia)’ (C4). Three consumers saw the nurse’s role as helping consumers take increasing responsibility for their lives at a time when they were unwell. One consumer considered the nature of the nursing role as a balance between allowing consumers to take responsibility and ‘recognizing when someone’s not in the situation that they’re well enough to make those decisions for themselves’ (C5). This was similarly described by a nurse: ‘Sometimes you have to take control, but in as least intrusive way as possible and respectful of their dignity and integrity’ (N4). Empathy was important to reducing conflict and facilitating empowerment within an often-coercive environment:

Having the empathy there in the first place, it makes the staff more approachable, which then puts the ball back in your court for taking control of your recovery. (C5)

Inherent within nurse–consumer empathy relationships were issues of power. One nurse compared community to acute care mental health nursing: ‘You’re in their space (in the community)...they’re in your world as an inpatient’ (N5). Empathy allowed nurses to be aware that their role involved actual and perceived power, and that conflict could be a way of consumers exercising power:

I just have to keep telling myself that this man is really unwell and...he sees us 'look at all of them with the power, I've got no power, I'm helpless, and I'm going to demand, and this is the only way I'm going to show my, or give me some sort of case in this community'. (N7)

Power was evident in the conflict situations discussed by consumers. For consumers, conflict centred on contact with nurses. Three consumers discussed wanting to speak with busy nurses. For one of these consumers, while such experiences were not 'confrontations', she felt 'very disempowered by the nursing staff' (C2). One consumer and two nurses described declining nurse situations; specifically, the consumer described not wanting to participate in group activities, and the nurses described consumers who would not eat or drink. Three consumers described absconding incidents.

What nurses and consumers brought to the situation

Another antecedent to the empathy experience was the ability of the nurse to be self-aware. This quality related to both the empathizer's innate dispositional abilities (Davis 1994) and learning from nursing experience. Conflict was avoided or amplified through awareness/lack of awareness of values, biases, and reactions to consumers. One nurse found when experiencing strong emotions or thoughts that surprised her, it was important to ask: 'Where did they come from? What triggered that?' (N4). Without this, there was potential to 'either fall apart or you end up...not being therapeutic to the patients' (N11). Many nurses discussed difficulties dealing with consumer histories (e.g. sexual abuse of children) and diagnoses (e.g. personality disorder), and how this could be a barrier to empathy:

If someone's really needy and dependent...I've got to work extra hard to be empathic...about their need...but my reaction is just to flee. (N5)

One consumer believed the nurses were biased towards him and did not want to engage:

I assume...(the nurse) was told 'Don't waste time over there' because there was more important work to do. (C7)

Even if nurses were not 'aware of what that thing is that strikes inside you' (N3), being non-judgmental, not imposing values, and 'doing the responding and not reacting' (N5) in heated conflicts was important.

Nurses also suggested it was important to be aware of how team dynamics and interactions with other staff could influence nurse-consumer conflict:

How do I get along with my colleagues? Am I working in a team where I get along well with everybody? Or am I working in a team where there is constant conflict and horribleness? That's going to impact on all my interactions with clients, not just with the staff. (N1)

This nurse experienced conflict and 'annoyance and anger' towards other staff, who she felt were not attempting to understand the reasons for a consumer's behaviour and had differences of opinion regarding treatment approach. Another nurse reflected on how her working with consumers could be influenced by practitioners from other disciplines, who might have spent limited time with the consumer:

That can impact on the way I work with that person because the person may have an idea of where they want to go, and it's not where the doctor wants to go, so that can cause a conflict at times. (N8)

Another nurse found that when there was conflict with colleagues, she found it useful to interact less with them: 'So I don't have to then use up my reserves of empathy on the other staff, so that I can keep that for my clients later on' (N5).

While Davis's (1994) model focusses on attributes of the empathizer, consumers also brought to conflict situations lives outside of their inpatient admission. Consumers felt nurse engagement helped alleviate their concerns that nurses 'just looked at me as an illness', rather than as a person 'experiencing a time in their life when they're experiencing illness, but they're not the whole illness' (C1). This involved engaging with consumers' everyday interests (e.g. television, books), in addition to allowing time for clinically-related information to emerge. When an empathic approach was not taken, consumers felt depersonalized, and that nurses could not differentiate between 'this is me and this is my illness' (C2).

Processes: Perspective taking as trying to understand

Participants believed the most important part of interaction during conflict situations was the nurse trying to understand. Both nurses and consumers were aware that they brought separate perspectives to the interaction, and consumers believed their experiences might be difficult to comprehend. A consumer who thought that staff at the nurses' station did not want to talk with her found one nurse who did behave empathically: 'She actually acknowledged that, although she couldn't

hear the voices ...for me they were a real experience at that point in time' (C2).

Nurses used several strategies to understand consumers' perspectives, such as asking the consumer questions in interviews or assessment. One nurse found that 'We hadn't been asking the right questions' (N1) to find out why a consumer refused food. It was important not to impose particular interpretations for a consumer's behaviour. At least initially, nurses needed to not focus on 'this is what I believe might be happening', but 'this is what the person is telling me' (N8).

Introspective strategies involved using past experiences and switching places imaginatively with the consumer. Nurses drew on their experiences of relationship difficulties or being unwell. For a nurse who was trying to understand a consumer who was self-harming, she reflected:

I just remember thinking I've suffered anxiety in my life a long time ago...what would I want someone to do if I was feeling this frightened? (N9)

However, nurses highlighted differences between their experiences and those of the consumer. A nurse treating a consumer who was suicidal after a relationship breakdown, and whom subsequently absconded, found that using her relationship breakdown to understand him was not 'a particularly healthy place to come from' (N2). Instead, she found it more useful to remind herself that 'this is his problem and I'm here to help him to deal with his problem' (N2). Therefore, nurses' focus on their own lives was at a general level of identification to maintain professional distance:

Something simple, like when you go to the GP (general practitioner) surgery, you sit in the waiting room, you can feel very disempowered yourself, even as a clinician. (N12)

It was important, however, to reflect on when one's own past experience was not useful:

When someone is grieving the loss of a child, I can't say to that person 'I understand what you're going through', because I don't understand what they're going through. I can only say: 'I can't even imagine what that's like' to empathize with them. (N1)

Consumers were less inclined to focus on internal strategies nurses used to understand them, but one consumer focussed both on their nurse and police officers who had brought him back after absconding:

I really thought that...they turned around and kind of (thought), 'Imagine this was my son or imagine this

was me or imagine this was a friend of mine; how would I feel?'. (C1)

Intrapersonal outcomes: Feelings for the consumer

Nurses believed that consumers felt a range of negative emotions, including 'petrified' (N3), 'out of control' (N4), 'apprehensive and anxious' (N5), 'fear' (N6, N9), 'horrible, confused', 'angry' (N11), and 'frustrated' (N12). Nurses largely did not mirror consumer emotions (parallel emotions in Davis's (1994) model). Instead, feeling for the consumer was a prevalent response, and this involved sadness, sorrow, concern, worry, discomfort, and frustration for the consumer; these feelings are reactive emotions. One nurse described feeling 'connectedness and compassion' with a consumer who did not want to take their medication, and for whom a code black had been called:

It's frightening enough having whatever's going on in your mind as a result of your illness, but from the practical sense being in a hospital is decontrolling for everybody; your power goes out the window as soon as you step your foot in the door. (N4)

When nurses spoke of experiencing similar emotions to those of consumers (i.e. not an empathic reaction to the consumer's emotions or feeling for the consumer), there was a reflection on the need to 'balance...being aware that...that's her emotion that I'm feeling' (N8). There were then deliberate attempts to separate perspectives in order to regulate and manage emotion. The nurse who discussed a consumer who was suicidal after a relationship breakdown reflected: 'I sometimes build a bubble around myself so that I'm very careful about who owns the emotion' (N2). Distinctions were drawn between constructive empathy and related concepts, such as over-involvement:

Empathy is feeling with...but when you start to emote about it and your behaviours deviate from what they would normally be in a professional sense, then you've moved onto something else; that's not empathy anymore. (N2)

Metaphors used included 'putting on an emotional uniform' (N2), 'lock(ing) part of myself out, put up a bit of a wall' (N6), and being able to 'step back and look at it instead of delving in' (N6); yet balance was required between maintaining professional distance and allowing oneself to 'be human with people' (N5). Consideration of boundaries was important because of

distressing situations mental health nurses come across, but also to avoid 'disempowering' and 'pitying' (N2) responses, as well as the nurse 'not necessarily...do (ing) what is in... (the consumer's) best interest' (N1). One consumer acknowledged that nurses need 'to protect themselves', but there is a 'difference between having a barrier that's a rigid wall and having a barrier that sort of sways with the wind a bit' (C2).

Interpersonal outcomes

Being there

Davis's (1994) model focussed on general interpersonal outcomes and behaviours undertaken by the empathizer (e.g. helping), whereas the participants discussed a range of specific nurse actions that led to consumers experiencing empathy. These behaviours were demonstrated to consumers by nurses 'being there' (N4, N5, C1), 'you hear that a lot from people, "thank you for being there; it helped"' (N4). According to consumers, 'being there' involved listening, questioning, negotiation, and providing choice, not being patronizing or overreacting to situations, having conversations in private, respecting space, and appropriate tone and body language. One consumer reflected on a nurse who was willing to negotiate more approved leave, but made it clear that the consumer would then have to return to hospital:

Being, I guess, assertive enough to actually go: 'No, you are detained and you need to come back'...but I think the way the person did it was still showing that empathetic feeling and showing that...(they) did understand. (C1)

Imposition of rules existed alongside nurses trying to understand consumer concerns. This was the experience of a consumer who absconded:

The questions that they asked were...genuinely wanting to know what was going (on) for me...There was no anger in their response, it was a genuine sense of 'We need to come to a conclusion that's going to work for both of us'. (C5)

While leave was subsequently restricted, the process of trying to understand was important.

For many consumers, empathy was 'more a method of enquiry, rather than a method of direction' (C5). This could help nurses to give useful advice and consumers to come to their own conclusions:

I guess that's a by-product of a person showing compassion and empathy...it makes you question yourself

a little bit and going 'Maybe I'm the one making the wrong decision here'. (C1)

While nurses reflected on diverse conflicts, all stressed listening skills, involving 'being there...and not rushing' (N5), 'go(ing) with it' (N10), and realizing that 'silence is really important' (N9).

Nurses acknowledged that administrative requirements could result in limited consumer time and the chance to experience empathy:

People get so caught up in 'I need to do all of this paperwork' that they're forgetting to stop and listen to the person and to get their point of view. (N1)

However, consumers stressed the need for even brief regular contact.

Empathic relationships withstand conflict

Rapport and trust between nurses and consumers as a result of the nurse taking their consumer's perspective, seeing them as a person, and being there were specific outcomes of empathy:

If they have that empathy, I'm much more able to communicate with them, and if I feel there's a rapport there. (C2)

One nurse found that being open and telling a consumer experiencing psychosis her concerns was useful:

I said, 'I'm very scared for you, I'm very worried'... I think that's probably what then made it easier for her to be able to keep seeing me and have some trust. (N8)

Well-formed empathic relationships based on rapport and trust could withstand conflict. A consumer who absconded found that:

When I got back to the actual unit the next day, I didn't feel judged at all...I felt the nurses looking after me were treating me the same as the day before. (C1)

One nurse who reflected on a consumer who had self-harmed after 'an enormous amount of conflict with...staff and other clients' felt that it was important to 'always think about the person in that moment as opposed to what they may have done yesterday or the week before' (N9).

Rapport built over time allowed nurses to ascertain 'where I can go' (N6) with consumers. Good relationships, often formed during previous admissions, provided:

A tiny thread of connection...they're backed into a corner...and if there's some sense of connection that they're not totally alone, then they come out of the corner. (N4)

In newly-formed relationships that involved significant conflict, an empathic interaction could still develop. One nurse who called the police after a recently-admitted consumer had absconded, reflected:

Afterwards, you try and establish rapport and then build the relationship, but at the time, it's about keeping people safe. (N2)

For another nurse, expressed empathy over time was a necessity to handling conflict:

If I've started well with my first interactions with the person, and I've developed that rapport, there may be some interactions where I'm not as empathic as I should be, it will still be okay. (N1)

Empathy influences nurse–consumer satisfaction

Conflict, and acute illness more generally, were not pleasant, but empathy was an important part of resolving individual conflict situations, consumer satisfaction, and moving towards recovery. The consumer who discussed her distressing voice hearing with a nurse was satisfied with the interaction:

Because of the way she did it, and she did not at any time make me feel like I was imposing on her. Then the voices said: 'She's only doing it to trick you', and I was able to say: 'No, she didn't'. (C2)

She contrasted this nurse's behaviour with that of another nurse, who had asked her to wait: 'There was a boundary there, and I didn't feel that I was actually relevant to the situation' (C2). Another consumer who absconded reflected more generally on the overall admission: 'The psychosis was nightmarish and very disorientating, and I thought I responded well to being treated in an empathetic way' (C4).

Empathy could have significant outcomes for the consumer:

I think if...I had nurses that didn't show empathy...or I was told that I was insightful and I was delusional and I'd never achieve my goals and those sort of things...I don't even know if I'd be around today. (C1)

Unlike consumers, nurses' satisfaction with the resolution of conflict related more to their ability to appropriately perform their nursing role, rather than their empathic approach. Often nurses who reflected on conflicts involving dangerous behaviour were not entirely satisfied, even if conflicts were resolved safely, because consumers and staff had experienced distressing situations. However, these nurses believed that they would not have done anything differently in the situation:

It was really horrible... (but) if he came in with the same presentation I would still do the same thing. (N2)

DISCUSSION

While empathy is acknowledged as key to successful therapeutic relationships (Elliott *et al.* 2011), little work has examined the specific ways in which it is developed and maintained during conflict situations in acute care psychiatric settings. In the present study, participant discussion supported and extended Davis's (1994) conceptualization of empathy experiences as involving specific antecedents (e.g. dispositional self-awareness), processes (perspective taking), and intrapersonal (feeling for consumers) and interpersonal (e.g. trust and rapport) outcomes.

The role of nurses, which has not been investigated as a specific antecedent in an empathic interaction, determined how empathy was enacted, experienced, and received during conflict. Nurses approached conflict situations and the use of empathy from their role as a nurse, in particular through a perspective of maintaining safety. This is not surprising, as conflict situations by their nature involve potential harm (Bowers 2006), and within dominant models of care it is largely considered the clinician's responsibility for managing the risk individuals might pose to self or others (Crowe & Carlyle 2003; Muir-Cochrane *et al.* 2011). However, the nurses' focus was in contrast with that of consumers, who felt that empathy was part of their wider hospitalization experience, and movement from individual conflict behaviours stemming from illness towards recovery and life outside of treatment. Differences in nurse and consumer perspectives reflect identified challenges in promoting autonomy, self-determination, and choice with consumers under involuntary orders and high acuity (McKenna *et al.* 2014). This also reflects power in nursing practice, with Cutcliffe and Happell (2009) examining how the removal of consumer freedoms (e.g. involuntary admission, increased observation, restraint), forced medication, and control over decision-making constitute both visible and invisible displays of power.

Nurses were aware of the importance of reflecting on how their biases, values, and emotional reactions to consumers influenced both conflict and empathy (Eng & Pai 2015; Gerace *et al.* 2013; Peternelj-Taylor & Yonge 2003). Similarly, perspective taking emerged as a deliberate and controlled process (Davis 1994; Hoffman 2000). The strategies used by nurses to understand a consumer are similar to those identified in the

psychological literature (Gerace *et al.* 2013; Van Boven & Loewenstein 2003). However, nurses were careful not to over-identify with consumers by psychologically switching places with them or relating consumers' experiences to their own (Davis *et al.* 2004; Gerace *et al.* 2013). This could reflect nurses' attempts to distance themselves from negative emotions (see Zaki 2014). It also likely reflects accurate assessment regarding the lack of similarity between experiences. Reflecting on one's own similar past experiences makes it easier to understand another person (Gerace *et al.* 2015a), but empathizers tend to insufficiently take account of the other person's unique experience (Epley *et al.* 2004).

Consumers understood empathy as a nurse's attempt to enter into their experience in a respectful, non-judgmental, and non-dismissive way, but that there might be an empathy gap between nurses and themselves (e.g. in hearing voices). In this way, both groups of participants shared a definition similar to that described in the literature, where empathy involves switching between one's own and another person's perspective (Gerace *et al.* 2013), and engaging in a 'qualified boundary cross, with the counsellor never totally leaving his or her own personal territory' (Hermansson 1997; p.140).

Nurses differentiated between feeling for a consumer and losing sight of whose emotion it was, as well as reflecting on the importance of emotional management. This seems more akin to what has been identified as empathic concern, compassion, or sympathy, rather than feeling a parallel emotion or personal distress (Batson *et al.* 1997; Davis 1994). Hayward and Tuckey (2011) found in their study that nurses engage in 'manipulation of emotional boundaries (which) encompasses both distancing and control mechanisms dependent on whether... (they) are driven to create an emotional space to protect emotional resources, or to invest their emotional selves in the developing relationship' (p. 1518). In the present study, there was not so much emotional distance (although metaphors of 'walls' or an 'emotional uniform' were present) as emotional management being facilitated by nurses maintaining their separate perspectives and emotions.

Findings move beyond focussing on the empathizer's attributes and role in the situation (Davis 1994) to examining the nurse-consumer relationship. Empathy emerged by being with consumers and engaging in discussion of clinical and more general history, which involved seeing consumers as more than their illness.

McKenna *et al.* (2014) found that knowing about consumer hobbies and interests could be used in a strength-based recovery approach. In addition, small talk and passing conversations helped to develop trust and meaningful therapeutic engagement. In the present study, empathic interactions created a space where open and honest communication occurred, and trust and rapport emerged. Consumers did not expect rule changes based on nurse empathy, but found listening and understanding important. This can lead to negotiation and sensitivity within restricted environments (Alexander & Bowers 2004; Cleary *et al.* 2012), and 'a shift in how power is enacted' (Cutcliffe & Happell 2009; p.122).

Nurses discussed how positive interactions could provide later connection, or ameliorate damage from particularly conflictual interactions. Threats to empathic encounters included tasks that did not involve consumer contact. While nurses might feel pressured to complete paperwork and assessment, particularly in acute care settings, spending time meets consumer needs for social inclusion, as well as leading to relationship enhancing and practical outcomes (Bee *et al.* 2008). Consumer satisfaction with the resolution of conflict situations was related to how empathic nurses were towards them during specific situations and over the course of their hospitalization (see Bee *et al.* 2008).

Limitations

The present study was a small, qualitative investigation with a somewhat heterogeneous sample. Generalization is difficult, and differences as a result of sex, age, nursing or hospitalization experience, and specific conflict might be obscured. Unfortunately, only female nurses volunteered to participate. Findings are mixed regarding whether there are sex differences in nurse empathic responsiveness (Yu & Kirk 2008). Outside of nursing, it has been suggested that socialization differences lead females to respond to problematic situations with increased interpersonal contact, with the reverse true of males (Batson *et al.* 1996). The impact of care facility and related factors, such as ward climate, could also not be investigated, as participants were not explicitly asked at which unit/hospital the conflict incident had occurred, and participants described both recent and older incidents. This meant that within-group differences could not be examined. The study was also structured around one framework, and specific definitions of empathy.

Another limitation was not being able to match nurses and consumers so that each could discuss the same situation. Retrospective reporting is a concern, particularly whether cognitions and emotions are recalled as they were experienced at the time. The literature, however, supports the validity of asking participants to reflect on empathy (Hodges & Wegner 1997), and this method is compatible with realist qualitative approaches (Braun & Clarke 2006). Finally, while satisfaction with empathic relationships is reflected in previous work, participants might have chosen situations where empathy was achieved or consumers felt understood.

CONCLUSION

The present study supported the importance of empathy in managing conflict in acute care settings. Nurses are mindful of their role and responsibilities, which influences experienced and expressed empathy towards consumers. Consumers want relationships involving understanding and connection, which unfold through time spent together.

Relevance for clinical practice

Challenges to increasing empathic time spent with consumers include increased workloads and changes in consumer acuity (Papadopoulos *et al.* 2012). However, given the demonstrated effects of empathy on consumer outcomes, as well as on nurse engagement, satisfaction, and reduced turnover (Dal Santo *et al.* 2014), an empathic approach and regular interaction should be highlighted as indispensable components of conflict resolution between consumers and their nurses. One way to accomplish this is through 'protected therapeutic time' (McKenna *et al.* 2014; p.530).

Ways to increase empathy at the individual level could involve experiential and simulation exercises to build understanding of consumer experiences, such as voice hearing, which has been found to lead to changes in attitudes, empathy, and insight (Dearing & Steadman 2009). Seeking feedback as to the consumer's thoughts and feelings is likely to increase nurse accuracy in understanding their perspectives (Marangoni *et al.* 1995). Nurses should also reflect, during clinical supervision, on previous experiences of conflict, inherent nurse–consumer power dynamics, their own values and biases, and both consumers' and their own interactions with other staff. Asking nurses to reflect on a specific situation involving conflict, and their strengths

and weaknesses in empathic responding, could be a particularly useful approach in clinical supervision. Quality clinical supervision is particularly useful in dealing with incidents, such as aggression, medication issues, and consumer complaints, as well as concerns regarding boundaries, with supervision particularly important for nurses of lower clinical grade (Paternelj-Taylor & Yonge 2003; Teasdale *et al.* 2001).

It is also likely that cultural and organizational factors that influence the therapeutic landscape and empathic approach of staff need to be addressed. Indeed, the Safewards Model (Bowers 2014; Bowers *et al.* 2014) and therapeutic interventions based on this approach, reflect the importance of perspective taking, empathy, and compassion in preventing and reducing conflict and containment. In this way, individual, systemic, and cultural changes are necessary to realize the potential of empathy to effect the positive resolution of conflict situations and facilitate therapeutic nurse–consumer interactions.

ACKNOWLEDGEMENTS

The research was funded by a Flinders University, Faculty of Medicine, Nursing and Health Sciences (Adelaide, SA, Australia) Competitive Research Grant.

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