THE PSYCHIATRIC NURSE’S EXPERIENCE AND MEANING OF
"CARING" IN HOSPITALS: A GROUNDED THEORY OF PROTECTIVE
EMPOWERING

by

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A thesis submitted in conformity with the requirements for the degree of Doctor
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ABSTRACT

THE PSYCHIATRIC NURSE'S EXPERIENCE AND MEANING OF "CARING" IN HOSPITALS: A GROUNDED THEORY OF PROTECTIVE EMPOWERING


This study explored with psychiatric nurses their experience and meaning of "caring" with patients in the hospitals. Seventeen registered nurses were interviewed from three general acute care psychiatric units, in two general hospitals and one psychiatric hospital. Using grounded theory qualitative methodology, it was discovered that "caring" occurred through a process called protective empowering, and a grounded theory of protective empowering was formulated. The nurses accomplished protective empowering of patients through six categories as evidenced through 1. keeping the patient safe; 2. encouraging the patient's health; 3. authentic relating; 4. interactive teaching; 5. respecting the patient; and 6. not taking the patient's behaviour personally. Each of the six main categories of protective empowering were defined by specific subcategories. All six main categories appeared throughout the process of protective empowering, except that each category represented a different feature of protective empowering. The two main categories of respecting the
patient and not taking the patient's behaviour personally were the antecedent and sustaining conditions of protective empowering. The other four categories keeping the patient safe, encouraging the patient's health, authentic relating, and interactive teaching represented the actions and contexts through which protective empowering changed. The consequence of protective empowering was manifested by the patient's ability to access their ability to act or accomplish their activities of daily living. The results suggest a practical and grass-roots theory of protective empowering that could be used as a valuable guide for articulating and reflecting on what psychiatric nurses do in their caring with patients on general psychiatric units; and, could be useful for both the clinical and political purposes of affirming and/or challenging the way in which psychiatric nurse "caring" with patients is articulated and allocated in hospitals.
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>xi</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>xii</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>5</td>
</tr>
<tr>
<td>Review of the Literature</td>
<td>7</td>
</tr>
<tr>
<td>Empirical Literature</td>
<td>8</td>
</tr>
<tr>
<td>Theoretical Literature</td>
<td>15</td>
</tr>
<tr>
<td>Research Questions</td>
<td>20</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>21</td>
</tr>
<tr>
<td>Who am I as Researcher? A Personal Note</td>
<td>23</td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>29</td>
</tr>
<tr>
<td>Research Design</td>
<td>29</td>
</tr>
<tr>
<td>Gaining Entry to the Field</td>
<td>31</td>
</tr>
<tr>
<td>Settings</td>
<td>33</td>
</tr>
<tr>
<td>Description of Sample</td>
<td>38</td>
</tr>
<tr>
<td>Sampling Method</td>
<td>40</td>
</tr>
<tr>
<td>Data Collection</td>
<td>42</td>
</tr>
<tr>
<td>Interview Method</td>
<td>42</td>
</tr>
<tr>
<td>Development of Initial Interview Guide</td>
<td>44</td>
</tr>
<tr>
<td>Modification of Initial Interview Guide</td>
<td>55</td>
</tr>
<tr>
<td>The Interview Process</td>
<td>56</td>
</tr>
<tr>
<td>The First Interview with Participants</td>
<td>61</td>
</tr>
<tr>
<td>The Second Interview with Participants</td>
<td>63</td>
</tr>
</tbody>
</table>
Theoretical Sampling........................ 65
Open Sampling.............................. 66
Variational Sampling........................ 67
Discriminant Sampling...................... 67
Data Analysis.................................... 69
Coding Procedures............................ 70
Opening Coding.............................. 71
Axial Coding................................. 72
Selective Coding............................. 74
Memo Writing.................................... 75
Ethical Considerations.......................... 78
  Protection of Confidentiality and
  Participant Rights............................ 78
  Confidentiality................................ 78
  Informed Consent and Participant
  Rights......................................... 78
  Risks and Benefits................................ 79
Credibility of the Study........................ 81

RESULTS.............................................. 91
An Overview of the Theory of Protective
Empowering........................................ 93
Basic Social Process: Protective Empowering...... 97
  Main Category: Keeping the Patient Safe....... 103
  Subcategory: Advocating for the patient..... 104
  Subcategory: Providing reassurance........... 106
Subcategory: Attending to patient self-care
and treatment..................109

Subcategory: Providing patient with information
and choices......................113

Main Category: Encouraging the Patient's Health..116
Subcategories: Promoting patient
responsibilities in increments
and Inviting the patient's
participation in activities..116

Subcategory: Bringing any changes to
the patient's attention.......120

Subcategory: Complimenting and cheerleading the
patient's efforts...............121

Subcategory: Drawing out the health
already there....................124

Main Category: Authentic Relating..................127
Subcategory: Being consistent....................127
Subcategory: Being available and responsive
to patient concerns of
daily living......................130

Variations: Subcategory of Being available
and responsive to patient
conscerns of daily living.......132
Subcategory: Matching the nurse's interaction
with the patient's receptivity and
capabilities......................136
Main Category: Interactive Teaching.................140
    Subcategory: Showing the patient through the nurse's example in interactions........141
    Subcategory: Building on the patient's, interests needs, and knowledge............143
    Subcategory: Giving feedback.....................144
    Subcategory: Pointing out expectations, alternatives, and life patterns..145
    Subcategory: Helping the patient anticipate how they will manage in the community.....148

Main Category: Respecting the Patient...............150
    Subcategory: Acknowledging the patient's concern or distress ............151
    Subcategory: Being non-judgemental...............152
    Subcategory: Not power-tripping.....................153
    Subcategory: Patient as knowledgable............156

Main Category: Not Taking the Patient's Behaviours Personally.......................158
    Subcategory: Knowing yourself......................160
    Subcategory: Knowing the patient....................162
    Subcategory: Consulting with other nurses, the health care team and the patient..164
    Subcategory: Viewing each situation as a learning experience.......................166
    Subcategory: Imagining the patient's situation.168
    Subcategory: Taking a break.......................170

viii
Statement of Relationships among the Six Major Categories........................................ 171
Limitations of the Study.......................... 177
INTEGRATION OF FINDINGS WITH THE LITERATURE....... 179

Literature Pertaining to
  Protective Empowering.......................... 181
Literature Pertaining to the Main Category of
  Keeping the Patient Safe......................... 197
Literature Pertaining to the Main Category of
  Encouraging the Patient's Health............... 212
Literature Pertaining to the Main Category of
  Authentic Relating............................. 217
Literature Pertaining to the Main Category of
  Interactive Teaching........................... 230
Literature Pertaining to the Main Category of
  Respecting the Patient.......................... 235
Literature Pertaining to the Main Category of Not
  Taking the Patient Behaviours Personally...... 246

SIGNIFICANCE FOR NURSING................................. 254
  Clinical Significance............................ 254
  Political Significance........................... 262

RECOMMENDATIONS FOR FURTHER RESEARCH............. 267
CONCLUDING STATEMENT............................... 272
  References....................................... 274
List of Tables

Table

1. Setting Characteristics Across Three Settings 37

2. Demographics of Participants Across Three Settings 39
List of Figures

Figure

1. Protective empowering: A pictorial depiction of the psychiatric nurses' experience and meaning of "caring". 95

2. Relationships between the six categories of protective empowering according to the coding paradigm 174
List of Appendices

Appendix A-Letter to Director Of Nursing........302
Appendix B-Sample Eligibility Criteria..........303
Appendix C-Study Information Sheet..............304
Appendix D-Consent Form..........................306
Appendix E-Initial Interview Guide..............307
Appendix F-Modified Interview Guide based
  Data from In-Depth Interviews..............308
Appendix G-Interview Face Sheet..................311
Appendix H-Post-Interview Comment Sheet.......312
Appendix I-Example of Coding Transcript
  using Open Coding.........................313
Appendix J-Example of Coding
  using Coding Paradigm....................314
INTRODUCTION

As a result of being a constant presence in the hospital setting, nurses serve a coordinating and integrating function crucial to the patient's and health care team's functioning. The integrating and coordinating functions of the nurse, as well as the nurse's managing the emotions of, or providing reassurance and support to patients and families have been cited as some examples of the taken for granted aspects of nursing (Braj, 1994; Diers, 1986; Campbell, 1988; Larsen and George, 1992; Warren, 1988; Wolfe, 1989). Even though nurses are educated (i.e., college and/or university education), self-governing, and in demand, nursing has had difficulty articulating what "caring" is to those responsible for allocating health care resources. This has meant that although nurses have been physically present in large numbers in hospital settings, nursing has been economically and socially invisible (Diers, 1986; Lynaugh and Fagin, 1988; Stuart, 1994; Wolfe, 1989). The invisibility of nurses' actions and experiences from historical and formal accounts of events is well documented and will not be repeated here (Armstrong, Choiniere, and Day, 1993; Growe, 1991; Larsen and George, 1992; Lynaugh and Fagin, 1988; Reverby, 1987a; 1987b; 1993). However, it is acknowledged that nurses have been invisible in terms of the "caring" they provide and one of the consequences of this
invisibility of caring has been that nursing has been incorporated as part of the indirect costs of hospitals (Lynaugh and Fagin, 1988). For example, some nurses have pointed out that "for way too long, nursing has been buried in the hospital bill along with brooms, breakfast, and the building mortgage" (Diers, 1986, p. 29; Larsen and George, 1992; Lynaugh and Fagin, 1988). Furthermore, it is acknowledged that nursing practice is affected by a host of different contextual factors including, but not limited to, oppression within the workplace, gender socialization, division of work in society, devaluation of caring expertise and knowledge, and the influence of patriarchy in society on nursing practice (Armstrong, Choiniere, and Day, 1993; Benner and Wrubel, 1989; Growe, 1991; Larsen and George, 1992; Lynaugh and Fagin, 1988; Reverby, 1987a; 1987b; 1993). In light of these contextual factors it is important to connect with the meaning and experience of caring to the psychiatric nurse. By giving a voice to the nurses' description of their meaning and experience of caring through the development of a grass-roots theory, an understanding of caring can be obtained from the perspective of the psychiatric nurse. This understanding can, in a later study, be examined in relation to the contextual factors that interfere and disrupt caring from occurring in the way which has meaning for psychiatric nurses.
Clarifying what "caring" is in the hospital setting from the psychiatric nurses' perspective is important in the present economic climate in which hospitals are pressed to justify expenses. Since a large portion of hospital expenditures is nursing services, nursing is in a unique position to clarify and articulate what "caring" is from the perspective of nurses who work daily with patients. The nurse's knowledge of "caring" can provide data about what nurses do with patients in the hospital setting. These data are urgently needed to justify nursing services in the hospital setting, especially in psychiatric nursing.

The impetus to clarify what "caring" is from the perspective of psychiatric nurses has peaked due to the proposed hospital closures in Ontario, health care reforms that focus on community based mental health care, and decreased hospitalization stays of less than 35 days (Ministry of Health of Ontario, 1993a). Moreover, clarifying what caring is, in the hospital setting and from the perspective of the psychiatric nurse, is important in this time when registered nurses are being replaced with less skilled or unskilled personnel (Huston, 1996).

Furthermore, clarifying and delineating "caring" from the psychiatric nurses' perspective allows nursing to accumulate a data base that can help nursing and hospitals plan their approaches, services, policies, and costs. A data base on "caring" may be helpful in affirming, modifying,
and/or challenging how psychiatric nursing is practiced in hospital settings.

The study to be described in this manuscript attempts to explicate a grass-roots theory about what "caring" is, how "caring" is accomplished, and the consequence of "caring". This study attempts to generate a theory of "caring" based on the perspective of psychiatric nurses who worked with patients in three hospitals.
Purpose of the Study

The purpose of this study is to add to the existing body of knowledge by explicating the basic social process experienced by psychiatric nurses in "caring" for patients on acute general psychiatric units in hospitals. Moreover, the purpose of this study is to generate a practical and grass-roots theory that can be used for both clinical and political purposes of affirming and/ or challenging the way in which "caring" in psychiatric nursing is practiced, organized, funded, or prioritized in hospital settings. The purpose of such a grass-roots theory is to serve as a flexible guide to policy development, curriculum development, and for development of payment or reimbursement instruments that reflect caring from the psychiatric nurses' meaning of caring from actual experiences with patients.

Since the choice of research method is closely associated with the purpose of a study, I will now briefly discuss why grounded theory method was chosen for this study. The choice of grounded theory method as a research approach for conducting this study was appropriate to this study's purpose of generating theory. Furthermore, since the purpose of this study was to explore the psychiatric nurses' meaning of "caring" with patients within a specific setting, the level and type of theory generated in this study was substantive theory.
According to Strauss and Corbin (1990) "substantive theory evolves from the study of phenomenon situated in a particular situational context" (p. 174). In this study, the particular situational context was caring provided by psychiatric nurses in acute general psychiatric units within hospitals.

The purpose of this study was not suited to the development of a formal or grand theory of professional caring. This would require exploring "caring" in a variety of contexts with other professionals such as nurses from other clinical areas, and/or with psychologists, social workers, doctors, community health nurses and so on.
Review of the literature

In the following literature review the main research studies that have contributed to an understanding of caring in psychiatric nursing from the psychiatric nurse's perspective are presented. The goal in describing these studies is to give a rationale for the potential contribution of this investigation and to show that no identical inquiry has been conducted. However, a discussion of the important contributions of these studies as well as other theoretical and empirical literature is provided in the discussion, as it relates specifically to the theory generated in this study. The literature is presented in the discussion of the findings in order to limit the influence of previous theoretical constructions on the theory development in this study, and is not intended to diminish or not recognize the valuable and important theoretical constructions and contributions of other researchers and theorists. Therefore, the literature is presented in the discussion, in order to abide by the stance of the researcher in a grounded theory approach, in which efforts are made to limit the influence of previous theoretical constructions on theory development in this study.

In this section, the research and the theoretical literature on the concept of "caring" in psychiatric nursing is reviewed. Psychiatric nurses' working with patients on acute care general psychiatric units within hospitals was
the focus for this literature review. The following review of the literature will be presented in two parts. In the first part the empirical research is presented. In the second part the theoretical literature on caring is presented.

**Empirical Research Literature**

The following review of empirical research showed that the concept of "caring" is not sufficiently addressed, from the psychiatric nurses' perspective. Moreover, empirical psychotherapy research identified "caring" as a core process associated with the improvement of patient symptoms and clinical status.

Few theories in nursing have been derived from interviews with nurses about their experiences in clinical practice (Benner, 1984; Benner and Wrubel, 1989; Ray, 1989; Watson, 1979). Benner (1984), Watson (1979), and Ray (1989) each interviewed nurses from a variety of clinical settings about their experience and meaning of caring. The concepts and theories generated from their work with nurses have provided new insights about "caring", as it is practiced in nursing across different clinical specialities. However, none of these authors focussed solely on what caring is from the perspective of the psychiatric nurse in hospitals.

Ray (1989) suggested that what "caring" is varies, according to the specific context of each situation. Ray
(1989) conducted an ethnographic and grounded theory research study (Ray, 1989) in an acute care urban hospital, from which she derived the theories of Bureaucratic Caring and the Theory of Differential Caring. Ray (1989) interviewed 200 respondents about what the meaning of "caring" was for the participants from fourteen different clinical areas within the hospital (i.e., admission department, emergency department, intensive care unit, cardiac laboratories, oncology, surgery, recovery room, surgical, medical, transitional (step down), rehabilitation (drug/alcohol, cardiac), pediatrics, obstetrics and gynaecology, and the delivery room). Ray (1989) discovered that the primary descriptions of "caring" varied from unit to unit. For example, on the surgical unit nurses described "caring" as: advocacy, team interrelationships and technical competency. In contrast, respondents from the pediatric unit, defined "caring" as involving the categories of safety, involvement, and unit maintenance.

The psychiatric unit was not included among the fourteen units in Ray's sample; nevertheless, the results revealed that each clinical unit had its own categories and definitions of caring. This finding attested to the significance of conducting this qualitative study about "caring" with psychiatric nurses working with patients in the psychiatric clinical area.

There were few research studies that addressed the
psychiatric nurses' perspective of "caring" with patients in the hospital setting. Three research studies and one unpublished doctoral manuscript addressed the psychiatric nurse's experience and meaning of "caring" with patients (Forrest, 1989; Kavanagh, 1988; Morrison, 1992; McElroy, 1990).

Two of these studies of caring addressed caring, but the nurses included in these studies were not exclusively psychiatric nurses. Instead, nurses from different clinical areas and positions were included in their studies (Forrest, 1989; Morrison, 1992). This is problematic in context of Ray's study (1989), discussed above, which showed that the meaning of caring varied according to the nurse's clinical area.

For example, in the first study on caring, Forrest (1989) interviewed seventeen registered nurses from different clinical nursing areas about their experience of caring. The nurses in the sample were from medicine, surgery, psychiatry, and pediatric clinical areas. However, it is unknown how many of the nurses from the sample were psychiatric nurses. Phenomenology was used and the data were analyzed, according to Colaizzi's procedure, in order to discover the themes of caring. Two main themes described and explained what caring was for nurses from a variety of settings. These were: 1. involvement with the patient (i.e., being there, respect, feeling with and for the other, and
closeness); and 2. interacting with the patient through touching and holding, picking up cues, being firm, teaching, and knowing the patient well).

In the second study on caring, Morrison (1992), like Forrest (1989) interviewed nurses about their meaning of caring, from different speciality areas (general nursing, midwifery, psychiatric nursing, and pediatric nursing). In Morrison's study (1992), psychiatric nurses were not the primary focus. Morrison (1992) used Personal Construct theory and Repertory Grid Technique to structure interviews with nurses. Morrison (1992) also used existential Phenomenology and phenomenological research methods. Furthermore, Morrison (1992) included nurses from hospital and community settings; again, this is problematic in context of Ray's (1989) study that showed that the meaning of caring changed according to the nurse's clinical area.

A third study pertaining to caring, in psychiatric nursing, was an ethnography of 36 psychiatric registered nurses (Kavanagh, 1988). Kavanagh (1988) provided an ethnography of the psychiatric nurses' experience of their interactions with: patients, each other, non-nursing staff, administrative staff, medical staff, the work environment, the psychiatric/mental health system, and with broader society.

The study was conducted on a psychiatric unit with actively homicidal, suicidal, and gravely disabled adults,
in an urban general hospital. Through participant observation and in-depth focussed interviews Kavanagh (1988) described the culture of the registered nurses on psychiatric units.

The ethnography provided a narrative of the stresses and rewards perceived by nurses, as well as the coping mechanisms used by registered nurses in the setting. No conceptual framework was generated, albeit that was not the purpose of the enthographic study. A grounded theory study with the purpose to generate a grass-roots theory of caring based on the psychiatric nurses perspective provides one more way of understanding "caring" in addition to Kavanagh's (1988) ethnography.

McElroy (1990), using Heidegger hermeneutics methodology, interviewed ten registered psychiatric nurses, with five or more years of experience in a psychiatric setting in order to uncover the clinical knowledge embedded in the experiences expert nurses had with patients. McElroy stated her findings were consistent with Patricia Benner's (1984) seven domains of expert nursing practice. However, McElroy (1990) discovered that Benner's domains of expert practice (which were derived from interviews with nurses from a variety of clinical settings) were insufficient in capturing some specific aspects of psychiatric nursing practice. That is, a domain entitled 'the relationship' emerged in McElroy's study with psychiatric nurses. The
"relationship" domain was separate from, and was added to, Benner's domains of nursing practice.

In addition, McElroy (1990) discovered that expert psychiatric nursing practice was characterized by the psychiatric nurse uncovering danger, acknowledging and marking the boundaries between people, and through the nurses' reflection on practice. McElroy (1990) recommended that further research be done on caring with patients who are assessed as a danger to self and/or others. These findings further supported this grounded theory study in which "caring" is explored specifically in relation to psychiatric nursing. The importance of exploring concepts such as caring and connection have also been cited by practitioners and researchers in the fields of psychology (Gilligan, 1982; Hall, 1990), education (Nodding, 1981), and in the literature on helping professions in general (Roach 1987; Sarason, 1985).

Lastly, "caring" was identified as one of the fundamental core processes in psychotherapy research conducted by the National Institute of Mental Health (Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester, Parloff, 1989; Imber, S., Pilkonis, P., Sotsky., Elkin, I., Watkins., Collins, J., Shea, M., Leber., W., and Glass, D, 1990). In a randomized controlled trial, 250 outpatients diagnosed with depression were randomly assigned to one of the four treatment
conditions: cognitive-behavioral therapy, interpersonal psychotherapy, imipramine medication with supportive management, and placebo with supportive clinical management. There was no evidence of greater effectiveness of one of the psychotherapies as compared to another. However, in a related study on the same database, Imber et al., (1990) discovered that the provision "of a warm, caring relationship... which tend[ed] to relieve the patient's distress and sense of demoralization" was a consistent factor common to the four treatment conditions compared above. Imber et al., further identified caring as a core process which was associated with the improvement of patient symptoms and clinical status. The identification of caring as a core process is significant to nursing since many interventions in psychiatric nursing are derived from the above four treatment conditions: cognitive-behavioral therapy, interpersonal psychotherapy, imipramine medication with supportive management, and supportive clinical management (Antai-Ontog, 1990a; 1990b; Baumann, 1990; Bishai, 1990; Brisson, 1990; Jiwani, 1990; Johnston, 1990a; Johnston, 1990b; Johnston, 1990c; Martin and Westwell, 1990; Westwell and Forchuk, 1990). Moreover, the identification of caring as a core process associated with psychotherapy success (Hall, 1990), lends support to conducting this grounded study, which attempts to explicate what caring is from the perspective of psychiatric nurses within hospitals.
Theoretical Literature

In three reviews of the literature (Bradshaw, 1995; Kyle, 1995; Morse, Bottorff, Neander, and Solberg, 1991), there were two major criticisms cited about the concept of caring. The first criticism pertained to the discrepancy between caring as expressed in contemporary nursing theories, and caring as expressed in clinical practice within the hospital. This discrepancy between the meaning of caring in theory and the meaning of caring in hospitals has led to criticisms of caring from nurses in clinical practice. That is, caring in theory was experienced as abstract, intangible, and thus having limited utility in clinical nursing practice. The second criticism about the concept of "caring" pertained to the private language found in nursing theories. That is, the language of theories in "caring" has been cited as unfamiliar to nurses in practice, and not easily related to nursing activities in the workplace (Barker and Reynolds, 1994; Levine, 1995). In the following paragraphs these two criticisms are discussed as they appeared in the theoretical literature.

The first criticism of caring, pertaining to the discrepancy between the meaning of caring in theory with the meaning of caring in hospital settings, was exemplified through the following situation. Authors noted that there were few descriptions pertaining to physical care in theories of caring (Barker and Reynolds, 1994; Bradshaw,
1995; Kyle, 1995; Morse, Bottorff, Neander, and Solberg, 1991). This was in contrast to the realities of nurses in clinical practice in the hospital setting, in which the nurse's work and the management systems used to document nursing services focussed on the physical care of the patient. For example, studies which have examined the use of patient classification systems illustrate this discrepancy between the meaning of caring in theory and the meaning of caring in practice. Patient classification systems (PCS) are management instruments which prescribe the definition of patient's needs for nursing care, and the nurse hours expended per patient. That is, the definition of a patient's need for nursing care is defined by PCS (Campbell, 1988). Nurses have reported dissatisfaction with PCS's ability to account for the emotional, spiritual, and cognitive needs of patients (Albiez-Gibbons, 1986; Benner, 1989; Campbell, 1988, Dale and Mabel, 1983, McNeal, Hutelmyer, and Abrami, 1987; McHugh, 1986; Nagaprasana, 1988; Schroder and Washington, 1982). For example, in a self-administered questionnaire survey of 218 nurse executives from 300 randomly selected hospitals across Canada, the greatest area of dissatisfaction was reported to be the PCAS's ability to capture: the educational patient needs (33%), counselling needs (42%), and emotional support needs of patients (31%) (Cockerill and O'Brien-Pallas, 1990).
The second criticism in the theoretical literature pertained to the 'language' used in nursing theories. Nurse theorists, such as Virginia Henderson, stated that nursing theories have tended to be complicated or not vivid enough to enable the nurse to remember the theory (Henderson as cited in Smith, 1989). Other nurse theorists, such as Myra Levine (1995), have noted that the language of nursing theories has been unfamiliar and not easily related to nursing activities in the workplace. According to Levine (1995), the unfamiliarity of the language in nursing theories has compromised the introduction of theory into nursing practice settings (Levine, 1995). Furthermore, Barker and Reynolds (1994) state that the use of "private language" and the manipulation of specific words, not used in nursing practice or found in an English dictionary has created obstacles to the wider discussion and debate of "caring" in nursing.

Both Barker and Reynolds (1994) and Levine (1995) state that in order for all nurses to participate in discussion and debate of "caring" there needs to be access to a common vocabulary. These concerns, about the concept of caring, attested to the importance of conducting grounded theory research in which a common vocabulary, based on the experience and meaning of caring, could be articulated. The main criterion for the adequacy of a grounded theory is that the theory is to be readily understandable to,
recognized, by those concerned (Glaser and Strauss, 1967; Strauss and Corbin, 1990).

According to nurses who have researched and analyzed the concept of caring, there is a need to specify what caring is in terms of its processes and dimensions (Gaut, 1986; Griffin, 1983; Valentine, 1989a, 1989b). The sources for theory development in nursing have been varied. For example, some theories in nursing were derived from the theorist's own observations and experiences in practice. Then there are other theorists who borrowed concepts and theories from other fields such as psychology, education, sociology, natural sciences, and anthropology, as the primary basis for theory development (Wesley, 1995). Some theorists who have borrowed concepts and theories from other fields as opposed to developing theory based interviews with nurses have been criticized as inconsistent. One example of this is Sister Callista Roy's adaption model of nursing. This model has been criticized as inconsistent, because in developing her theory, Roy borrowed concepts from behaviouralist thought, systems theory, and humanism (Blue, Brubaker, Fine, Kirsch, Parazian, Riester, 1989).

In Blue et al's., (1989) evaluation of Sister Callista Roy's adaption model of nursing, they point out that "assumptions borrowed from behaviouristic thought and systems theory are difficult to reconcile with the assumptions of humanism" (p. 335). These contradictions
further underlined the importance of conducting this research, based on the psychiatric nurses' experience and meaning of caring with patients in practice. Generating theory, based on nurse descriptions of "caring" with patients, can help to minimize the potential for the distortions which can occur when predetermined concepts from different theoretical orientations are applied to nursing practice.

Over the last two decades, there has been increased recognition that "there is much theorizing left to do and practitioners are needed to help identify it" (Levine, 1995, p.13). Myra Levine (1995), a nurse theorist, asserted that each theorist "offers a fresh vision, familiar concepts brought together in bold, new designs" (p.14). She also encouraged that there be a variety of theories "for there is no global theory of nursing that fits everything" (p.13). These recommendations along with the concerns and criticisms associated with the concept of caring in nursing provided adequate incentive to explore "caring" with psychiatric nurses in a grounded theory study.
Research Questions

1. What does "caring" mean to psychiatric staff nurses working with patients in hospitals on acute general psychiatric units?

2. What is the basic social process associated with the psychiatric nurses' experience of what "caring" means with patients within acute general psychiatric units hospitals?
Definition of Terms

This section on the definition of terms is provided so that the terms used in the above research questions are operational. However, it is important to note that "caring", which is the phenomenon of interest in this study was not defined. This means that "caring" was introduced as the phenomenon of interest to be explored with nurses, and not as an arbitrary label. Consequently, in this study, psychiatric nurses were left to define "caring" within the context and language of their experience in hospital settings, in order to give it meaning.

1. Caring: Psychiatric nurses' work with patients and is specified by the nurses in this study.

2. Staff Nurse: a generalist clinical nursing role held by a registered nurse in a first level clinical nursing position in a hospital setting (Chaska, 1992). A psychiatric staff nurse is a first level clinical nursing position in the clinical area of psychiatric nursing within the hospital setting.

3. Patient: "a person who is under observation, care, and treatment in a psychiatric facility" (Ministry of Health of Ontario, 1993b, p. 36)
4. Hospital: Acute care hospitals with patient hospitalization stays of thirty-five days or less (Ministry of Health of Ontario, 1988).

5. Psychiatric Facility: "means a facility for the observation, care, and treatment of persons suffering from mental disorder, and designated as such by the regulations [of the Ontario Mental Health Act]...mental disorder means any disease or disability of the mind (Ministry of Health of Ontario, 1993b, p. 36-37). In this study, acute general psychiatric unit will be used to refer to psychiatric facility.

6. Basic Social Process (BSP): is a core variable or main pattern which represents the stories told by the nurses about "caring" with patients. The BSP "accounts for most of the variation in a pattern of behaviour and which helps to integrate other categories that have been discovered in the data" (Mullen and Reynolds as cited in Carpenter Rinaldi, 1995, p. 159). The BSP is a conceptual label that is broad enough to encompass the main pattern of "caring" described by psychiatric nurses with patients. That is, the BSP represents the stories told by the nurse participants in the study. The BSP earns its way into the theory through its repeated presence in the actual participant data.
Who am I as a Researcher? A Personal Note

Locke, Spirduso, and Silverman (1993) discussed the importance of "coming clean about the ways in which personal biography will influence the research process" (p. 114). For these reasons, I will comment, briefly, on why this study was important to me. Furthermore, this discussion informs the reader about the position from which I analyzed and interpreted the data. This "coming clean process" helped me to be aware of my views during the research process and helped me to differentiate my views from the nurse participants' views in this study.

I pursued this study because nursing as a discipline, specifically psychiatric nursing, has not sufficiently addressed the processes and dimensions of caring. For both personal and professional reasons, I felt it necessary to develop my own understanding of caring at the same time as making a contribution to the knowledge of nursing and psychotherapy.

My espoused values are eclectic. They have been supported and developed by an undergraduate and graduate university education and clinical experiences in nursing, psychiatric-mental health nursing, and applied psychology and counselling in educational and clinical settings. Specifically my eclectic views arose from my clinical experiences with patients and clients in diverse settings. I have had clinical experience in medical-surgical intensive
care nursing, acute general psychiatric nursing, maternity and postpartum nursing, pediatric nursing and medical-surgical nursing in hospital settings. In the community, my clinical experiences ranged from working with clients as a community health nurse to working with clients through the department of psychology in a community health centre and in psycho-educational clinic.

Throughout my education and practical clinical experiences many of my professors and clinical advisors espoused an eclectic approach with clients and patients. Consequently, I was exposed to a variety of nursing theories, and models of psychotherapy.

theories range from the objectivist perspectives of behaviourism to subjectivist perspectives including, but not limited to, hermeneutical thought.

In so far as my education and clinical experiences in applied psychology and counselling were concerned, my professors and clinical supervisors were supportive of an eclectic approach. Consequently, I was exposed to and influenced by ideas from psychoanalytic, interpersonal, person-centred, cognitive-behavioural, gestalt, transactional, and existential psychotherapies.

Interestingly, some of the nursing theories and models were derived from the above psychotherapies. For example, a substantial part of Peplau's (1952; 1982) Interpersonal Model of Nursing was derived from Harry Stack Sullivan's Interpersonal Therapy (as cited in Peplau, 1952).

All of these theorists have contributed in one way or another to the development of my own beliefs and assumptions toward person, environment, health, and caring. Like Levine (1995), I believe each theorist "offers a fresh vision, familiar concepts brought together in bold, new designs" (p.14). I am an advocate of the notion that there be a variety of theories "for there is no global theory of nursing that fits everything" (Levine, 1995, p.13).

Moreover, I believe that each client and patient is unique and in order to work effectively with different clients and patients, it is "necessary to borrow ideas,
insights, and techniques from anywhere I can find them" (Moursund, 1993, p.1). My eclectic approach was further supported and affirmed when I realized that there is no research which points to any one approach or theory as superior (Luborsky, Singer, and Luborsky, 1975 cited in Moursand, 1993, p.7). No differences in effectiveness with patients were reported when these researchers examined comparisons of behaviour therapy versus psychodynamic therapy, time-limited versus unlimited therapy, and group versus individual therapy. Furthermore, Moursand (1993) also cited Smith, Glass, and Miller's (1977) study, in which no consistent differences in effectiveness with patients were found among the different schools of psychotherapy. Parallel comparisons among nursing theories are virtually nonexistent but I believe similar results would follow in the nursing context. This is because most nursing theories are based on the aforementioned different schools of psychotherapy.

I believe my journey of understanding my own biography in relation to this research first began on a conscious level when I seriously reflected on the tentative nature of theory. In Webster's dictionary, theory is defined as "a mental viewing, a contemplation, a speculative idea or plan as to how something might be done...a mere conjecture, or guess" (Neufeld and Guralnik, 1988, p. 1387). Thus for me a theory of caring is conceptualized as tentative and as
having multiple versions, and not as "dogmatic....[or a positive, arrogant assertion of opinion]" (Neufeld and Guralnik, 1988, p. 404). These ideas about the tentative nature of theory encouraged me to explore the multiple realities or ways of caring with other psychiatric nurses. Moreover, my reflection upon the notion of ideology was also important to understanding how my biography influences the research process. According to Webster's dictionary, ideology involves the "body of ideas on which a particular political, economic, or social system is based" (Neufeld and Guralnik, 1988, p. 670). Moreover, ideology has a tendency:

- to be accepted as truth or dogma rather than as tentative philosophical or theoretical formulations,
- despite the fact that ideologies are modified in accordance to sociocultural changes" (Theordorson and Theordorson, 1969, p. 195).

These ideas about ideology and the tentative nature of theory enabled me to appreciate the theoretical formulations of others as a product of social cultural forces. Furthermore, through my reflection of the notion of ideology, I became sensitized to the importance of identifying and bringing my own views out into the open. In doing so I have been able (as much as possible) to distinguish, and set aside, own my views so that the views of others about caring were allowed to emerge in this study.

Therefore, these are some factors which have maintained
my view that "the long-predominance of the major theories is over and that an eclectic position has taken precedence" (Garfield and Bergin cited in Corsini, 1989, p. 9). Based on this belief, I view theory or ideas about caring as tentative in nature, and that theory needs to change in order to meet the conditions that come from the unique interaction between the patient and nurse.

It is therefore of no surprise that I use different theories of caring, from which I take different ideas. Together, these ideas become my own espoused theory of caring. Therefore, I follow my theory of caring but I do so tentatively and with a flexibility that allows the other person's theory of caring to emerge as well. My eclectic view of caring is a major facet of my own education and experiences.

My eclectic stance and the absence of a comprehensive articulation of caring in the literature illustrate why this study on caring has had for me personal, academic, and professional significance.
METHODOLOGY

Research Design

Generally, the purpose of qualitative research is to explore and understand, as opposed to test or prove, phenomena (Marshall and Rossman, 1989). The qualitative research design of grounded theory methodology was used to discover and understand the basic social process of "caring" and its core processes from the perspective of psychiatric nurses (Corbin and Strauss, 1990; Glaser and Strauss, 1967; Strauss, 1987; Strauss and Corbin, 1990; 1994). One of the basic purposes of the grounded theory method is to generate theory, rather than verifying preconceived theory (Glaser and Strauss, 1967; Skolol Wilson, 1977; Strauss and Corbin, 1990; 1994).

According to Strauss and Corbin (1990), grounded theory methodology is underpinned by the philosophical orientation of Pragmatism (i.e., Dewey, 1925; and Mead, 1934), and the sociological orientation of Symbolic Interactionism (Blumer, 1969). The three basic tenets of grounded theory methodology are: change, actions and interactions, and context. Although these three tenets of grounded theory methodology emanated from pragmatism and symbolic interactionism, grounded theory is a separate methodology.

The first tenet of grounded theory methodology is change. That is, phenomena are viewed as constantly changing
in response to evolving conditions (Strauss and Corbin, 1990; 1994). Change is conceptualized as a process. Evidence of process comes from noting "changed actions in response to changed conditions (Strauss and Corbin, 1990, p. 171). Furthermore, "the notion of changing conditions brings time and movement into the analysis...the duration or amount of time between each sequence is not as important as the conception of its passage or movement [through changing conditions] (Strauss and Corbin, 1990, p. 150).

The second tenet of grounded theory methodology is actions and interactions. That is, the actions and interactions of the participants are the basis for theory building. The actions and interactions of participants are processual and evolving in nature. People construct meanings of their experiences based on their own interpretations of their actions and interactions with themselves (i.e., self-reflection) and with others (Strauss and Corbin, 1990; 1994).

The third tenet of grounded theory methodology is context. Context is central to understanding the actions and interactions of the participants. Context represents the specific conditions in which the actions and interactions of a person are embedded (Strauss and Corbin, 1990; 1994).
Gaining Entry to the Field

Thesis committee approval and approval from the ethical review committee was obtained from the University of Toronto. Then the proposal was approved by the Nursing Research and Publication Committee, Nursing Research Committee, Research Project Advisory Committee and Ethic Committees of the three participating urban, university affiliated hospitals.

An introductory letter (Appendix A), participant selection criteria (Appendix B), a copy of a standardized study information sheet (Appendix C), and consent form (Appendix D) were sent to nurse administrator and managers of the three acute general psychiatric units.

A meeting was arranged with each of the nursing unit administrators, and nursing unit managers from each of the general psychiatric units to discuss the study. At this meeting, I asked for assistance with some practical issues such as when the best days and time frames were to interview nurses, times when rooms for interviewing were available, days when patient admissions to hospital were less frequent, and a schedule of the activities on the unit. Having established the days and time frames with the nursing unit administrator and nursing managers, I then made myself available during these days and times for possible
interviews with psychiatric nurses. Whether an interview was conducted was always left to the discretion of the psychiatric nurse.

Moreover, I also asked the nurse managers and administrator for assistance in identifying which staff on the unit were fulltime and regular part-time registered nurses. At this meeting, I also asked the nurse administrator to give me an idea of the number of years of experience each nurse had so that I could ensure that there was variability in the sample.

Then, I placed a copy of the study information sheet (Appendix C) and the consent form (Appendix D) in each of the psychiatric nurses' mailboxes, located on the psychiatric unit. A self-addressed stamped envelope was also placed in the psychiatric nurse's mailbox should he or she decide to send me any correspondence as opposed to calling me on the phone. For some nurses a telephone call would entail long distance charges.

In addition, the nursing unit administrator and nurse managers provided me with a tour of the setting and introduced me to the staff available on that particular shift. Moreover, each of the nurse administrator and nurse managers briefly informed the psychiatric nurses of the study and my name through their usual routes of communication (ie., nurse meeting, nurse communication book, and bulletin board).
Settings

The study was conducted at three, urban, teaching hospitals on three general acute psychiatric units. Two of the hospitals were general hospitals and one was a psychiatric hospital. The patient population was not specific, and as such the patients on the psychiatric units had a variety of diagnoses associated with major affective disorders, dissociative identity disorders, addiction related disorders, anxiety disorders, psychotic disorders, and schizophrenia. The number of patient beds in the first setting was 35 beds. The second setting had 15 beds, and the third setting had 24 patient beds. The average length of stay at each of the three hospitals was 35 days in the first setting, 30 days in the second setting, and 30 days in the third setting. The number of full-time nurses working on each of the three units was twelve in the first setting, nine in the second setting, and fifteen in the third setting. A nurse with an employment status of full-time worked five days per week or a total of 37.5 to 40.0 hours per week. The number of regular part-time nurses was three in the first setting, seven in the second setting, and five in the third setting. Nurses with an employment status of regular part-time worked an average of 24 hours a week over two to four days during the week. The nurses in one of the two general hospitals, in this study, worked both twelve
hour and eight hour work day, evening, and night work shifts. The psychiatric nurses from the other two hospitals (ie., one a general hospital and one a psychiatric hospital) worked eight hour day, evening, and night work shifts.

As indicated in Table 1, each of the three general psychiatric units utilized a primary nursing approach within a multidisciplinary team as their method for providing nursing care. In primary nursing, the primary nurse coordinates the patient's care in consultation with the health care team and the associate nurse (Beck, Rawlins, and Williams, 1984; Zerwekh and Claborn, 1994). In the primary nursing approach practiced in the three settings of this study, one psychiatric nurse was designated as the patient's primary nurse for the duration of the patient's hospitalization. The primary nurse maintained an on-going relationship with the patient and worked with the health care team to implement the patient's care in a consistent and continuous manner. In the primary nursing system of nursing care delivery, the patient was also assigned an associate nurse. The associate nurse also followed patients for the duration of their hospitalization stay. When the primary nurse had completed his or her work shift for the day, the associate nurse continued with the plan of care coordinated by the primary nurse. Therefore, primary nursing is a system of nursing care delivery that facilitates continuity of care, even though the primary nurse is not
available or present on a twenty hour basis. Also the psychiatric nurses stated that a primary nursing approach allows the patient to work with one consistent person.

The nursing division at the three hospitals advocated theoretical pluralism. This means that psychiatric nurses were free to choose a theory of their choice for the conceptualization and implementation of the patient's care. However, one of the general hospitals in this study explicitly and formally advocated Roy's Adaptation Model of nursing as the method for documenting the nurse's assessment of the patient. However, these psychiatric nurses stated that they needed to supplement Roy's theory with other theories and their own personal theories of caring. The nurses from the other general hospitals and the psychiatric hospital also stated they used a variety of theories and their own personal theories in providing nursing care. The nurses made specific reference to using some principles and ideas from Neuman's Systems Model of Nursing (1989), and Peplau's Interpersonal Model (1952; 1991). Also some nurses referred to using principles from existential therapies, behavioural therapies, cognitive therapies, cognitive-behavioural therapies, and psychoanalytic therapies. However, the psychiatric nurses did not refer to any particular theorist in these areas. The nurse's theoretical affiliations were not explored in this study because the purpose of this study was to extract a grass-roots theory of
caring embedded in the psychiatric nurse's experience and meaning of caring with patients in daily practice. The characteristics associated with each of the three settings of this study, described above, is summarized in Table 1.
Table 1

**Setting Characteristics Across Three Hospital Settings**

<table>
<thead>
<tr>
<th></th>
<th>Setting #1</th>
<th>Setting #2</th>
<th>Setting #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching Hospital</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>General Hospital</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychiatric Hospital</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Psychiatric Unit</td>
<td>Acute Care</td>
<td>Acute Care</td>
<td>Acute Care</td>
</tr>
<tr>
<td>Psychiatric Patient Population</td>
<td>Non-Specific</td>
<td>Non-Specific</td>
<td>Non-Specific</td>
</tr>
<tr>
<td>Number of Beds</td>
<td>35 Beds</td>
<td>15 Beds</td>
<td>24 Beds</td>
</tr>
<tr>
<td>Full-Time R.N.</td>
<td>12</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Part-Time R.N.</td>
<td>3</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>35 Days</td>
<td>30 Days</td>
<td>30 Days</td>
</tr>
<tr>
<td>Nursing Approach</td>
<td>Primary Nursing with a Multidisciplinary Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theoretical Model</td>
<td>Pluralism</td>
<td>Roy Adaptation Model</td>
<td>Pluralism</td>
</tr>
<tr>
<td>Urban/Rural</td>
<td>Urban</td>
<td>Urban</td>
<td>Urban</td>
</tr>
</tbody>
</table>
Description of the Sample

The aim was to obtain as heterogenous a sample as possible. Seventeen psychiatric nurses were included in this sample. Fourteen nurses had a full-time employment status and three had a regular part-time status. Years of experience in psychiatric nursing ranged from one year to twenty-seven years (mean = 10.03 years). Years of experience in nursing ranged from one year to forty-three years (mean = 13.53). Ages of the psychiatric nurses ranged from 24 years to 60 years of age (mean = 40.88 years). Table 2 shows the psychiatric nurses' demographic information in terms of employment status, education, gender, and cultural groups. It also provides specific information on the distribution of nurse demographics across the three settings of this study. Table 2 shows that each of the demographic variables were basically similarly distributed across the three psychiatric settings.
Table 2

Demographics of Participants Across Three Settings

<table>
<thead>
<tr>
<th></th>
<th>Setting 1</th>
<th>Setting 2</th>
<th>Setting 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Participants</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Time</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Part Time</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Experience in Psychiatric Nursing (Years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-9</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>10-19</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>&gt;20</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Experience in Nursing (Years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-9</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>10-19</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>&gt;20</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Degree</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Male</td>
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<td>1</td>
</tr>
<tr>
<td>Cultural Group</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Black</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Oriental</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Age (Years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24-34</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>35-59</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>≥60</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
Sampling Method

The eligibility criteria for this study included staff nurses who were registered nurses with the College of Nurses of Ontario, and had an employment status of full-time or regular part-time staff (Appendix B). Sample selection was initially done by convenience (Strauss, 1987). This meant that any psychiatric nurse who came forward, and met the above eligibility criteria, was interviewed.

The first round of interviews with each of the psychiatric nurses stopped when the same data emerged repeatedly and no new information emerged from the interviews. Seventeen nurses were interviewed and from these interviews a tentative model was built. This tentative model reflected the categories of caring that were relevant to the psychiatric nurses; and, were the categories that were repeatedly spotted when each of the psychiatric nurses' descriptions of their experience and meaning of "caring" were compared.

Sampling was deliberate. That is, in order to test the theoretical relevance and representativeness of information, sampling involved deliberately seeking out psychiatric nurses from a variety of backgrounds. For example, if a nurse with two years experience said that keeping the patient safe was one of the ways in which caring was accomplished, then I would deliberately seek out psychiatric nurses with more or less than two years of experience. For
instance, I sought out a nurse with twenty years experience and interviewed her about her experience and meaning of caring. This was done to see if keeping the patient safe also emerged as a relevant category of caring for nurses with different years of experience. The same was done for educational background (ie., registered nurses with diploma and registered nurses with a degree), cultural group, gender, and employment status (full-time and regular part-time).

Seventeen nurses participated in this study. Two of the nurses left the place of employment prior to the second interview. Consequently, the results were not discussed with them. All seventeen psychiatric nurses completed a 60 to 90 minute interview, albeit some were done in twenty minute intervals.
Data Collection

The data were collected through interview methods and a method of sampling called theoretical sampling (Strauss and Corbin, 1990; 1994; Hutchinson, 1986; Carpenter Rinaldi, 1995). The constant comparison method was used to analyze the data and involved two analytic procedures of: 1. asking questions of the data; and 2. making comparisons between incidents in the interviews to verify the evolving theory (Strauss and Corbin, 1990; 1994; Hutchinson, 1986; Carpenter Rinaldi, 1995). Consequently, there was a back and forth movement between data collection and analysis. However, for clarity, the methodology is divided artificially into two conventional parts of: data collection and data analysis. The interviews with the seventeen psychiatric registered nurses occurred between February and August, 1995. Data collection and analysis of the transcribed interviews occurred between February, 1995 and September, 1996.

Interview method

Interviews were audiotaped and conducted using an open-ended, semi-structured format. The possibility of recall bias was decreased with the taping of all the interviews and provided a detailed precise record of the interview content (Strauss and Corbin, 1990; 1994). An interview guide was used for the interviews. There was an initial interview
guide and a modified interview guide. The initial interview guide, shown in Appendix E, was modified to reflect the content areas of the questions which were verified by the psychiatric nurses to be relevant to their experience and meaning of caring. The modified interview guide is shown in Appendix F. Questions one to four were the non-specific questions asked consistently of all the participants from both the initial interview guide (Appendix E) and the modified interview guide (Appendix F). The difference between the two interview guides was that I asked the psychiatric nurses to describe their caring "role" on the initial interview guide (Appendix E). Constant comparisons of data revealed that the psychiatric nurses did not view caring as a role. Rather caring was described as encompassing everything nurses did in psychiatric nursing. Consequently, in the modified interview guide, in questions one to four, I revised the initial interview guide (Appendix E) by asking the nurses to describe their "caring" as opposed to "caring role" on the modified interview guide (Appendix F).

The participants were informed there were no wrong or right answers, and that some of the language used in the questions may not be relevant to the psychiatric nurses. The psychiatric nurses were briefed on the research process in a detailed way, so that the importance of their contribution was emphasized as crucial to the emergent quality of this
In addition to the four non-specific questions on the initial interview guide, there were specific questions. For example, questions five to eleven represent the specific questions asked on the initial interview guide (Appendix E). These questions were derived from the literature. Prior to discussing the modified interview guide, the literature which led to the development of probe questions for the initial interview guide are presented.

The Development of the Initial Interview Guide

The following is an account of how the questions on the initial interview guide (Appendix E) were developed. The questions on the initial interview guide (Appendix E) were derived from a preliminary review of the literature on the factors that influence the psychiatric nurses' experience and meaning of their caring with patients. Each question derived from the literature was considered provisional until the nurses verified them to be relevant to their experience and meaning of "caring".

In accordance to the grounded theory methodology approach, the primary purpose of the literature review was to facilitate the development of the questions to be used for the initial interview guide (Appendix E). The information and the stories the psychiatric nurses shared became the primary basis for any modifications of the
questions on the initial interview guide. The questions on the initial interview guide were used tentatively, until the incoming data from the nurse participants sharpened the focus of the questions and the study (Baker, Wuest, and Noerager Stern, 1992; Strauss and Corbin, 1990).

In the literature surveyed, it was revealed that the nurse's experience and meaning of caring was discussed in terms of the nurse's conceptualization of nursing role. The notion of caring in the general nursing literature, especially literature from the 1960's, was equated with discussions and descriptions of role. The nurse's role was documented to be influenced by the following seven factors: 1. dimensions of professional nursing practice; 2. role discrepancy and incongruent expectations between the nurse and work setting; 3. patient rounds; 4. nursing care delivery models used in hospitals; 5. nurse management leadership styles; 6. nursing role models; and 7. nursing documentation systems in hospitals.

Each of these factors played a role in developing the initial interview guide and are presented (and referenced accordingly) in the sections below.

**Dimensions of Professional Nursing Practice.** There has been a considerable amount of research on the behaviours and qualities associated with professional nursing practice (Alexander, Weisman, and Chase, 1982; Anderson, 1973;
Curtin, 1990; Dennis and Prescott, 1985; Hendrickson and Doddato, 1989; Katzman and Roberts, 1988; Norris, 1989; Prescott and Bowen, 1985; Prescott, Dennis, Creasia, and Bowen, 1985; Prescott, Dennis, and Jacox, 1987; Rothrock, 1985; Swider, McElmurry and Yarling, 1985; Reverby, 1987; Tarsitano, Brophy, and Synder, 1986; Weiss, 1985). For example, some specific behaviours and qualities associated with the nurse's professional role include genuine concern for patients, commitment, intelligence, maturity (Dennis and Prescott, 1985), and caring (Curtin, 1990; Morris, Solberg, Neander, Bottorff, and Johnston, 1990; Norris, 1989; Reverby, 1987). However, Norris (1989) pointed to an inadequacy of 'caring' as a conceptual definition for a quality or behaviour of professional nursing practice. Norris (1989) suggests that concepts such as caring need to be further articulated in an explicit behavioural manner. Moreover, the review of the literature showed that there was an absence of empirical and theoretical literature on the psychiatric nurse's perspective of "caring" in hospitals. The literature in this area led to the development of questions one to four on the initial interview guide (Appendix E). Through questions one to four the psychiatric nurse is asked to articulate "caring" in an explicit manner by having nurses talk about their behaviours, emotions, and reflections as they pertain to their experience and meaning of caring.
**Nurse role discrepancy and nurse expectations.** Studies conducted by Forrester (1988) and Oechsle and Landry (1987) showed that nurses believe that the values which underpin service and professional role orientations (i.e., caring, nurturing, holistic care) existed less in clinical practice than the bureaucratic values of quantitative measurement. Conflict arising from competing bureaucratic, professional, and service orientations within a work setting is regarded by several authors as the basis for understanding the nurses' experience or meaning of their caring role with patients in hospitals (Corwin, 1961; Corwin and Taves, 1962; Kramer, 1974). This finding led to question five on the initial interview guide (Appendix E), in which the psychiatric nurses were asked about the factors that influenced their work with patients.

Other factors which influenced the nurses' conception of their role pertained to disagreements that arose between professionals from different disciplines (Prescott and Bowen, 1985). Factors such as the type of information exchanged between professionals also influenced the nurses' conception of their role. This point, although related to disagreements, is addressed in the next section in which the type of information exchanged is the factor emphasized; and, is examined for its influence on the nurse's conceptualization of role. Disagreements which arose between nurses with different levels of education and competence
also influence the nurses' conception of their role. These situations led to the development of question six on the initial interview guide (Appendix E). Question six asks the psychiatric nurses about their experience of caring when they participate in discussions in team meetings. The nurse's experience and meaning of caring when interacting with the health care team was introduced as a probe for accessing the nurse's meaning of caring.

Moreover, Ward (1986) addressed role discrepancy and related it to job dissatisfaction. Others like McCloskey and McCain (1987) discussed the implications of role discrepancy on the nurses' conceptualization of their roles. Generally, these authors suggested that the inability of nurses to practice their caring role as they envision it may lead to decreased professionalism, lowered organizational commitment, and job dissatisfaction. These findings suggested that asking the nurses how they feel about the work they do with patients, in the setting, may provide insight into the psychiatric nurse's experience and meaning of caring with patients. It is for this reason that question two was placed on the initial interview guide (Appendix E).

The nurse's conceptualization of role and patient rounds. The nurses' perception of their role was influenced by the manner in which they participated in medical rounds (Busby and Gilchrist, 1992). For example, Busby and
Gilchrist (1992) investigated the role of the nurse in hospital medical rounds. These authors reported that the nurse's function in meetings with medical staff mostly involved the nurse providing information. Most of the information provided pertained to the patient's physical needs, and to a lesser degree pertained to the psycho-social needs of the patient. These findings suggested that asking the psychiatric nurses about their experience of their caring role in team meetings may further prompt the nurse to articulate what caring means. Consequently, question six asks the psychiatric nurses about their experience and meaning of caring in team meetings (Appendix E).

Nurses' conceptualization of their role and the type of nursing care delivery model used in the hospital. The nursing care delivery model used to provide nursing care (ie., primary or team nursing) also influenced the nurses' experience and meaning of their role with patients in hospitals (Alexander et al., 1982). In primary nursing, the patient is assigned to one primary nurse and an associate nurse. In primary nursing, the same nurses follow the patient from admission to discharge from hospital. The primary nurse maintains an on-going relationship with the patient during the patient's hospitalization stay. Moreover, the primary nurse develops, maintains, and coordinates with the health care team the implementation of the care plan for
the patient (Beck, Rawlins, and Williams, 1984; Zerwekh and Claborn, 1994).

In contrast, team nursing is a method of providing nursing care in which patients are assigned to a team of nurses by a team leader or a charge nurse. In team nursing, more than one nurse provides the patient's care during any individual work shift of eight or twelve hours. For example, in one eight hour or twelve hour day, one nurse may be assigned as the medication nurse and would be responsible for giving patients their medications. Another nurse may be assigned as the treatment nurse for the patient, while a licensed practical nurse or nurse assistant may be assigned to the hygienic care for that same patient (Beck, Rawlins, and Williams, 1984; Zerwekh and Claborn, 1994).

Alexander et al., (1982) found that primary nursing significantly predicted the nurses' perceived autonomy with patients, and their role with patients. This finding led to the development of question ten on the initial interview guide and suggested that asking about the nursing approach used to organize care would further encourage the psychiatric nurses to articulate their experience and meaning of caring in hospitals (Appendix E).

*Nurse's conceptualization of role and nursing management leadership styles.* Alexander et al., (1982) found that the nurses' attitudes towards their nurse
manager's responsiveness and leadership significantly predicted the nurses' perceived autonomy and their role with patients. The nurses' perceived autonomy may have some bearing on the psychiatric nurses' experience and meaning of "caring"; therefore, this finding led to the development of question eight on the initial interview guide (Appendix B). In question eight, the psychiatric nurse is asked to reflect on the extent to which the leadership style on the unit supported the nurses' meaning of their caring role with patients.

Nurse's conceptualization of role and nurse role models. Nurses' conceptualization of their role was influenced by the nurse's role models, which included faculty role models and role models from the clinical setting. Professors and instructors were cited as faculty role models. In contrast, nurses administrators and physicians were cited as comprising clinical role models (Green, 1988). Researchers have reported that bureaucratic, professional, and service orientations of the nurse were associated with different role models (Croker and Brodie, 1974; Green, 1988; Lynn, McCain, and Boss, 1989). For example, faculty role models were associated with professional and service orientations of care (i.e., focus on nurturing and holistic care). In contrast, clinical role models in the hospital setting tended to be associated with
bureaucratic orientations (quantitative measurement and cost analysis). These findings suggested that asking the nurse participants about their role models may provide insight into the nurse's experience and meaning of "caring" with patients in hospitals. Consequently, question nine on the initial interview guide (Appendix E) addresses the extent to which nursing school faculty, instructors, and clinical colleagues have supported the psychiatric nurse's caring role with patients.

The nurse's role orientation and nursing documentation systems in hospitals. There were varying attitudes and perceptions of what the nurse's role involved according to registered nurses (Bradley, 1983; Pilkington and Wood, 1986; Ray, 1989; Stanton, 1986; Von Essen and Sjoden, 1991), student nurses (Buckenham, 1988; Talotta, 1990), patients (Brown, 1986; Reiman, 1986; Von Essen and Sjoden, 1991), and other professionals (Anderson, 1973; Katzman and Roberts, 1988). These authors suggested that transitions occurred in the nurses' conceptualization of their role as nurses moved into the hospital setting to work. Nurses reported they had to adapt to increasingly more bureaucratic orientations in the hospital setting. This meant their actions were directed by cost-benefit values and primarily focussed on the physical care of the patient (Kinney, 1985). Kinney (1985) reported that maintaining a service and professional orientation was difficult in hospitals. Ketefian (1985)
recognized that the nurses' orientation towards their role needed to be linked with the particular context and setting in which the nurse worked. This suggested that some settings reinforced certain orientations over others. It was for this reason that question eleven was included on the initial interview guide (Appendix E).

Furthermore, Kinney (1985) suggested that the bureaucratic, service, and professional orientations needed to complement, not compete, with the other. However, in hospitals, patient classification systems are used. These patient classification systems have a tendency to emphasize bureaucratic orientations to care at the expense of professional and service orientations of care (Campbell, 1988). Authors have reported that patient classification systems are one of the major tools used for cost analysis, nursing resource allocation, and focus primarily on the physical needs of the patient (Albiez-Gibbons, 1986; Cockerill and O'Brien, 1990). In all three hospitals in this study, computerized patient classification systems were used to document and prescribe the nursing services provided to a patient. Patient classification systems prescribed the number of hours the nurse spent with a patient, and the services the nurse provided per patient. These findings suggested that asking the nurse participant about patient classifications systems may provide insight into the nurse's experience and meaning of "caring" with patients in the
hospital setting. Consequently, question seven, on the initial interview guide, asked psychiatric nurses to describe the extent to which patient classification systems used in daily practice supported their caring role with patients (Appendix E).

Furthermore, question seven also asks the psychiatric nurses about other documentation systems used in daily practice. The impetus to ask about documentation systems, came from a study which evaluated a daily assessment and documentation form (Chiovitti, 1993). In this study, the form was evaluated for its ability to account for patient problems associated with the psychiatric nurse's perception of treatment difficulty. Chiovitti (1993) reported that the daily assessment and documentation form did not account for three interpersonal processes: 1. patient isolation and withdrawal from relationships; 2. wide variability in moods; and 3. lack of patient involvement in treatment. These findings suggested that these are problems that nurses encounter in their role with patients, but are not accounted for on formal systems used for funding and for determining nursing services to be provided to patients. Consequently, asking the psychiatric nurse about documentation systems may provide insight into the psychiatric nurse's experience and meaning of caring. Therefore, question seven was included on the initial interview guide in which participants were asked to describe the extent to which documentation systems
supported the psychiatric nurse's caring role with patients (Appendix E).

The Modification of the Initial Interview Guide

As more information came in from the participants, the questions on the initial interview guide were revised. Emerging concepts were added to the modified interview guide because the incoming information from the participants determined what information was sought next. However in the first interview, the probe questions on the modified interview guide (Appendix F) were rarely introduced because questions one to four (Appendix F) rendered dense and rich descriptions of the participant's meaning and experience of caring. Questions five to eleven on the initial interview guide (Appendix E) were replaced by questions five to twenty-one on the modified interview guide (Appendix F). These questions on the modified interview guide were substantiated by their repeated occurrence in the actual data and represented the content areas relevant to the psychiatric nurse's frame of reference. These specific questions were used as probes to further refine and verify the categories introduced by the nurse participants in the interviews.
The Interview Process

The interviews were held in private meeting rooms or offices approved by the nursing unit administrator and managers, on the psychiatric unit. At the beginning of each initial interview, the psychiatric nurses were greeted and thanked for their attendance. The nurse participants were informed that I too was a nurse and then proceeded to summarize my motivation for conducting this study with psychiatric nurses. The study was reviewed according to the Study Information Sheet (Appendix C). The study consent form (Appendix D) was reviewed with the psychiatric nurse. Prior to the start of the interview process, written consent was obtained for taping of the interviews and the use of the data from the interviews (See Appendix D). Psychiatric nurses were encouraged to ask questions regarding the study and were given a copy of both the explanation and consent forms (Appendices C and D).

My role as a researcher was explained as affiliated with the University of Toronto and that this research was part of a requirement for a doctoral degree. However, the psychiatric nurses were also informed that their hospital had shown an interest in this research on "caring", and had invested in this research by allowing the psychiatric nurse participants to be interviewed during work hours.

Moreover, I explained that I would be moving back and forth between data collection and analysis. That is, I would not interview all the nurses first and then analyze the data later. Instead, I would be collecting and analyzing data
simultaneously to verify that the analysis was on track with what their meaning and experience of caring was in the hospital setting. This meant that what the psychiatric nurse said in the interview was coded and analyzed, then these codes were verified by making constant comparisons of the data collected from other nurse participants, and from previous interviews.

Once information about the process of the study, and information about the researcher was provided, demographic information about the nurse participant was requested according to the Interview Demographic Facesheet (Appendix G). For example, collected information included, but was not limited to the nurse participant's age, gender, years of experience in psychiatric nursing, theoretical basis for practice, and the nursing delivery model on the unit (i.e., primary or team nursing).

Before and during the interviews, the psychiatric nurses were informed that the questions on the initial interview guide were provisional and would be retained, deleted, or modified based on the extent to which the questions held up as relevant to the psychiatric nurses' experience or meaning of "caring" in hospital. The origin of the questions on the initial interview guide was also briefly explained to each of the psychiatric nurses as coming from a general survey of the literature. Consequently, the psychiatric nurses were informed that the
specific questions on the initial interview guide were regarded as a starting point and would be modified according to the participant's frame of reference as the study progressed. Eventually as the study progressed, there were more questions on Appendix F (twenty-one questions) than on Appendix E (ie., eleven questions). Furthermore, questions five to twenty-one, in Appendix F, were different from questions five to eleven in Appendix E. This is because the modified interview guide (Appendix F) reflected the questions which were verified to be relevant to the psychiatric nurse's experience and meaning of caring. For example, in this study, psychiatric nurse's described caring as involving safety, therefore a question on safety (ie., question five) was incorporated on the modified interview guide (Appendix F).

Throughout both the first and second round of interviews with the participants, a non-intrusive stance was assumed. During the interview process, I further encouraged the participants to describe their own experience and meaning of caring by gesturing with head nods and uh-humm. Moreover, participants were further prompted by such comments as: "please elaborate", "can you give me an example", "can you please clarify what you mean by that term". In fact, the participants were surprised when I asked them to clarify some situations or terms. They assumed I would know what they meant given that I am a nurse. In
these situations I acknowledged that some of my questions may seem basic, while at the same time I reinforced my commitment to understanding their meanings and experiences. Consequently, the participant was informed that the final theory would be limited to those categories that exist in the actual data collected, not what I might "think, or assume", the participant believed about caring (Strauss, and Corbin, 1990, p.112).

Moreover, a non-intrusive stance, meant that whenever the participant's responses appeared not to address the purpose of the study, no attempt was made to interrupt the participant's story. Instead, at the conclusion of their story, the participants were asked to clarify, as necessary. Through this approach, the emergent nature of this study was facilitated. It encouraged the participants to go beyond the boundaries of the questions on the initial interview guide (Appendix E) which led to the modified interview guide (Appendix F). The modified interview guide reflected the questions that were verified as pertinent to the participant's experience and meaning of "caring".

Interviews occurred during the participant's work hours on the day or evening shift during the weekday or weekend. The participants were informed that the interviews were 60 to 90 minutes, if done in one session. However, the participants in the study were informed that the interviews could be done in intervals convenient to them (Appendix C).
Moreover, the participants were given the liberty to interrupt, and/or postpone an interview, all of which was left to the discretion of the participant. In this study, participants were usually able to meet for twenty to forty minute interviews. Longer interviews were usually marked with brief interruptions by another nurse, the nurse leaving momentarily in response to a sound on the unit or stopping the interview to listen to information over the public announcement. The nurse participants stated that my allowance for these practical concessions, which were also introduced on the Study Information Sheet (Appendix C), positively influenced the psychiatric nurse's decision to participate in this study and helped the participant's focus on the interview.

These practical concessions enabled the participant to have control over the interview process, and alleviated any concerns about time. I allowed for this in this study based on my own professional experience as a nurse and based on my own personal belief. That is, I believe as a researcher coming from the outside I could never possibly know how much time the psychiatric nurse has, and when the participant could meet with me. Therefore, this control was left to the participant, and in turn it enabled the participant to focus on the interview. This was the feedback I received from the participants which was recorded on the post-interview comment sheet (Appendix H).
Furthermore, information pertaining to the physical setting, time of day of the interview, and the interpersonal context of the interview such as the emotional tone of the interview, methodological and personal difficulties were also recorded on the post-interview comment sheet (Appendix H).

There was an average of a three month time frame between the first interview and the second interview with each participant nurse. The second interview with each nurse began when theoretical saturation of concepts was achieved in the first round of interviews. Theoretical saturation was achieved when similar information was repeatedly present when comparing data in the interviews and no new information or categories about "caring" were identified (Strauss and Corbin, 1990; 1994). The methodology followed in each of the two interviews with the participants is presented in the next sections.

The First Interview with Participants. The first interview with the participant, exploratory in nature, involved first asking each of the participants four exploratory questions about their experience and meaning of caring:

1. Please describe what you do on a day to day basis in your "caring" with patients in this setting. (Pause) Perhaps think back to today or yesterday, what did you do with
2. How do you feel about these things you do?
3. How does your employer feel about what you do?
4. Please describe an actual experience you have had with a patient in this setting that will help me understand what "caring" means to you? or Please describe an actual experience with a patient that stands out in your mind, in this setting, that reflects "caring".

These questions were part of the initial interview guide in Appendix E, questions one to four. Then the probe questions on the initial interview guide (Appendix E, questions five to eleven) were asked if they were not addressed through the exploratory questions. Since the probe interview questions on the initial interview guide were derived from the literature, and not from the participants, they were modified based on the information provided by the participants.

As information about the participant's meaning and experience of caring came in, the probe interview questions on the initial interview guide (Appendix E, question five to eleven) were revised and the modified interview guide was developed (Appendix F, questions five to twenty-one). That is, the specific actions that were indicated by the participants as relevant to their experience and meaning of caring were added to the modified interview guide (Appendix F, questions five to twenty-one). The questions on the
modified interview guide were then used as probe questions in subsequent interviews with nurses. However, because of the rich and dense descriptions of "caring" obtained from asking the participants the four exploratory questions about their: 1. actual caring done in practice; 2. feelings about their caring with patients; 3. reflections about their caring; and 4. reactions to their caring with patients in hospitals (Appendix E, questions one to four), I rarely introduced the probes on the modified interview guide. This was because the participants discussed the information identified in the probes when answering the first four exploratory questions (Appendix F).

The Second Interview with Participants.

The second interview, verifying in nature, asked participants to confirm whether my understanding of what they revealed in the first interview was on track with what "caring" meant in the hospital setting. In the second interview the results were shared with the participants for their reaction. The participants were also informed that the second interview was an opportunity for the nurse to modify, add, clarify, and elaborate on what was said in the first interview. The participants were very active in affirming, clarifying, and elaborating on what they said in the first interview. The intent in the second interview was to develop and verify the categories identified in the first interview.
and to discover the relationships between the categories of caring.

Each second interview with the participant then was started with a summary of what was said in the first interview. This meant starting the second interview by posing the question: What does "caring" with patients in the hospital setting mean to you? Then I proceeded to answer the question based on the analysis of the data collected from the first interview with the participant. However, because of the rich and dense descriptions of "caring" obtained from asking the participants about their: 1. actual work; 2. feelings about their work; 3. reflections about their work; and 4. reactions to their work with patients in hospitals (Appendix F, questions one to four), I did not have to introduce the probes on the modified interview guide, because the participants had already mentioned the information in the first interview. Instead, in the second interview, the probe questions on the modified interview guide (Appendix F) were used as a guide to further refine and develop the categories and subcategories identified by the participants. Moreover, the probe questions on the modified interview guide were used as a mechanism for sharing the results of the analysis with the participants.

The participant's response to this format was favourable and met with some surprise, because the nurses stated they thought they would not remember what they said
three months ago in the first interview. Instead the participants stated they recognized their experience and meaning of caring in the categories and subcategories generated in the analysis. The participants also recognized the language used in the analysis as representative to their meaning and experience of caring. Therefore, in the second interview, the analysis of the interview data was checked against the participant's experience and meaning of "caring". Also the language used in the theory generated from the analysis of the interviews was checked with the participants.

**Theoretical Sampling**

In addition to the interviewing method, the data were collected using a sampling procedure referred to as theoretical sampling (Corbin and Strauss, 1990; Strauss and Corbin, 1990; 1994). This meant that the information that was sought in the interviews with the nurse participants was determined by the information that the participants themselves identified as relevant. Furthermore, in theoretical sampling, the representativeness of the information was checked and verified in the second round of interviews with the nurse participants.

There were three types of theoretical sampling used during data collection and analysis. These were: 1. open sampling; 2. variational sampling; and 3. discriminate
Sampling (Strauss and Corbin, 1990; 1994). During theoretical sampling, one may move between one form of sampling and another (Strauss and Corbin, 1990; 1994). Movement between different forms of sampling helped to ensure that the concepts which emerged from the participants themselves were well developed and integrated. Sampling ceased once the categories were determined to be saturated; that is, no new data were obtained or no new categories emerged from interviews with the psychiatric nurses. In this study, no new categories emerged during the second round of interviews with the last five psychiatric nurses interviewed. Open sampling, variational sampling, and discriminate sampling will now be presented.

Open Sampling

At the start of the study, sampling was open or non-specific, because there was no data from the psychiatric nurses to direct what information needed to be sought and explored. This meant that initially, psychiatric nurses in the study were interviewed with the purpose of identifying the categories of caring that were relevant to their experience and meaning of caring. Open sampling shifted into variational sampling once the categories of caring relevant to the psychiatric nurse's experience and meaning of caring began to emerge. These specific categories of caring then began to direct sampling. Thus sampling was no longer open,
but specific. In specific sampling, the aim was to determine
the variations that existed in the categories of caring
which were identified. This was the focus of variational
sampling and is presented next.

Variational Sampling

Variational sampling began when the information
provided by the nurse participants directed what information
was sought and explored. Therefore, each interview with the
participant was transcribed, coded, and analyzed before
proceeding to the next interview. Variational sampling
involved finding differences in the information provided by
participants about "caring" with patients. This meant
deliberately recruiting nurse participants from different
educational backgrounds, employment status, years of
experience, ages, gender, and cultural groups, in order to
identify variations in the categories and subcategories of
caring identified in the evolving theory.

Discriminant Sampling

Similar to variational sampling, discriminate sampling
also proceeded according to the information that emerged
from the interviews with the participants. However, the aim
of discriminative sampling was to verify the evolving
theory's storyline and relationships by comparing incident
after incident in the data. For example, in this study when
it was discovered through open sampling and variational sampling that 'keeping the patient safe' was a category which represented caring, then through discriminant sampling, the connections and relationships between this category and other categories were discovered. This meant discovering what 'keeping the patient safe' meant, what it represented, involved, how it was accomplished, and what it was related to and/or apart of. Discriminative sampling involved verifying the existence of these connections and relationships in the transcribed interview record and continued right into the last writing stages of this manuscript.
Data Analysis

The method of data analysis used in grounded theory methodology is called the constant comparative method. The goal of using constant comparative method was to understand what was going on in the data. The constant comparative method provided a systematic way to identify the core variable associated with the psychiatric nurse's meaning and experience of caring. This core variable is referred to in grounded theory methodology, as the Basic Social Process (BSP) (Glaser, 1978; Strauss and Corbin, 1990; 1994). The BSP represented the patterns of behaviour, social and psychological processes associated with the psychiatric nurses' meaning and experience of "caring" in hospitals. The findings from each interview were compared with previous interviews for differences and similarities. Data collected were transcribed and analyzed immediately following each interview. This was important, since in this grounded theory study, the themes and categories that emerged during the analysis of each completed interview determined what information was sought in the next interview.

Coding procedures were used to record the theory as it developed step by step during the research process. Open coding, axial coding, and selective coding were the three types of coding procedures used during data analysis. It is important to note that similar to open sampling, variational sampling, and discriminant sampling presented in the data
collection section, that the distinctions between each open, axial, and selective coding are artificial and that different types of coding do not necessarily take place in a linear fashion. For example, one may move between one form of coding and another in a single coding session (Strauss, 1987; Strauss and Corbin, 1990).

**Coding Procedures**

Coding procedures helped to identify, relate, and develop categories that had relevance for the psychiatric nurse. Proven theoretical relevance was achieved when any significant category or subcategory met the following criterion: when the category or subcategory was repeatedly present when different incidents were compared in the interviews. That is, the categories and subcategories earned their status of a category or a subcategory through their repeated presence in the actual participant data. The coding procedures of open coding, axial coding, and selective coding recorded how the categories and subcategories were developed in the study (Corbin and Strauss, 1990; 1994). During the three coding procedures, the two analytic procedures of making comparisons and asking questions were used. In this study, coding (open, axial, and selective) was done within the transcribed interview. Coding was done on the right hand margin of the transcript. The codes represented what was happening in the data. Moreover,
regardless of the type of coding done, asking questions of the data was crucial and part of specifying the conditions in which the codes appeared. Next, the different types of coding (open, axial, and selective) are presented.

**Open Coding**

The goal of open coding was to establish: 1. what was happening in the data? (Glaser, 1978; Strauss and Corbin, 1990); and 2. what action a particular happening, incident, event, or idea indicated? (Strauss and Corbin, 1990).

Taped interviews were transcribed on the left hand side of the page. Then coding was completed on the right hand side (Appendix I). Each happening, incident, idea, or event was given a name or conceptual label that represented or stood for what was happening in the data (Strauss, 1987; Corbin and Strauss, 1990). Similar ideas, incidents, and happenings were then compared and grouped under a common subcategory. Subcategories which pertained to the same phenomenon were then grouped under a category that stood for the group of subcategories. The category was given a name or label which was more abstract than the subcategories under it (Strauss and Corbin, 1990; 1994). Categories represented the actual actions described by the nurse participants. In open coding, there are two types of codes that can be used to represent data. There are: substantive codes and vivo codes. In this study, substantive codes were the descriptive
words that described the nurse participant's action in the setting. Vivo codes were the exact words of the nurse participant used in the interview, and were used by the researcher to develop the categories and subcategories of the theory generated. An example of an interview transcript in which open coding was done is included in Appendix I. Notice the vivo codes of empowering, ensuring safety and others in the right hand margin which emerged from the actual word used by the nurse participant. Also notice the questions asked of the data to facilitate comparison of the data.

**Axial Coding**

As in open coding, asking questions and making comparisons of the data were crucial in axial coding. However, in axial coding the aim was to identify the relationships between the categories (Strauss and Corbin, 1990). In grounded theory methodology, relationships between the categories identified in open coding are analyzed in terms of a paradigm model. The purpose of the paradigm model for coding was to systematically arrive at a theory of caring.

Coding according to the paradigm model involved examining the relationships between categories and subcategories of caring, in terms of the paradigm features of antecedent conditions, contexts, actions and
interactions, and consequences of caring. The paradigm model of coding involved identifying, in the data, which categories represented what features of the paradigm model.

1. antecedent conditions to caring, 2. the contexts of caring, 3. the actions /interactions of caring, and 4. the consequences or outcomes of caring (Strauss and Corbin, 1990).

Antecedent conditions are the happenings, incidents, actions, or events that seem to precede the occurrence or the development of the phenomenon of "caring". Furthermore, in the paradigm model, actions and interactions refer to what the psychiatric nurse does in order to accomplish caring (i.e., communication, thought processes, and actions).

Moreover, in the paradigm model, contexts represent the specific conditions in which the actions and interactions of caring occurred. The consequence feature of the paradigm model refers to the outcomes of caring. This paradigm model is the basis of axial coding and helped to identify the core category or the basic social process, which encompassed all the other categories of caring. An example of the use of the coding paradigm in axial coding is included in Appendix J. Notice that the axial codes pertain to the different features (i.e., antecedent conditions to caring, contexts of caring, actions and interactions of caring, and consequences of caring). Also notice that, in the right margin of the
transcript, these axial codes were only provisionally proposed until these concepts and categories could be verified in the actual data (Appendix J). It is for this reason that the axial codes illustrated in Appendix J are in the form of a question.

Selective Coding

The aim of selective coding was to select a central phenomenon or the core category around which all categories identified in the theory were encompassed (Strauss, 1987; Strauss and Corbin, 1990). Categories that needed further refinement and development were identified and developed (Strauss, 1987; Strauss and Corbin, 1990).

Representativeness of each category and the evolving theory was tested through a process called theoretical sampling. During theoretical sampling, the theory derived from the first interviews with the psychiatric nurses was tested against data from the second interviews. In the second interview, the psychiatric nurses clarified, specified, elaborated or added to what they said in the first interview; and, this helped to facilitate selective coding. By the second interview with the nurse, the probe questions on the modified interview guide were those which represented the content areas that were relevant to the psychiatric nurse's experience (Appendix F). Two of the seventeen nurses were not available for the second interview
as they left the setting. Given the emergent and self-perpetuating quality of this research, their interviews were interwoven into data collection and analysis because in grounded theory methodology the information given by the nurse participant at each interview determines the information sought (i.e., questions asked).

File folders labelled according to the codes obtained through open coding, axial coding, and selective coding were established, in order to track the development of each of the codes. Each code represented the categories and subcategories of caring derived from the transcribed interviews. Segments of interview transcripts which supported and verified the categories and subcategories of caring, and the queried relationships between the categories were added to the file folder whose heading corresponded to the categories and subcategories. The codes which represented the categories and subcategories of caring were constantly compared to determine their grounding in the data. The repeated presence of categories and their subcategories in the data is what earned their way into the theory.

**Memo Writing**

In this study, personal, observational, methodological, and theoretical memos were recorded. Personal memos identified reactions of the researcher during the interview which may have affected data collection. Observations made
while listening to nurse participants during the interviews were recorded in observational memos. Methodological memos described how the interviews with the nurse participants proceeded. Theoretical memos are notes that contain the researcher's insights about what is happening in the data. Personal, observational, methodological, and theoretical memos were recorded immediately, after the completion of each interview on the post-interview comment sheet (See Appendix H).

In this study memos were written on the actual transcript of the interview in the right hand margin. For example, as demonstrated in Appendix J), I wrote a memo or insight about the category of respecting the patient. Based on what the psychiatric nurse said in the excerpt, I provisionally wrote that respecting the patient was a prerequisite for caring. A theoretical memo was written to query whether respecting the patient occurred as a prerequisite or antecedent condition to caring.

A file folder with the heading "prerequisite/antecedent condition to caring: respecting the patient" was established in order to track the development of this memo and other memos. Additional segments of interview transcripts which verified queried relationships were added to the file folder whose heading corresponded to the memo. Through the repeated presence in the data of the category of 'respecting the patient', this queried relationship about
the category of 'respecting the patient' as an antecedent or prerequisite to caring earned its way into the theory.

Therefore, theoretical memos reflected the researcher's thinking in relation to the raw data. Moreover, theoretical memos contained the researcher's ideas and insights during the research process, albeit any ideas or insights were considered provisional until they were confirmed by comparing incident after incident in the actual interview data. Writing theoretical memos assisted the researcher in tracing the development of a category and its subcategories as well as the relationships between categories. Furthermore, theoretical memos assisted in the identification of unrelated categories that could be discarded. Memos also helped the researcher to move from providing a descriptive account of what was happening in the data to providing a conceptual account of what was happening in the data.
Ethical Considerations

Protection of Confidentiality and Participant Rights

This study was approved in accordance to the Ontario Institute for Studies in Education guidelines for Theses and Oral Manuals and the Ethical Review procedures, at the University of Toronto. This study was also approved by each of the three hospital settings through their own research and ethical review committees.

Confidentiality

At the beginning of each interview participants were informed that confidentiality would be maintained. Participants were informed that all tapes, transcripts, memos, and coded data were labelled with a number to prevent their identification. A master list identifying each participant by a corresponding number, was kept in a locked drawer with only the researcher having access to it. Tape recordings of the interview used during data analysis were available only to the researcher.

Informed Consent and Participant Rights

Informed consent was obtained from each of the psychiatric nurses who participated in the interviews (Appendix D). Consent was obtained to use data shared by the psychiatric nurses. The psychiatric nurses were also
informed that their participation in this study was voluntary. Psychiatric nurses could refuse to answer any questions during the interview or withdraw from the study at any time. None of the seventeen nurses withdrew from the study. Psychiatric nurses were informed at the beginning of each interview that they had the option to interrupt, discontinue, or postpone the interview to another time. Psychiatric nurses were also given control over the tape recorder, and were given the liberty to stop the tape at any time. The nurses usually stopped the tape to reflect or think about their responses. Only two participants stopped the tape to relate material which they did not feel comfortable taping.

Risks and Benefits

At the beginning of the study, psychiatric nurses were made aware of the extra workload that may occur from meeting with me during work hours. In an attempt to decrease this potential risk, a flexible interview format gave the nurse control over when to meet, and how long to meet for. Moreover, I made myself available on each of the psychiatric units according to the general schedule of events for the unit. This was done to decrease the potential for time conflicts between the interviews for this study and the
nurse's responsibilities, such as team meetings, change of work shift, room availability for interviews, programs, patient admissions and the like.

Although there were no direct benefits for psychiatric nurses who participated in the study, psychiatric nurses were informed that the information they shared could be used to develop a valuable guide for articulating and reflecting on what psychiatric nurses do in their "caring" in hospitals. Moreover, psychiatric nurses were informed that the information they provided could be useful for both clinical and political purposes of affirming and/or challenging the way in which the nurse's caring with patient was practiced, organized, funded, or prioritized in hospitals. Also psychiatric nurses commented that it had been helpful to talk about their meaning of "caring" as "caring" with patients was integral to daily practice but rarely articulated in hospitals.
Credibility of the Study

Lincoln and Guba (1985) and Marshall and Rossman (1989) have described criteria for evaluating grounded theory methodology research. These criteria are credibility, transferability, dependability, and confirmability. In this section, the measures which were taken to ensure that these criteria were met are presented.

The first criterion for evaluating this grounded theory research is credibility. Credibility refers to the confidence the reader can put in the internal validity of these research findings. This means examining what was done in the research to ensure that the phenomenon of "caring" was accurately identified and described. In order to ensure that caring was accurately identified and described, data collection and analysis were carried out simultaneously, until each category was saturated (i.e., explained to its fullest and no new information emerged from the interview transcripts). This meant that the information collected from the interviews guided what information was explored, retained, and deleted. Therefore, the information sought and retained, as well as the questions asked, was a function of the emerging information provided by the participants. This further ensured that the phenomenon of caring was accurately identified and described. Consequently, the participant's experience and meaning of caring sharpened the focus of the study and ensured credibility.
The themes and categories that emerged from the analysis were provisional until they were verified in the actual data. Verification of the emerging theory with the participants ensured that the theory generated was "credible to the constructors of the original multiple realities" (Lincoln and Guba, 1985, p. 296).

Clarification of unclear data from the first interview with the psychiatric nurses was sought in the second interview. If there remained unclear data after the analysis of the second interview, I informed the psychiatric nurse I would arrange for another meeting. No third interviews were arranged with the participants. This and other measures taken in this research ensured the credibility of the findings. For example, each interview was tape recorded to reduce recall bias. Each category was verified in the data, and more than one interview was conducted with each nurse. Furthermore, observations were recorded in memos immediately after each interview, and during the coding of the interview transcripts. Each memo was filed and verified with the data, thus helping to facilitate the credibility of the results.

The second criterion for evaluating grounded theory research is transferability. Transferability refers to the applicability of the findings to other contexts. In qualitative study, the concept of external validity or generalization to a larger population is problematic, because the aim in grounded theory is to specify, not
generalize the phenomenon of "caring". The transferability of the results comes from the in-depth descriptions of the categories, subcategories, and contexts of caring which were deeply embedded in the data from the participants. The transferability of the theory generated in this study can only be judged by the reader. However, in this manuscript the parameters of this research and the manner in which this research was conducted is specified so that readers can further judge the transferability of the results to their own experience.

Therefore, those readers who work within similar parameters as those described by this study can determine whether the theory of caring described here can be transferred to their setting. For example, some readers may recognize the theory of caring in this study in their work with geriatric patients, or pediatric patients. Other readers may recognize or know the theory generated in this study to be true in their psychotherapy practice with individuals, couples, or families. Moreover, readers may recognize the theory in their work with students or in education. Therefore, the theory of caring described here may be used in a variety of settings and situations and may not be limited to psychiatric settings in hospitals.

Furthermore, data collected from the three hospitals, two of which were general hospitals and one was a psychiatric hospital, also enhanced the transferability of
the theory of caring presented here. Data from these varied sources and settings were used to illuminate, corroborate, and elaborate "caring". No differences regarding the meaning and experience of caring were discovered between these settings.

A third criterion for evaluating grounded theory research is dependability. Within the criterion of dependability is the assumption that the social world is always changing. Dependability refers to the attempts the researcher made to account for the changing conditions of "caring" as well as the changes in design created by an increased understanding of the caring from the participants in the setting. The changes in design that occurred as result of the in-coming information from participants were reflected through the revisions made to the initial interview guide (Appendix E, questions five to eleven), and are reflected in the modified interview guide (Appendix F questions five to twenty-one). Therefore, the replication of this study is possible, with the caveat that other researchers who attempt to replicate this study remain sensitive and receptive to discovering new or modified conditions of caring, as was done in this study through the revisions of the initial interview guide.

A fourth criterion for evaluating grounded theory methodology is confirmability. Confirmability refers to whether the findings of this study could be confirmed by
another. In this study, confirmation was provided by the thesis supervisor, who checked the emerging list of categories and subcategories against the psychiatric nurse narratives. This was done in order to validate and confirm the researcher's assignment of categories and subcategories in the theory.

In addition, in grounded theory methodology, the subjectivity of the researcher will shape the research, because the researcher is a social being who also creates and recreates what is happening in relation to caring (Baker, Wuest, and Stern, 1992). Consequently, controls for bias in interpretation were provided. These included: 1. the articulation of my personal biography in relation to the study and 2. the categories, subcategories, action/interactions, contexts, and consequences of the theory of caring were confirmed with the participants from three different settings. Other ways in which my potential for bias in interpretation was monitored were: 1. recording my insights in memos immediately after each interview; and, 2. recording insights during coding. This allowed me to remain open to surprises and new directions taken by the participant. Moreover, interviews were conducted with a heterogeneous participant population within three different hospital settings; thus, participant accounts from three hospitals helped in the search for negative instances and facilitated a rich account of caring (Glaser and Strauss,
1967; Strauss and Corbin, 1990; 1994). Another way in which the researcher's potential for bias was monitored was by checking that the evolving theory of caring was limited to those categories of caring and relationships that existed in the actual data collected, not what I might think is happening, and might not have come across (Strauss and Corbin, 1990). This meant checking and rechecking the data for possible rival categories of caring and relationships between categories, and asking questions of the data while making comparisons between incidents.

The following questions were asked of the data during coding. These questions helped to control my potential for bias in interpretation by ensuring that any category of caring that emerged from the analysis was verified in the actual data. Furthermore, these questions were helpful in making my thinking visible, thus enhancing the confirmability of the findings by another. These questions were derived from Glaser (1978), Strauss (1987), and Strauss and Corbin (1990). The questions asked were:

1. what is happening in the data?
2. What are the incidents, ideas, actions of the nurse in the data?
3. What does the incident, action, idea in the data represent?
4. What categories do the ideas, actions, incidents in the data indicate? Does this conceptual label or category fit
the story in the data? Is this conceptual label familiar to
the nurse participant and derived from the data?
5. Is this category related to another category?
6. Are there categories that reflect similar patterns? Is
this a subcategory of a broad category?
7. Is there a single category or basic social process that
seems broad enough to encompass other categories; That is,
is there a single category that encompasses everything that
has been described in the theory?
9. What are the antecedent or prerequisite conditions
necessary in order for caring to occur?
10. What are the actions and interactions associated with
caring?
11. What are the contexts of caring; that is, what are the
conditions in which the actions and interactions of caring
are embedded?
12. What are the consequences or outcomes of caring?
13. What are the relationships between categories of caring?

The above questions were used to identify the
categories of caring. Then, in order to explore the
relationships between categories a paradigm model was used
(Strauss and Corbin, 1990; 1994). In grounded theory
methodology, the paradigm model for data analysis offers a
method for examining relationships between the categories.
This meant identifying which aspect of the paradigm model
each category and subcategory denoted (ie., conditions,
action/interactions, and consequences of caring). Although the following questions seem similar to questions nine to twelve above, they are different. Question nine to twelve are asked to identify the individual categories of caring. In contrast, the questions below are asked to identify, compare and verify in the data the relationships between categories. Consequently, the following questions were consistently asked of the data during analysis:

a) does this category denote the antecedent conditions of caring? 

b) does this category denote the actions and interactions of caring?

c) does this category denote the contexts or the conditions in which the actions/interactions of caring are embedded?

d) does this category denote the consequences or outcomes of caring?

e) what paradigm feature does each category represent? That is, which categories represent antecedent condition? contexts? actions and interactions? or consequences?

An example of how the coding paradigm was used to identify relationships between categories is illustrated in Appendix J in the right hand margin. Notice in the sample of a transcript (in Appendix J, page 315), that respecting the patient is identified as an antecedent condition to caring. Also notice that 'respect' as an antecedent condition to caring is proposed provisionally until it can be verified
through constant comparisons with the interviews. Therefore, in asking questions of the data and conducting constant comparisons within the data, it was possible to verify the relationships that existed within the data and to monitor my own bias in interpretation.

Locke, Spirduso, and Silverman (1993) stated that "what the investigator brings to the setting can become a positive part of the research process, but only if it is recognized as an inextricable background from every step from question to conclusion" (Locke et al., 1993, p.114; Bateson, 1980; Peshkin, 1988). My views of caring were articulated in the research for the purpose of helping me differentiate my views of caring from those of the participants. This enabled the participants' meanings of caring to emerge (Baker et al., 1992; Locke et al., 1993). During the initial stages of developing the proposal for this study on "caring", the following views of caring came to mind:

1. I believe "caring" involves listening to the patient's perspective, clarifying perceptions, team work, advocacy, providing encouragement, helping patients to communicate, acknowledging and validating the patient, assisting with and, attending to, the patient's self-care as needed, educating, supporting, counselling, and reflecting on nursing practice for the purpose of planning patient care, making referrals or consulting with other professionals, and for self-renewal.
2. "caring" can involve helping patients identify, manage, and cope with what is happening to them, so that they do for themselves, as much as they can.

3. "caring" is a type of therapy that occurs in the relationship between the patient and the nurse. In this relationship, the nurse works with the patient cooperatively, so that the patient can learn for themselves what they need to do in order to accomplish the activities of daily living that are meaningful to them; and, that are minimally required in order to thrive physically, emotionally, and socially.

4. caring is an ethic that reflects a commitment to "valuing" people. This includes patients, nurses, and other health professionals, in terms of their own experiences, meanings, perceptions, knowledge, history, culture, development, happenings, strengths, and limitations.

These were some of my views on caring that I was aware of at the time. Stating them was another way of controlling for bias and for remaining sensitive to the participant's views of caring.
RESULTS

There were four major findings in this study: 1. psychiatric nurse's experience and meaning of caring was reflected through a process of protective empowering, 2. there were six major categories of protective empowering; 3. the relationships between the six major categories of protective empowering characterized the approach used with patients and the different contexts in which protective empowering occurred, and 4. protective empowering does not happen all the time in hospitals because of variables which interfered with caring, such as nurse variables, patient variables, health care team variables, and workplace and societal variables. Since the purpose of this study was to explore the psychiatric nurse's meaning and experience of caring as opposed to factors which interfere with "caring", these variables will not be presented. However, the variables that interfered with "caring" were only mentioned above, so as to prevent the impression that protective empowering occurred at all times.

The structure of this chapter on the results of the study is as follows. First, an overview of the theory generated is presented, by providing an overview of the theory of protective empowering. Second, the basic social process of protective empowering is presented in terms of the protecting and empowering actions that comprise it.
Third, each of the six main categories of protective empowering is introduced, and examined, in terms of its subcategories. Fourth, the relationships between the six categories of protective empowering are presented, according to which part of protective empowering they denoted (antecedent conditions, contexts, actions and interactions, and consequences).
An Overview of the Theory of Protective Empowering

The basic social process identified by psychiatric nurses in this study was protective empowering. Protective empowering represented the psychiatric nurse's experience and meaning of "caring" with patients on acute general psychiatric units in hospitals. Protective empowering encompassed the six different categories through which caring occurred between the patient and the nurse. The six main categories of protective empowering that emerged from the data are: (1) keeping the patient safe as evidenced through the subcategories (i) advocating for the patient to the team, (ii) providing reassurance to the patient, (iii) attending to the patient's self-care/treatment, and (iv) providing the patient with information and choices; (2) encouraging the patient's health as evidenced through the subcategories (i) promoting patient responsibilities in increments; (ii) inviting the patient's participation in activities; (iii) bringing any changes to the patient's attention; (iv) complimenting and cheerleading the patient's efforts; (v) drawing out the health already there in the patient; (3) authentic relating as evidenced through (i) being consistent, (ii) being available and responsive to the patient's concerns of daily living, (iii) matching the nurse's interaction with the patient's receptivity and capabilities; (4) interactive teaching as evidenced through
(i) building on the patient's strengths, interests, needs, and knowledge; (ii) showing the patient through the nurse's example of interaction; (iii) giving feedback; (iv) pointing out expectations, alternatives, and life patterns; (v) respecting the patient as evidenced through the subcategories (i) acknowledging the patient's concern or distress; (ii) being non-judgemental of the patient; (iii) not power-tripping; (iv) viewing the patient as knowledgeable; and (vi) not taking the patient's behaviour personally as evidenced through the subcategories (i) knowing yourself, (ii) knowing the patient, (iii) consulting with other nurses, the health care team and the patient, (iv) viewing each situation as a learning experience, (v) imagining the patient's situation, and (vi) taking a break.

A pictorial depiction of the psychiatric nurse's experience and meaning of "caring" as expressed through the process of protective empowering and its categories is illustrated in Figure 1. The subcategories which are associated with each of the six categories will be illustrated when each category is examined below.
**FIGURE 1**

**Protective Empowering**
A pictorial depiction of psychiatric nurses’ experience and meaning of “caring”

<table>
<thead>
<tr>
<th>Subcategories</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. advocating for the patient to the team</td>
<td>keeping the patient safe</td>
</tr>
<tr>
<td>ii. providing reassurance to the patient</td>
<td>encouraging the patient’s health</td>
</tr>
<tr>
<td>iii. attending to the patient’s self-care / treatment</td>
<td>authentic relating</td>
</tr>
<tr>
<td>iv. providing the patient with information and choices</td>
<td>interactive teaching</td>
</tr>
</tbody>
</table>

| i. promoting patient responsibilities in increments | respecting the patient |
| ii. inviting the patient’s participation in activities | not taking the patient’s behaviour personally |
| iii. bringing any changes to the patient’s attention | |
| iv. complimenting and cheerleading the patient’s efforts | |
| v. drawing out the health already there in the patient | |

| i. being consistent | |
| ii. being available and responsive to the patient’s concerns of daily living | |
| iii. matching the nurse’s interaction with the patient’s receptivity and capabilities | |

| i. showing the patient through the nurse’s example in interaction | |
| ii. building on the patient’s interests, needs, and knowledge | |
| iii. giving feedback | |
| iv. pointing out expectations, alternatives, and life patterns | |
| v. helping the patient anticipate how they will manage in the community | |

| i. acknowledging the patient’s concern or distress | |
| ii. being non-judgmental of the patient | |
| iii. not power-tripping | |
| iv. viewing the patient as knowledgeable | |

| i. knowing yourself | |
| ii. knowing the patient | |
| iii. consulting with other nurses, the health care team, and the patient | |
| iv. viewing each situation as a learning experience | |
| v. imagining the patient’s situation | |
| vi. taking a break | |
The basic social process of protective empowering encompassed and explained the relationships between the six categories. All six categories appeared throughout the process of protective empowering, except that each category represented a different feature of protective empowering. The two main categories of respecting the patient and not taking the patient's behaviour personally were antecedent conditions of caring. These two main categories reflected the nurse actions which ensured that protective empowering with patients occurred and was sustained. The other four categories of keeping the patient safe, encouraging the patient's health, authentic relating, and interactive teaching emerged from the data as the four major contexts through which protective empowering varied and changed. The protective nature of protective empowering was evidenced through the category of keeping the patient safe. Empowering was evidenced through the categories encouraging the patient's health, authentic relating, and interactive teaching. Together, all six main categories had the outcome of patient action, in which the patients accessed their ability to take action in accomplishing their activities of daily living.
Psychiatric nurses described their experience and meaning of "caring" with patients in the hospital setting as involving the process of empowering the patient while at the same time described "caring" as having a protective nature. This led to the theory of protective empowering. The psychiatric nurses defined protective empowering as helping patients access their abilities to act or accomplish their activities of daily life as the following excerpt illustrates:

Any little effort the patient might make with caring for themselves and trying to do for themselves...so any little bit that they do like putting on a shoe, or getting up out of bed, or just knowing that they need to go for breakfast, or just being able to handle an interpersonal situation on their own, like arranging an appointment, getting their affairs in order in the community, or getting involved in activities or programs are signs that the patient is empowered to take action (013)

Empowering the patients occurred not only for those patients who were assessed as capable of doing something with the empowerment or taking action with the empowerment, but also
for patients with little control over themselves. Nurses described a consistent interplay between protecting and empowering the patient. This was because patients admitted to the general psychiatric unit in the hospital setting were assessed as being potentially harmful to themselves or others, or as too disabled to be capable of performing their own activities of daily living, such as hygiene, nutrition, taking medication, and the management of interactions and behaviours in the community. The following excerpt illustrated the protective nature of "caring" with patients in protective empowering:

I protect them to a certain degree, because the patient is in a vulnerable position. In being ill, their level of responsibility for themselves might be dampened or might not be realized to the full extent by the patient (002).

Protective empowering emerged as a consistent pattern where a discussion of any one of either empowering or protecting would eventually incorporate the other, as the following excerpt illustrates:

You are always ensuring safety in the hospital, but I think empowering starts right from the minute the patient walks in the door. Even for somebody who has very little control, because they are psychotic. There
are small ways you can empower them by giving them choices, or two choices. For example, if they are out of control you can give them a choice between taking medication liquid or injection, if that is appropriate for that patient. I think that is empowering them because it gives them a choice (004).

The protective aspect of protective empowering was mainly evidenced through the main categories of keeping the patient safe and not taking the patient's behaviour personally. The protective nature of keeping the patient safe is illustrated in the following excerpt:

I think there is a protective component to my caring in psychiatry, but it is not the type that comes from countertransference, or that I am rescuing them. It has to do with maintaining the safety of the person emotionally so that they are comfortable and feel safe physically and emotionally (004).

Keeping the patient safe pertained to the patient's emotional and physical sense of safety that came from the psychiatric nurse protecting the patient while at the same time empowering the patient to assume control and responsibility, as the following excerpt shows:

I think I have a protective role to some degree because the patient is vulnerable, but it is my role to help
them have a sense of control over their environment, over their predicament, and to let them believe that they are still the person in control and have responsibility, and that I am just an extension of it for now (002).

The protective nature of protective empowering was also evidenced through the main category of not taking the patient's behaviour personally. Not taking the patient's behaviour personally was used by psychiatric nurses to protect themselves and the patient by getting perspective on situations that were challenging, threatening, and difficult for the nurse. The psychiatric nurses described that by not taking the patient's behaviour personally, the nurses were able to restore themselves to the point that they could think about the care of the patient, as the following excerpt illustrates:

Some patients will say 'I do not want to work with you because you are a coloured individual' or for whatever reason...or the patient may call you names or a servant... If I am a sensitive person about that, and I am not thinking about the care of the patient, then I will begin shunning the patient or avoiding them all the time... I learned over the years that I don't gain anything from that and neither does the patient (014).
Although keeping the patient safe and not taking the patient's behaviour personally emerged as the main categories which reflected the protective aspect of protective empowering, these categories were not exclusively protective in nature as they occurred along side empowering features. For example, psychiatric nurses provided the patient with information and choices in keeping the patient safe. The psychiatric nurses emphasized small choices in order to help the patients believe that they could succeed in larger decisions. This progression from small choices, and their associated decisions, led to the patient making larger decisions, and was accomplished by approaching the patient according to the main categories: encouraging the patient's health; authentic relating; and interactive teaching. Psychiatric nurses also used the actions within the category of not taking the patient's behaviour personally and respecting the patient as a way to establish, sustain, or re-establish care that focusses on the patient.

Although no one excerpt can capture all the categories and subcategories of the theory of protective empowering, the following excerpt illustrates the interplay between protecting and empowering. The excerpt illustrates: 1. the subcategories of 'reassurance' and 'providing the patient with information and choices' from the keeping the patient safe category; 2. the category of encouraging the patient's health; 3. 'giving feedback' and 'consulting with the
patient' from the main categories of interactive teaching and not taking the patient's behaviour personally; 4. matching the nurse's interactions with the patient's level of receptivity and capability in interactions, from the main category of authentic relating and 5. not power-tripping from the main category of respecting the patient:

In empowering the patient, the patient is given information and a number of choices [main category keeping the patient safe: subcategory of providing the patient with information and choices]. Even if the patient is disorganized, they will be given two choices or the choices will be very limited, but they are still given a choice and allowed to make the choice if they want to [authentic relating: subcategory of matching the nurse's interaction with the patient's receptivity and capabilities]. Part of my role is to reflect on that choice with them, respect that choice [respecting the patient: subcategory of not power-tripping], and to provide feedback about that choice [interactive teaching: subcategory of giving feedback; not taking the patient's behaviour personally: subcategory of `consulting with other nurses, the health care team, and the patient] and to give them encouragement [encouraging the patient's health] and reassurance [keeping the patient safe: subcategory of providing reassurance to the patient] (017).
In the next section, an in-depth examination of protective empowering is provided in terms of its six main categories and their respective subcategories.

**Main Category: Keeping the Patient Safe**

The protective nature of protective empowering was defined by the psychiatric nurses through the category of keeping the patient safe as the following excerpt shows:

> I think there is a protective component to my caring...
> It has to do with maintaining the safety of the person (004).

Keeping the patient safe was about helping patients feel adequate in their situation, as the psychiatric nurse in the following excerpt illustrates:

> It is protecting the patient's feeling of adequacy, helping them feel that they are adequate in their situation so that they try to accomplish their own self-care (012)

Psychiatric nurses stated that the ways in which they accomplished the main category of keeping the patient safe in protective empowering was by: advocating for the patient to the team, providing reassurance to the patient, attending
to the patient's self-care/treatment, and by providing the patient with information and choices. Each of these subcategories of keeping the patient safe represented the different actions nurse's took when keeping the patient safe during the process of caring, in a protective empowering way (Figure 1, p. 95). The nurses actions of keeping the patient safe occurred when patients were fearful or suspicious of their environment. Also the actions associated with keeping the patient safe were evident when the patients were a potential physical harm to themselves and/or others or patients were too disabled to be capable of accomplishing their own needs of daily living (ie., nutrition, hygiene, work activities), without assistance. Each of the subcategories of keeping the patient safe are subsequently presented.

**Main Category: Keeping the Patient Safe**

**Subcategory: Advocating for the Patient to the Team**

One of the ways in which psychiatric nurses accomplished keeping the patient safe was by advocating for the patient to the team the patient's preferences, concerns, and criteria for health. This involved communicating to the team what the patient said about how they felt about goals for treatment, activity restrictions, and medication side effects. Even though psychiatric nurses knew keeping the
patient safe was necessary because patients were assessed as being a harm to themselves or others, or were too disabled to accomplish their activities of daily living, the psychiatric nurse lobbied for opportunities that would allow patients to make decisions in their lives. This meant voicing concerns when it seemed that the health care team objectives were not consistent with the patient's objectives and goals, as the following excerpt illustrates:

I believe that it is a large part of my role to try and convey, in team meeting, the things that patient feels and to convey my perception of what the patient is saying. It might be different from what other professionals believe, so encouraging the team members to go back and ask the patient if it is unclear (009).

In advocating for the patient to the team, psychiatric nurses described the importance of asking questions such as: whose criteria of health and interests are being served and accomplished? Psychiatric nurses in this study all believed that advocating for the patient meant allowing the patients the right to choose their quality of life. That is, allowing the patients' right to choose whether they wanted to obtain a better result or whether they were satisfied with the result achieved. Psychiatric nurses consistently discussed the need to advocate for the patient when the psychiatric nurse had reservations about the patient's safety. These
aspects of advocating for the patient to the team were illustrated in the following excerpt:

I really had reservations about starting this one patient on this new medication... if you knew what this patient was like when she was ill, she was not connected to any family, her family did not know where she was, she was living under a bridge and eating out of restaurant garbage cans. Our hope was just to reduce some of the negative symptoms. I know that trying new medications is important. And yes wouldn't it be nice to cure her, and wouldn't it be nice if she was more dynamic, if she was this or that. I told the team to consider that the way she is may be just a manifestation of the schizophrenia and who she is as a person, and that we should consider this instead of pushing and trying to see if we can get better results with her... I said to the team she feels she is doing well, she is taking care of herself, and has maintained connections with the health care team (011).

Main Category: Keeping the Patient Safe

Subcategory: Providing Reassurance to the Patient
Psychiatric nurses also accomplished keeping the patient safe by providing reassurance to the patient. Reassurance was accomplished by orienting and redirecting the patient to
what was safe behaviour and what was not safe behaviour. Nurses provided reassurance when the patients were fearful or suspicious of their environment. Also the actions associated with providing reassurance were evident when the patient was a potential physical harm to themselves and/or others or the patients were too disabled to be capable of accomplishing their own needs of daily living (ie., nutrition, hygiene, work activities). Psychiatric nurses also reassured the patient by identifying the nurse as someone who was available to help the patient. The psychiatric nurses described orienting the patients to their environment, so that the patients could predict that they would be safe in the environment, and feel less fearful. The psychiatric nurse's emphasis on keeping the patient safe led to the identification of providing reassurance to the patient as a subcategory of keeping the patient safe. The following three excerpts show the essence of the subcategory of reassurance:

(i) I feel best when I can somehow calm down or reassure the patient that we do not want to hurt him, that we want to help him, even if right now he may not think we are (012).
(ii) the kind of help I can give him is to keep him safe right now, because he would literally harm himself, climbing into the tub of water, putting his head under the water, just keeping him safe, reassuring him by saying we are looking after you, we are here to help you, we will make sure you are okay, helping him get dressed, helping him have a bath all these things (011).

(iii) I think that psychotic patients, and this is not true of all of them, because again each one of them is an individual, and some of them would bounce off the walls if I tried doing some of this with them, but in most cases you need to direct them at first. Like telling them to brush their teeth, now sit down you are going to eat, now I am going to give you your medication, and this kind of thing. In many cases this is quite comforting, reassuring to the person, because they know they are out of control, and its terrifying for them (008).
Main Category: Keeping the Patient Safe

Subcategory: Attending to the patient's self-care and treatment

Nurses also described accomplishing keeping the patient safe category by attending to the patient's self-care/treatment and involved three levels of protecting the patient. Similar to all the other subcategories of keeping the patient safe, attending to the patient's self-care/treatment occurred when the patients were fearful or suspicious of their environment. Also attending to the patient's self-care/treatment occurred when the patients were a potential physical harm to themselves and/or others or the patients were too disabled to be capable of accomplishing their own needs of daily living (ie., nutrition, hygiene, work activities). Attending to the patient's self-care/treatment also involved the three different levels of protecting the patient which were accomplished through: 1. explaining, 2. opposing, and 3. taking control for the patient.

'Explaining' involved informing the patient of the rationale for treatment by providing the patient with the information necessary to understand treatment. Psychiatric nurses used explaining as one of the strategies for attending to the patient's self-care and treatment, as the following excerpt illustrates:
Trying to explain to the client why I think they should take the medication, why the team thinks they should take the medications, what is going to happen if they take the medication, what is going to happen as they get better, and why it is important to take the medication. It is important to explain this because most patients when they are admitted into hospital do not feel safe. They do not trust anything foreign like medications and staff. They may not recognize their behaviours as being part of their illness and that medication can help them to control their illness or behaviours (016).

`Opposing' the patient's unsafe behaviours was another strategy, psychiatric nurses used in attending to the patient's self-care and treatment while keeping the patient safe. The psychiatric nurse used the strategy of `opposing' the patient's behaviours when the patient's actions or lack of actions were physically harmful to the patient and/ or others. For example, in the following excerpt, the participant uses the strategy of opposing the patients' unsafe behaviour of banging their head on the wall:

This person is presenting as a behavioral problem whereby they are doing alot of testing of limits, attention-seeking behaviours, the good nurse/bad nurse
kind of thing...this person is not psychotic at this point...if I have someone like that I make no bones about it, I tell them my expectations of them while I am on duty what the consequences are if they can't live up to them...but I should not say my expectations, because they are talked about prior so they are both our expectations...these are basic expectations like no banging your head against the wall, no hanging yourself, no slitting their wrists and so on (003).

In addition to the strategies of explaining and opposing, psychiatric nurses also described 'taking control for the patient'. This was a strategy they used in attending to the patient's self-care and treatment while they were keeping the patient safe. Psychiatric nurses described 'taking control for' the patient, when the patient was only able to experience what was happening to them (ie., anorexia, terror, depression, agitation, anger), but the patient was not able to take any actions to help themselves. The situations depicted in the following three excerpts illustrate the 'taking control for' strategies that psychiatric nurses used to attend to the patient's safe care and treatment in the keeping the patient safe category:

(i) A good example that shows the protective aspect of my caring is when the patient's thinking in a manic state is such that the patient is very sexually
flamboyant and offers themselves to others sexually. I know that it is part of their illness, so I take over for the patient in the short term (015).

(ii) I prevent the person from phoning business contacts when they are psychotic, so that they don't leave the hospital and their reputation in the community is ruined. As I protect them from that sort of thing, I suppose, in a way, you take over, and you decide what is best (008).

(iii) Eating doesn't seem to be that much of a problem unless it is a severely depressed person, their appetite is gone, and it becomes life-threatening...that is taking control for the person temporarily because they are experiencing it and can't do anything about it right now (006).

The above three excerpts illustrated that the psychiatric nurses did not take control, unless the patient's actions or inactions were a threat to the patient or others physically. Psychiatric nurses consistently pointed out that taking control 'for' the patient was different from taking control 'from' the patient. According to the psychiatric nurses taking control 'from' the patient meant imposing what the psychiatric nurses wanted at the expense of what the patient
needed to do for themselves, and did not constitute attending to the patient's self-care and treatment in a protective empowering way. The following excerpt shows the essence of taking control 'for' as opposed to taking control 'from' the patient:

I have known patients who have just insisted on running their own water from the tap. They didn't feel it was contaminated that way, and that is fine...If you make it [food, medication, anything] into a big issue it takes on a different meaning, because you are trying to prove something or use power or force them to do what you want, rather then what they need to do for their nourishment (005).

Main Category: Keeping the Patient Safe

Subcategory: Providing the patient with information and choices

In caring for patients in a protective empowering way, psychiatric nurses oriented patients to their environment by giving them information and choices that allowed patients to gain control and predict their own safety in the situation. These themes were reflected in the following two excerpts and illustrate the role of information in keeping the patient safe in a protective empowering way:
(i) a patient who is having a flashback of a traumatic episode in their past...you help them back to where they are in the present by giving them information and by helping them distance that memory so that they are not reexperiencing it. You tell them that it is only a memory and that they are safe now, so that their anxiety will come down (004).

(ii) Sometimes patients are not aware they need to decrease their stimulation, that they need to get away from whatever it is that is making them agitated, act out, so you have to take control...I think they [the patients] get to understand that taking control for the patient by putting the patient in the seclusion room, for example, is part of helping them regain their control. That the seclusion room provides a defined space that they have control over. It is important to me that they don't see it as punitive, and that they see it as a way of helping (013).

Moreover, psychiatric nurses also described providing the patient with choices. This meant helping patients take action and regain control over their own activities of daily living, as the following excerpt shows:
Even for somebody who has very little control, because they are psychotic. There are small ways you can empower them by giving them choices, or two choices. For example, if they becoming agitated you can give them a choice between taking medication, going to their room to collect their thoughts and emotions, or going into the seclusion room. This helps them have a sense of control over their own behaviour and how to manage their own behaviour (016).

In summary, the category of keeping the patient safe was accomplished by the subcategories of: (i) advocating for the patient to the team, (ii) providing reassurance to the patient, (iii) attending to the patient's self-care/treatment, and (iv) providing the patient with information and choices. Figure 1 (see p. 95) illustrates the subcategories of keeping the patient safe during the process of protective empowering.
Main Category: Encouraging the Patient's Health

One of the six main categories of protective empowering was encouraging the patient's health. Psychiatric registered nurses empowered patients to access their abilities to accomplish their activities of daily living by encouraging the patient's health. The psychiatric registered nurses accomplished encouraging the patient's health through the subcategories: 1. promoting patient responsibility in increments; 2. inviting the patient's participation in activities; 3. bringing any changes to the patient's attention; 4. complimenting and cheerleading the patient's efforts; and 5. drawing out the health that is already there in the patient. These are the five subcategories of encouraging the patient's health and are presented in the next sections.

Main Category: Encouraging the Patient's Health

Subcategories: Promoting Patient Responsibilities in Increments and Inviting the Patient's Participation in Activities

On the psychiatric units of this study, patients had varying amounts of freedom. The amount of freedom that the patient had was represented by the privilege level assigned by the health care team. The patient's privilege level
ranged from "one", low patient freedom to move around on unit, to a privilege level "five", high patient freedom to move around on and off the unit. Psychiatric nurses described "caring" as helping the patient progress through each of the five patient privilege levels on the psychiatric unit. In order to understand this subcategory of encouraging the patient's health, a brief description of how the psychiatric nurse monitored the patient's privilege levels is provided.

Generally, a privilege level of "one" meant that the patient remained on the unit and the nurse was with the patient at all times. The nurse only left the patient when relieved by another nurse. Privilege level "two" represented an increase in the activities and freedom of the patient in which the patient was allowed to move around on the unit, but the patient had to remain on the ward. In privilege level "two", the nurse checked with the patient frequently usually every 15 or 30 minutes, depending upon the patient's needs and condition. In privilege level "three", the patient again was required to remain on the unit, but was able to leave the ward or unit when accompanied by the nurse. Moreover, in privilege level "three", the nurse checked with the patient less frequently than privilege level "two". In privilege level "three", the nurse expected the patients to take more responsibility for their own self care and to participate in the development of their care plan. In
privilege level "four", the patient was allowed to go out onto, but not leave the hospital grounds. Finally, in the fifth level of privileges, the patient was allowed to leave the hospital property on "passes" into the community. During this time, the patients usually left to take care of their housing affairs, to look for work, and to explore community programs and groups, but returned to the hospital as negotiated with the team.

The psychiatric nurses described that helping the patient through each of the five privilege levels, meant helping the patient build his/her self-confidence by promoting the patient's responsibility in increments. Psychiatric nurses described Promoting the patient's responsibility in increments as a subcategory of encouraging the patient's health which in turn helped to empower the patients to access their own abilities to accomplish their activities of daily life, as the following excerpt illustrates:

Privileges are a way of being honest about what they can and cannot do, and also gives them a sense of accomplishment when privileges are increased, and a sense of safety when they are decreased. It also gives them a sense that when they come in, they all start at the same privilege level until the staff get to know them, and until they earn the right to be freer, to be on the hospital grounds. The purpose of privileges is
to instill responsibility in the patient, and to have responsibility returned to the patient...as they get better they can have more control and more autonomy, until they have the courage to go out [in the community] and re-establish themselves (0017).

Furthermore, the subcategory of promoting the patient's responsibilities in increments involved inviting the patient's participation in activities, which was another subcategory of encouraging the patient's health. Upon the patient's admission into hospital, the psychiatric nurses described the importance of promoting the patient's responsibilities in increments and inviting the patient's participation in activities as the following excerpt exemplifies:

When a patient is psychotic, he is unable to look after himself, so you take control for the patient. I mean you bathe them, supervise their hygiene, supervise their eating, elimination patterns...I introduce these things again...because sometimes they forget... I help them until they are generally able to do these things themselves, and it depends where they are in their illness...I had this patient...I had a hard time convincing and teaching her to go and eat. I spent at least 15 minutes every single day before breakfast. I
spent 30 minutes before lunch and 15 minutes before dinner reminding her and convincing her to go and eat. I did this for at least two weeks. Then she started to come around and she remembered to go and eat (014).

As the patient progressed, promoting patient responsibilities in increments was further accomplished by helping the patient experience success at an activity. Nurses focussed on identifying and promoting the patient's strengths as the following excerpt exemplifies:

You have to realize that you can't change what the client cares about...you don't want them to go after something that it is likely, based on what you know about the patient, that they will fail at. So if you can find a strength and get them going at that, then they begin to learn they can succeed and accomplish things (016).

Main Category: Encouraging the Patient's Health

Subcategory: Bringing any Changes to the Patient's Attention

Psychiatric nurses also described encouraging the patient's health by bringing any changes to the patient's attention. Psychiatric nurses described patients as not always recognizing their own progress. For this reason, the
nurses emphasized the importance of bringing changes to the patient's attention as part of encouraging the patient's health. Moreover, psychiatric nurses described that some changes in the patient may seem trivial to a casual observer, but in context of the psychiatric nurse knowing the patient's life situation, a change as simple as a patient getting out of bed is considered a success, as the following excerpt exemplifies:

Maybe what I do is not a big thing for you, or you can't see it, but if you knew the patient it is a big thing!...even if you see a little change, that is a big success...even just the little thing to the patient, it is very important to recognize that little thing [and show it to] the patient, and say 'you are doing well'...sometimes they do not recognize their own progress so you have to point it out to them (014).

Main Category: Encouraging the Patient's Health

Subcategory: Complimenting and Cheerleading the Patient's Efforts

Encouraging the patient's health was also accomplished by the nurse complimenting and cheerleading the patient's efforts, such as the patient remembering to eat or the patient getting out of bed. Giving the patient praise was described by the nurses as important in affirming that the
patient, not the nurse, was responsible for an accomplishment. Moreover, cheerleading the patient's efforts involved praising all of the patient's efforts and attempts, no matter how small, and making the patient feel good about themselves as the following excerpt illustrates:

...Any little effort the patient may make with caring for themselves and trying to do for themselves I try and give them praise for that, like saying 'you are doing good', 'you did it!' and being enthusiastic if it is appropriate. I let them know, what they have done, and make them aware of that progress... So any little bit that they do like putting on a shoe, or getting up out of bed, or just knowing that they need to go for breakfast, I try and give them praise for that, and give them encouragement to continue on so that they maintain that positive behaviour (013)

Cheerleading involved giving the patient hope and courage. In cheerleading, psychiatric nurses provided the patient with information and with verbal assurances such as "you are on track, you just have to trust, [and] you have to persevere" (015). Psychiatric nurses cheered patients, that were discouraged with their progress, by utilizing the nurses' knowledge and experience with other patients in similar situations. In doing so, psychiatric nurses ENCOURAGED THE PATIENT'S HEALTH by helping the patient
understand what to expect in illness and in recovery from illness, as the following excerpt illustrates:

I have seen a range of patient behaviours, I am familiar with what patients say they feel and think during illness, and I know the length of time it takes for medication to work. For example, when you start an antidepressant the first week you are on a bit of a high because you think you are finally getting treatment and hope this is going to get better. So patients usually take the medication. Then in week two and three and going into week four, sometimes patients state that nothing is different even though they are pouring these pills down their neck every night. Patients say they don't feel any different. Patients say 'what is the use of this!'. But then all of a sudden, in week five, the clouds might start to lift. I tell them that getting through week two, three, and four is hard...and that these pills are not like aspirin which they take for a headache, and then 20 minutes later the headache starts to lift, these medications take weeks (015).
Main Category: Encouraging the Patient's Health

Subcategory: Drawing out the Health that is Already There

Encouraging the patient's health was also accomplished through the subcategory of drawing out the health already there in the patient, and pertained to helping the patient remember what was important to them. Psychiatric nurses stated that, drawing out the health already there in the person, involved determining what the patient cared about. This could be their children, family, occupation, or spiritual-cultural beliefs. The psychiatric nurse used whatever was important to the patient, as a way to motivate the patient, to take action in their own recovery, as the following excerpt shows:

Looking at the patient's strengths starts from the very beginning, it might be very basic when they first come in. The patient's strength could be a family member, it could be their religion or it could be trusting the treatment team. Maybe they have a skill or a profession that they have come from, which you can get into, that you can draw from to help them remember the strengths they have, so the patient can get into accomplishing their activities of daily life again (016).
Psychiatric nurses also drew out the health that was already there by helping the patient focus on the things they did when they were well. The psychiatric nurses described helping the patient remember and access those abilities, as the following excerpt exemplifies:

It is very difficult for patients to remember that not so long ago they were functioning quite well in a job or in their life. In the hospital, all they know is misery at first. I tell them I recognize that this is a bad, horrible experience for them, but I also work with them on how we can put what is happening to the patient into context... This is part of helping the person to accept the fact that they have recurrent depression, borderline personality disorder, psychotic illness. I help them look to the times when they are not psychotic and to work towards those times when they are not depressed or manic...the disease is only part of the person, even though it could be the major part at this time for this person... I try not to focus only on the illness, I try to focus on the health of the person. I try to draw on the health of the person (008).
In summary, the main category of Encouraging the Patient's Health was accomplished by the subcategories of 1. promoting patient responsibility in increments; 2. Inviting the patient's participation in activities; 3. bringing any changes to the patient's attention; 4. Complimenting and cheerleading the patient's efforts; and 5. Drawing out the health that is already there in the patient. Figure 1 (p. 95) illustrates the subcategories of encouraging the patient's health in the process of protective empowering.
Main Category: Authentic Relating

One of the main categories of protective empowering was authentic relating. The category of authentic relating emerged from the data as one of the specific actions and interactions nurses had with patients. Authentic relating was one of the main categories of protective empowering that nurses implemented to help the patients access their abilities to take action or accomplish their activities of daily living. Psychiatric nurses accomplished authentic relating through the subcategories: 1. being consistent; 2. being available and responsive to the patient's concerns of daily living; and 3. by matching the nurse's interactions with the patient's receptivity and capabilities. These are the three subcategories of authentic relating and are presented in the next sections.

Main Subcategory: Authentic Relating

Subcategory: Being Consistent

Through the provision of consistent care, the psychiatric nurses established themselves as trustworthy and genuine. Being consistent involved providing care that the patient could learn to predict. That is, being consistent with the patient when providing physical care, and when
interacting with the patient, as the following excerpt shows:

the key word is consistency and doing things that we can do every single day until it sticks with them that they can do it, and that they know I will not impose something on them (014).

Nurses described that a consistent approach with a patient was important to helping the patients predict their safety. Nurses stated that patients were calmed by having the same nurses work with them, and this approach was referred to as primary nursing. A primary nursing approach was used in all three settings. Psychiatric nurses stated that primary nursing was an essential part to building the patient's trust in the nurse. The importance of the primary nursing delivery model, and being consistent with the patient, are exemplified in the following three excerpts:

(i) The primary nurse oversees everything...and you are the person that has the most interaction with them. If you are working two weeks of days, and two weeks of evenings you are constantly working with that person while they are on the unit (002).
(ii) We try to assign patient care to the nurse that is already assigned...it is easier for the person to come and talk to you because you have already built your rapport with them. They are more comfortable coming to you than a person they don't know (014).

(iii) If it is my patient, and I know them well, and we are in a situation that we have to seclude a patient, I take a leadership role. I let people know how it should be handled and why. Rather than letting someone else do it that might make it difficult for the patient (010).

Moreover, psychiatric nurses stated that consistency between health professionals was just as important as the consistency of the individual nurse with the patient. This was exemplified in the following excerpt:

Consistent care is important so it does not create splitting [divisions] amongst the staff. Even if the nurse has her own approach, each nurse has to follow through on the approach initiated. Sometimes our agreed upon plan is not followed through. We work very closely on this unit, we usually talk to each other, or try to point out the lack of follow through to another nurse or another professional. We point out what we have agreed upon. If they have something to contribute
more to the plan that is welcome, but we have to discuss it so that all of us on the team can do it, because this is a multidisciplinary team (014).

Main Category: Authentic Relating

Subcategory: Being available and Responsive to the Patient Concerns of Daily Living

Psychiatric nurses described being available and responsive to the patient's concerns of daily living as essential to accomplishing authentic relating with the patient. Nurses defined the patient's ordinary needs as responding to everyday concerns related to self-care. Some of the patient's ordinary needs and requests included:

1. making sure that the patient has a meal tray
2. dealing with complaints about not receiving the food they ordered on their meal tray
3. patients requests to change their meal menu or order extra food
4. disputes between patients about missing food on meal trays
5. unlocking doors for patients
6. getting laundry out of the laundry room for the patient
7. ordering snacks for the patients
8. handling requests for supplies, such as toiletries
9. taking patients to the smoking room and supervising them
10. ordering supplies
11. switching patient rooms

Inherent in the nurse being available and responsive to the patient's concerns of daily living was the nurse's sensitivity to the social, economic, and political forces that contributed to the patient's situation. Nurses stated that an understanding of these forces further enabled the nurse to be receptive to the patient's ordinary needs as the following excerpt represents:

We all have ideals about how you will help alleviate the suffering of humanity, but then in practice you find out that suffering is not the same for everyone. A person's suffering could be about the most trivial and ordinary things that you or I might take for granted. For example, for some patients that come from the street, suffering is they do not have socks... So if you respond to this ordinary need without humiliating him or without lecturing him about why he is going barefoot, you are showing him you understand his circumstance, that he does not have any socks, that he came here from the street, and that he did not have nothing to begin with (012).

All of the seventeen psychiatric nurses described the subcategory of being available and responsive to the patient's concerns of daily living as part of the
psychiatric nurse's "caring". However, the nurses were divided about the extent to which these patient concerns of daily living should be addressed as part of "caring". These divisions are presented in the next section on Variations.

**Main Category: Authentic Relating**

**Variations in Subcategory of Being Available and Responsive to the Patient's Concerns of Daily Living**

All seventeen psychiatric nurses in this study described authentic relating as evidenced through the subcategory of being available and responsive to the patient's concerns of daily living, and included this as part of their caring. However, there were three different viewpoints regarding the degree to which nurses felt they should be available and responsive to the patient's concerns of daily living. One group of nurses believed the patient's ordinary needs of daily living should be delegated to unskilled staff. A second group of nurses believed that being available and responsive was important to building trust and establishing a relationship with the patient. A third group of nurses believed that nurses should remain available and responsive to the patient's concerns of daily living, but not to the extent to which nurses are today. The third group of nurses also advocated reallocation of nursing resources.
One group of nurses (two of the seventeen participants) described being available and responsive to the patient's concerns of daily living as menial and was represented by the following excerpt:

Anyone can give a person a [food] tray to feed themselves, but that is part of what we do, we make sure that everyone has got food, and their trays are accurate. Also, dealing with the patient's complaints about food, like someone did not get what they ordered, or someone stole their food. Your eight hours go by fast doing menial things. This is a menial thing (001).

A second group of nurses (thirteen of the seventeen participants) described being available and responsive to the patient's concerns of daily living was important to building trust and establishing a relationship with the patient, as the following excerpt represented:

Nothing is too small for the psychiatric nurse to respond to, even if it is the most trivial request, what is important is how you deliver your service to the patient's most trivial request, this is what makes the psychiatric nurse a real professional...I think that through the most ordinary patient things [requests] which we do for the patient we can actually establish a therapeutic relationship (012).
These nurses also included, and addressed, the following patient concerns of daily living as part of their caring:

1. where can I find this or that?
2. may I get another towel?
3. where can I get socks?
4. when will I be allowed out?
5. the bathroom is dirty can you open another bathroom?
6. when will I get more privileges?
7. can you find a telephone number for me?
8. what should I do about that?
9. Can I have a hug?
10. Where can I get salt?
11. why can't I make toast for myself?
12. where is my nurse? Is my nurse here?
13. when will my nurse give me more privileges?
14. can you tell my nurse to call the kitchen, I would like to go on a weight reducing diet.
15. when will I go to the gym?
16. when is hairdresser day?

These nurses stated that in responding to the patient's most seemingly trivial needs, they were able to build some trust and a relationship with the patient. These nurses described that in being available and responsive to the patient's most ordinary needs and requests, the nurses
established themselves and eventually represented, to the patient, as someone that was available to help the patient.

The third group of nurses (two of the seventeen participants) stated that responding to the patient's ordinary needs of daily living was important but did not warrant the amount of time that nurses spent on them in the practice setting. Also these nurses described certain patient ordinary needs and requests as taking time away from the counselling work that nurse's do with the patients. These nurses described a need for re-prioritizing the way in which nurses spend their time with patients. These themes were exemplified in the following excerpt:

I really feel that getting caught up in [meal] trays and complaints about what they have got to eat and opening doors for them to rooms, is a waste of my valuable time, but I can offer them other things like one to one interactions. I see responding to the patient's ordinary needs as part of my caring with patients in the hospital setting, but not to the extent that others do. I would be quite happy if someone else could do it and not have it as part of my caring...I think it is a gross mismanagement of resources (004).
Although these variations pertained to the nurse's vision and hopes for this subcategory, they were included because they naturally emerged during the interviews.

**Main Category: Authentic Relating**

**Subcategory: Matching the nurse's method of interaction with the patient's receptivity and capabilities**

Authentic relating also involved the nurses matching their degree of interaction with the patient's receptivity and capability to interact. That is, the nurse followed the patient's lead when deciding how to interact with the patient. This was illuminated by the following excerpt:

Some patients with mania, or that are out of control, can be verbally obnoxious, because of their illness...So I just try to understand that as best I can. I give the patient more space and that actually helps, because they can't tolerate alot of contact when they are like that. It does not help them feel any better about themselves if I keep going in, and they keep screaming at me. So at this point I make short contacts to make sure they are okay. And maybe I just ask once or twice, during the shift, how they are doing, and giving them space (009).
This meant the relationship between the nurse and the patient was manifested in different ways and had no one definition, as the following two excerpts illuminate:

(i) The relationship I have with the patient depends on the kinds of patients I have. For instance, right now I have someone who is manic, but who is also possibly organic, with a very short attention span. She has many small perceived needs, so what I find I am doing with her is meeting briefly and getting her through the shift. That means spending a few minutes with her, because she can't tolerate more than that, and she escalates when she gets over stimulated. So I tend to spend a few minutes frequently five or six times during the evening. Then there is somebody else, I just made an appointment with and this is somebody I have worked with on several admissions, she has a dissociative identity disorder, and we have set the time for nine o'clock [pm]. I will probably spend a good hour working with her (005).

(ii) What I do with the patient varies, there is an example of this today. I have an assignment of five patients...of my five patients three patients are at the point that they are signed out for passes [into the community]. I spoke with two of them at length
regarding their problems and difficulties to help them on their passes in the community. I focus on their relationships and the significant others in their life, that has been lacking in the communication aspects, or such that they avoid and use outdated coping skills to deal with their problems. My caring for these people is such that I try to elicit different responses from them in dealing with people so that they are able to navigate through some difficult periods with these individuals [in the community]. I tend to sit down with [these] patients and go over different ways of communicating and how they can be improved. I listen to them and I listen to their defenses and defensiveness...I just simply try to understand them better by having them try to understand the way they communicate (006).

In relating to the patient authentically, the nurses described the importance of determining what type of interaction the patient was capable of, and/or receptive to, at any point in time. Many nurses described the problems encountered when they "went by the book" and expected patients to interact in traditional ways. For example, psychiatric nurses stated that some patients are not capable of having a discussion with the nurse as the following
excerpted illustrated:

If I go by the book, and sit down and ask him [the patient] how are you? then he will start mumbling about the end of the war and this and that...with very disorganized speech, which will actually discourage him (012).

In summary, the main category of authentic relating was accomplished by the subcategories of: 1. being consistent; 2. being available and responsive to the patient's concerns of daily living; and 3. by matching the nurse's interactions with the patient's receptivity and capabilities. Figure 1 (see p. 95) illustrates the subcategories of authentic relating in the process of protective empowering.
Main Category: Interactive Teaching

Psychiatric nurses accomplished protective empowering through the main category of interactive teaching as evidenced through the subcategories: 1. showing the patient through the nurse's example in interactions; 2. building on the patient's interests, needs, and knowledge; 3. giving feedback; 4. pointing out expectations, alternatives, and life patterns; and 5. helping the patient anticipate how they will manage in the community.

Psychiatric nurses believed that patients could develop, or already had, the capabilities to do things for themselves, even though the patient may not be able to access those capabilities upon admission to hospital, for whatever reason (i.e., lack of physical, biochemical, social, emotional and/or situational resources). This is illuminated in the following excerpt:

I find alot of patients know what they need to do. They know the areas that need to change. But for whatever reason maybe it is their environment that they don't have enough support. They may have a heavy load, maybe they are a working mother who is juggling work and home and gets depressed. There are so many factors. Alot of people know the areas they want to work on, but can't do it alone...They may need some medication to help
control some of the symptoms, but it is not all a matter of the patient's will or desire to get well, it is biological and situational too (005).

Main Category: Interactive Teaching
Subcategory: Showing the patient through the nurse's example in interactions

Psychiatric nurses described a continual exchange of information between the patient and the nurse. Nurses stated teaching occurred interactively between the patient and the nurse. Interactive teaching was accomplished through the subcategory showing the patient, by way of the nurse's example of interactions with others. For instance, a psychiatric nurse stated: "we teach patients all the time through our responses and how we approach them. In every interaction with a patient there is some kind of information exchanged" (012).

A psychiatric nurse described that "the nurse's example helps the patient get an idea about how to problem-solve, it helps them to know how to go about doing things and asking for things. It is like being a role model for the patient" (013). Psychiatric nurses stated that showing the patient through the nurse's example of interacting with the patient and others was evidenced by helping the patient "problem-solve and make decisions about how to respond to questions about their hospitalization, how to assert
themselves when they perceive others are being nosey, how to ask their doctor about their medications in terms of whether they are addictive, their dosage, and what to expect" (010). Showing the patient through the psychiatric nurse's example involved "not expecting big things" (012). Nurses showed the patient how to interact by "really listening to the patient and letting them know that they were being listened to and understood" (004). Nurses used showing the patient as a strategy for interactive teaching in the hope that the patient would imitate the nurse's manner of interaction. Nurses reported that showing a patient a "respectful approach really makes a difference in how the patient responds to you and others" (005). Nurses were resigned to the conviction that "people are not going to change their mode of thinking, behaving, and responding to the world, because they have been this way ever since they were young and have learned that way of coping" (002). Nurses stated they did not expect that "we are not going to change them in the week or weeks they are here...but we can show them how to respond by responding to the patient in a very non-threatening way" (001).
Main Category: Interactive Teaching

Subcategory: Building on the patient's interests, needs, and knowledge

Interactive teaching with the patient was based on what the patient knew and cared about. For example, psychiatric nurses stated that they could "support, encourage, cheerlead, educate, and facilitate, but the bottom line is that the patient has to take the responsibility, and care about the treatment goal" (015). Therefore, psychiatric nurses were concerned with sharpening the focus of teaching, so that it was meaningful to the patient. The way in which psychiatric nurses accomplished this was through the subcategory of building on the patient's interests, needs, and knowledge. This meant psychiatric nurses helped the patient take ownership of their actions, and what action to take, by building on the patient's interests, needs, and knowledge. For example, psychiatric nurses described they would "ask the patient what would you like to be involved in? what are the things that you were doing before, which you enjoyed, that we can help you do it here?" (0014). Nurses stated they found it "easier to work with them [the patients] when they take responsibility to choose what they want to do" (009). This meant helping the patient remember what they liked to do, when they were well. Psychiatric nurses stated they would say things like "if you just try to
resume what you usually do, when you are well...it may help you" (012). Psychiatric nurses stated that this approach to exploring the patient's interests was effective even with patients which were a challenge to engage in a relationship, as the following excerpt illustrates:

I began to ask what kind of things do you like, what kind of hobbies do you have, what kind of things do you like to do, and she began to take some interest in that. Now sure if I talk to her today, maybe everything might be shifted and we will have to look after that again, but at the same time for that brief time she was here and we connected (011).

Main Category: Interactive Teaching

Subcategory: Giving feedback

Psychiatric nurses provided the patient with feedback about: 1. how the patient came across in interactions; and 2. the impact that the patient's choices had on the self and others (i.e., pointing out potential harm). For example, psychiatric nurses described "always trying to give the patient the aura of comfort, of safety, trying to help the patient feel like they are still in control, and that they have a choice, but it is the nurse's responsibility to tell them what they are doing, what their actions are, and what the effects are on others" (017). In providing the patient
with feedback in interactive teaching, psychiatric nurses helped "the patient think through what they are doing, why they were doing it, what were some of their options, and what would be the expectations associated with each decision the patient considered choosing" (010).

Giving Feedback by communicating the nurse's point of view of the patient's impact on others was accomplished by helping the patients examine "the way they communicate...and helping them consider how their beliefs about things, hold up against evidence in the environment or situation" (006). Nurses stated that in providing feedback to patients they "do not provoke them...[instead nurses] help them look at how their fears and anxieties prevent them from getting what they want, or having the relationships they want" (006).

Main Category: Interactive Teaching

Subcategory: Pointing out expectations, alternatives and patterns

Psychiatric nurses described pointing out expectations, alternatives, and patterns actions and meanings to those patterns as part of interactive teaching. Psychiatric nurses described that patients had a tendency to interpret situations according to their own beliefs and that these beliefs were blindly applied to most situations. For
example, in the following excerpt, the psychiatric nurse described a patient who had showed the pattern of interpreting most situations as devaluing. The nurse pointed out alternative meanings to the patient's automatic meaning of a situation as devaluing:

I mean somebody just looks at her the wrong way and she feels totally demoralized, devalued, and is ready to fall apart and you have to spend an hour with her helping her work through those feelings, where they are coming from, how did she perceive what happened, and are their alternative meanings, and just helping her work through all that (004).

Psychiatric nurses also pointed out alternative actions to the patient's automatic actions. For example, nurses described helping patients "control their impulses, and learn potentially new ways of coping so that their lives will be easier" (009). Psychiatric nurses pointed out alternative actions in order to help the patient identify ways of by-passing the barriers which interfered with the patient's health. This meant "teaching about illness, medication, and their management in the hospital" (007). For example, psychiatric nurses described situations in which "sometimes people are put into the seclusion room. When they come out, nurses help them deal with, and sort out, what
happened in the seclusion room, what led up to them going into the seclusion room, and what they can do differently in the future to prevent the patient's loss of control. For example, "instead of letting the patient's tension escalate, the patient developed a new coping skill of going for a walk to help him relax" (003).

In pointing out the patient's patterns and alternatives, psychiatric nurses tried to inspire the patient to consider other ways of viewing and acting in situations as the following excerpt illustrates:

we talk about coping strategies in group, and I think over the years there must be 38 different coping strategies generated by the patients. The patients just keep adding to it and they include everything from yoga to you name it. Then we will spend a session of what isn't healthy. I always tell them that if they hear something that they are doing isn't healthy, I tell them that they will learn that they can change their behaviour, because you don't want to frightened them, especially if they see that all their ways of coping on the negative list (010).
Main Category: Interactive Teaching

Subcategory: Helping the patient anticipate how they will manage in the community

Psychiatric nurses accomplished interactive teaching through the subcategory helping the patient anticipate how they will manage in the community. Psychiatric nurses helped the patient anticipate the community by educating the patient on "how to stay well". Although the level of teaching varied according to the patient's ability to focus, psychiatric nurses stated that as the patient was able to maintain his/her attention and concentration, the nurse talked about "what is out there in the community in terms of support" (011). That is, psychiatric nurses discussed with patients topics like taking their medication, going to their follow-up appointments, spotting early warning signs, and not waiting to go back to the doctor, if the symptoms returned. Psychiatric nurses stated that they encouraged patients "to call and get in to see their doctor early to avoid another hospitalization" (012). Also psychiatric nurses helped patients anticipate the community by suggesting that patients keep "a personal record of how they are feeling, sleeping, and eating so that they can take it to their doctor's appointment" (010). Psychiatric nurses provided patients with information on supports available in the community, such as their "family, church, friends,
support groups, a drop in mental health clinics, volunteer groups, and public health nurses" (011). Psychiatric nurses helped the patient anticipate the community by: 1. reviewing the "supports that the patient has, which have been successful for them in the past" (003); and 2. discussing with the patient how they planned to accomplish their activities of daily living. For example, "if they [the patient] has to go to an appointment to the other side of the city, [then] helping them problem solve [around] how they would manage that, so it [teaching] is not only around illness (015)". Moreover, psychiatric nurses stated that helping the patient anticipate how they will manage in the community "empowers them with the illness, gives them information, gives them support" (015).

In summary, the main category of interactive teaching was accomplished by the subcategories of: 1. showing the patient through the nurse's example in interactions; 2. building on the patient's interests, needs, and knowledge; 3. giving feedback; 4. pointing out expectations, alternatives, and life patterns; and 5. helping the patient anticipate how they will manage in the community. Figure 1 (p. 95) illustrates the subcategories of interactive teaching in the process of protective empowering.
Respecting the patient emerged as the prerequisite to caring in a protective empowering way. Respecting the patient represented the psychiatric nurse's general method of interacting with the patient. Respecting the patient encompassed the four actions and interactions of protective empowering: Keeping the patient safe, encouraging the patient's health, authentic relating, and interactive teaching. Psychiatric nurses stated that respecting the patient was: "more of a way of doing everything else I have to do...Respect is the basis of the relationship with the patient and trying to develop a trusting relationship, so that the patient can better interact in the community" (009).

Psychiatric nurses accomplished respecting the patient through the subcategories: 1. acknowledging the patient's concern or distress, 2. being non-judgemental of the patient, 3. not power-tripping, and 4. viewing the patient as knowledgeable about what needs to be done. Each of these subcategories pertaining to the category of respecting the patient is presented.
Main Category: Respecting the Patient

Subcategory: Acknowledging the patient's concern or distress

Acknowledging the patient's suffering and distress involved showing concern for the patient. Nurses conveyed that what the patient had to say was important and acknowledged, as the following excerpt shows:

I try to talk to each of them each day for 10 minutes at least, and really sit down and listen to them. And this is really helpful most of the time, because generally speaking, psychiatric patients suffer from loneliness, they feel that they don't count, so when you give them your attention, they feel that they are somebody, that they are a person who is worthy enough to be listened to (012).

Although acknowledging the patient's distress and concern did not mean condoning patient behaviours that threatened the physical safety of the patient and others, psychiatric nurses did not discount the patient's feelings, as the following excerpt represents:

I am understanding and accepting of the patient's feelings, but I help them consider what else they can do with their feelings that is not going to hurt anybody, that would be more productive and not destructive (009)
Main Category: Respecting the Patient

Subcategory: Being Non-Judgemental of the Patient

Being non-judgemental of the patient involved approaching the patient with deference and "showing the patient unconditional acceptance for who they are" (009). That is, the nurse set aside the nurse's own wants, wishes, opinions, judgements, and focussed on what the patient said they wanted, needed, preferred, and wished. Being non-judgemental meant "there is a basic respect for another human being, whatever his behaviour may be" (012) and involved separating what the patient has done in the past or is doing in the present, from who the patient is, as the following excerpt illuminates:

Being non-judgemental and just accepting them for the way they are. Not trying to change them drastically. Making them feel they are accepted. When a patient presents themselves, you don't want to judge them, change them, or mould them in the way that you want them to be, because they are an individual... As a nurse you want to promote the positive aspects of their individuality, not hold their individuality against them, that is what I mean by being non-judgemental. I think from day one when they are admitted to hospital you have to give them a sense that they are respected, they are an individual, and that you just want to help
them. Help them with whatever, or build on, or enhance or promote, whatever positive aspects of their individuality that they may have. You respect them for who they are... patients have their own lifestyle and beliefs which I respect, not hold it against them, or try to impose my beliefs on the patient (0013).

Main Category: Respecting the Patient

Subcategory: Not Power-Tripping

Psychiatric nurses differentiated between the nurse taking control `for' the patient and the nurse taking control `from' the patient. Nurses described taking control `for' the patient, when the patient was only able to experience the distress and suffering of his/her situation, but were not able to take action to help themselves. In these situations, the psychiatric nurses described taking control `for' the patient. Taking control `for' the patient has already been presented through the subcategory attending to the patient self care and treatment of keeping the patient safe category; therefore, is not presented here. Psychiatric nurses described not power-tripping as the basis for not taking control `from' the patient. Not taking control from the patient was pivotal to respecting the patient.
Psychiatric nurses described not power-tripping as allowing the patient to do what they needed for themselves, as opposed to coercing the patient to do what the nurse wanted. That is, the nurses allowed the patient the opportunity to make choices for themselves, as the following two excerpts illustrate:

(i) Years ago there was a fairly new RN on, and she came to me, because she was having a problem with a patient. The patient would not go to bed and I remember that my initial response was to ask 'why won't she go to bed?', and the nurse said 'I don't know'. So I went up to see the patient. I went to see her and I commented on the time, and that she had not gone to bed yet, and I asked `why?'. She said that her bed was full of snakes, but no one had thought to ask why she did not want to go to bed. For this patient, it was enough to put her in a different room that did not have snakes. I think that often times there is just these expectations of people to fit into a little slot, and we say `you go to bed at this time', and `you do this at this time' without looking or questioning the nurse's own power. People actually need to question their power as a nurse, and for me caring means not being black or white about things, and that there are grey areas, with a variety of choices...for me caring is about not having that power trip over patients(010).
(ii) to be sarcastic, argumentative, or power-tripping... All we are doing is antagonizing, and getting a reactive stance rather than getting the person to work with you on developing the skills necessary to care or act for themselves (005).

Psychiatric nurses also accomplished not power-tripping by giving the patient the opportunity to voice his/her concerns and what they cared about, as the following excerpt shows:

clarifying if they say something to you, clarifying it back to them in their own words, and asking them "Is that what you are trying to get across?". Using silence, and not really interjecting alot is important and allows them to tell their own story. (002)
Main Category: Respecting the Patient

Subcategory: Viewing the patient as knowledgeable

Psychiatric nurses described patients as knowledgeable about what needed to be done, what they wanted to do, and what was feasible. That is, the patient was viewed as an expert of his/her own experience, and the psychiatric nurses viewed themselves as having the knowledge, experience, and resources to help the patient determine what they wanted to do. The following excerpt illuminates the essence of the subcategory patient as knowledgeable:

I believe that inside every person they know what needs to be done because they have lived with themselves, they have memories, they have the experience, they probably know what works and what does not work, or at least they know the things that don't work. So I help them consider 'what can you do that will work'. I can't tell the person what to do, even though I know where the programs are and who might be the best therapist when they are discharged. Although I can try as much as possible to understand another person, I really can't get inside them and feel their experiences, so for me respecting the person's whole life, and their experience is something that is very important. No one can tell the patient how they should feel, what they should do, but I can help them to put things into
perspective and into context, so that the patient can say 'this is what I need to do for me' (008).

In summary, psychiatric nurses accomplished respecting the patient through the subcategories: 1. acknowledging the patient's concern or distress, 2. being non-judgemental of the patient, 3. not power-tripping, and 4. viewing the patient as knowledgeable about what needs to be done. Each of these subcategories pertaining to the category of respecting the patient was presented. Figure 1 (p. 95) illustrates the subcategories of respecting the patient in the process of protective empowering.
Main Category: Not Taking the Patient's Behaviour Personally and its Subcategories

Not taking the patient's behaviour personally was the main category that represented how nurses maintained and sustained the respectful approach represented through the category of respecting the patient. Psychiatric nurses described that not taking the patient's behaviour personally was not only important to keeping protective empowering on track, but also helped nurses protect themselves and the patient by getting perspective on situations that were challenging, threatening, and difficult for the nurse. When the nurse was able to not take the patient's behaviour personally, caring in a protective empowering way was facilitated as the following excerpt illustrates:

When I am in a situation where the patient is verbally abusive, physically abusive, I think of the patient as crying out for help. I do not focus on my side by taking what they do to heart, or giving myself the idea that what they do is directed at me personally (013).

Psychiatric nurses described not taking the patient's behaviour personally as more difficult to achieve when patients were perceived as having control over their behaviours and choices, but chose to verbally or physically threaten the nurse. This is illustrated in the following
excerpt:

From someone who is in control and who knows what they are doing, perhaps with the intent to provoke, the intent to hurt, with the intent to shock, then initially I tend to take it a little more personally and get angry. It might take a little longer to re-synthesize or reconstitute myself before I acted. This is what happens in extreme cases, but for the most part, I don't take it personally (017).

Not taking the patient's behaviour personally involved restoring the nurse's self to the point that the nurse can continue to relate to the patient in a respectful manner. Psychiatric nurses stated that "caring" could easily be derailed if the nurse was not able to NOT TAKE THE PATIENT'S BEHAVIOUR PERSONALLY, especially when the patient made devaluing remarks about the nurse in terms of the nurse's gender, role, and race. The following excerpt illuminates the pivotal importance of not taking the patient's behaviour personally to caring:

Some patients will say 'I do not like to work with you because you are a coloured individual' or for whatever reason... or the patient may call you names or a servant... If I am a very sensitive person about that, and I am not thinking about the care of the patient, then I will begin shunning the patient or avoiding them
all the time...it was hard initially, it was very
difficult for me when I was new in this institution,
but I learned over the years that I don't gain anything
from that and neither does the patient (014).

Psychiatric nurses accomplished not taking the
patient's behaviour personally through the subcategories: 1. Knowing yourself; 2. Knowing the patient; 3. Consulting with other nurses, the team, and the patient; 4. Viewing each situation with the patient as a learning experience; 5. Imagining the patient's situation; and 6. Taking a break. Each of these subcategories pertaining to the main category of not taking the patient's behaviour personally is presented.

Main Category: Not Taking the Patient's Behaviour Personally

Subcategories: Knowing Yourself

The subcategory of knowing yourself was described, by the psychiatric nurses, as important to not taking the patient's behaviour personally. Knowing yourself involved the nurse recognizing his/her own needs, wants, preferences, and biases in relation to the patient. That is, psychiatric nurses stated that working through, or processing, the nurse's response to the patient was important to the occurrence of caring, as the following two excerpts
(i) When there is no time to sort out or analyze what you are feeling and why you are feeling the way you do about a patient, you are not going to be very caring. Because your feelings will be reflected in how you communicate to that patient. For example, a patient diagnosed with schizophrenia, who was well controlled medically, had a dependent personality type. I found that his dependency would irritate me, because he was so needy...if I can get perspective on this, then I can respond to him in a caring way and in a way that facilitates him being more independent and not so needy (004).

(ii) I think it takes alot of time to work through your response to a patient... It is more difficult to be caring if you are not aware of your own emotional reactions to the patient...you start to internalize the patient's feelings...you might feel the patient is testing you...but if there is alot happening on the unit like one patient is freaking over there and another patient is acting out over here, and there are two other patients trying to get your attention, it is hard to work through your response to a patient but it is necessary (008).
Main Category: Not Taking the Patient's Behaviour Personally

Subcategory: Knowing the Patient

Knowing the patient in terms of his/her thought processes, understandings, needs, wants, preferences, and biases was important to the nurse not taking the patient's behaviour personally. In knowing the patient, the nurse was less likely to disengage from the patient or take offense from the patient's lack of progress or non compliance. That is, the nurse was more apt to explore what the patient cared about, as the following excerpt represented:

You have to know the patient. You have to realize there may be barriers for them not to progress and reasons why they are shutting down. For example, 'is there something that they do not understand?' 'are they fearful?', 'are they feeling that maybe they are not heard? So really taking the time to know the patient by actively listening to them, sitting down with them, and asking them what is going on. Lets say that a patient may feel that their needs are not being met. Or if they have a personality disorder they may feel abandoned, a sense of emptiness, a sense of loss, and they may act out. They may become uncompliant or engage in types of self-harm, so really looking for the reasons behind their behaviour. This can be hard, it can be overwhelming for the nurse because the patient may self
mutilate and they may be manipulative, but you have to look behind that sort of thing and see where the behaviour is coming from so that both you and the patient don't shut down (002).

Through knowing the patient, the nurse was able to sustain caring and maintain a stance that was in accordance with the category of respecting the patient. By knowing the patient, the psychiatric nurse was able to provide caring in a non-judgemental way, as the following excerpt shows:

I know that when patients are on medications for a while and they start feeling better, they start thinking 'I will stop it now and see what happens'. I know this is just a given, that patients think like this, so I just accept that it will happen from time to time. By knowing the patient in this way, I can be non-judgemental and continue to work with the patient. I can help them understand the medication and the importance of talking things over, before going off the medication. I continue to work with them, admission after admission, because I am hoping that one of these admissions it will sink in and that they will understand and learn how to keep themselves well (013).
Main Category: Not Taking the Patient's Behaviour Personally

Subcategory: Consulting with other nurses, the team and the patient

Psychiatric nurses described consulting with other nurses, team members, and the patient as a way to not taking the patient's behaviour personally. Psychiatric nurses were able to not taking the patient's behaviour personally when they consulted with other nurses and team members about events that had transpired with a patient or on the unit. For example, psychiatric nurses consulted with other nurses and the health care team to help them obtain perspective about a situation. Psychiatric nurses stated that they needed to get perspective and not taking the patient's behaviour personally, when: 1. the patient was slashing themselves, irrespective of the nurse's efforts; 2. the patients that were in control but were intentionally provoking and hurting others; and 3. when the acuity on the unit was high and the nurse felt "dumped-on" (005) by others. The following excerpt is representative of a situation in which nurses would consult each other, the team, and the patient. Although this excerpt specifically addressed a situation in which a patient committed suicide, nurses described a similar process for any other situation which shocked or was emotionally draining to the nurse:

A patient died by his own hands and alot of people,
patients, and staff were quite upset at it. They had been working fairly closely with him and the suicide was not expected. There was a lot of talk and speculation too. People were concerned about what the impact of this would be on other patients that needed to grieve. We tried to explain things like this in community meetings, in which patients and staff come together to talk about concerns on the unit, but the nurses had raw feelings battling their own sense of grieving as well as trying to help the other patient's through that. One thing I wanted to do, instead of spending a lot of time with a lot of different people trying to talk about what happened, I felt it was important to get together and see what would help the staff through this. So I helped arrange a meeting of the staff. We talked through our feelings, fears, memories, anger, the surprise, the hurt, all those feelings. We tried to talk about those in an open forum. After I came out of meeting I felt much closer to the staff. I felt we had all shared the grief and my load was lighter. There was a sense of closure.

In addition to meeting as a group, psychiatric nurses also described individual consultations with other nurses, team members, and the patient on an individual basis, as the following three excerpts represent:
(i) I like to explore what things mean to the patient so that we can both understand what is happening. When I am able to do that, it helps me get in touch with any power struggles that might be going on (014).

(ii) I think you choose who you think is going to help you get perspective. If I need a good laugh, I will go to someone who I know will make me laugh. If I need a good cry, I know who to go to. If I need someone to help me talk about things in a serious manner, I know who to go to for that (017).

(iii) When I have a very difficult patient. I really sit down sometimes and figure out what I have to do to be able to move this person to become better. Sometimes I read a book, talk to a co-worker, but mostly I read articles about the patient's condition so I know how to approach them (006).

Main Category: Not Taking the Patient's Behaviour Personally

Subcategory: Viewing each situation as a learning experience

Psychiatric nurses accomplished not taking the patient's behaviour personally by viewing each situation with a patient as a learning experience. This involved turning whatever "happened into a learning experience"
In this way, nurses focused on what they learned as opposed to taking the patient's behaviour personally. Viewing each situation with a patient as a learning experience was also described as a way to accentuate the positive aspects of an experience, as the following excerpt illustrates:

For the most part, I try to make every experience have some positive component to it or at least take something positive from the experience (001)

The following excerpt represented how nurses used the strategy of viewing each situation as a learning experience as part of not taking the patient's behaviour personally:

I was new on the unit. I got slapped very hard across the face by a patient, and you could hear the slap down the hall...I did not realize that you always had to be aware of yourself, your environment, and the other patients around you. I learned tolerance, forgiveness, and understanding from that slap across the face. Until I was able to get perspective on the kind of situation I was working in I felt abused and not valued. Then I was able to come to an understanding within myself and learned from that for the future. I learned to understand patient behaviour so then I was able to not take it to heart or personally (013).
Main Category: Not Taking the Patient's Behaviour Personally

Subcategory: Imagining the patient situation

Psychiatric nurses accomplished not taking the patient's behaviour personally through the subcategory of imagining the patient's situation. Within this subcategory, the psychiatric nurse shared in the patient's experience of distress or concern and the nurse showed his/her desire to help the patient alleviate his/her distress, as the following two excerpts represented:

(i) I would imagine that their sense of reality is very distorted, things that made sense before are not making sense right now. They don't know who to trust, they are just so anxious, so fearful of what is going to be done to them, about what is happening to them and so I think that as a nurse imagining their situation in this way helps me want to help them (005).

(ii) I always try to think how would I feel if I were in this patient's situation (015)

In imagining the patient's situation, the nurses allowed patients to progress at their own pace and worked according to the patient's lead. In so doing, nurses described they were able to focus on the patient as opposed to focussing on
themselves or taking the patient's behaviour personally as the following excerpt represented:

I thought how would I react if I were in his shoes. I think my ability to put myself in his shoes enhanced my caring, because first I was able to identify with him on so many issues. He was so close to my age...he was young, he was in university and life was going great. Then one day, he woke up and described his thoughts as clouded and could not clear his head. He became paranoid that his family members were out to get him, were out to kill him...he was admitted against his will...he did not believe he was sick...he was diagnosed with schizophrenia... his whole life as he knew it was changing...By realizing that I could be that patient or that I was not above having a psychotic break or getting sick myself, I was able to have patience and let the patient do what they needed to do in order to cope. This was how I was able to get perspective and not take the patient's behaviours, not to cooperate, personally (002).
Main Category: Not Taking the Patient's Behaviour Personally

Subcategory: Taking a break

Psychiatric nurses described taking a break from the patient as a strategy for not taking the patient's behaviour personally. For example, psychiatric nurses asked co-workers to take the patient for one or two shifts. Also psychiatric nurses were able to get perspective and take a break from the intensity of some situations by using humour as the following excerpt represents:

We use humour. I think many of us use it daily to help put things into perspective. It takes some of the pressure off, but you still carry it around. I think people are sensitive to each other on the team and will help you if you need to laugh, cry, or talk (011).

In summary, psychiatric nurses accomplished NOT TAKING THE PATIENT'S BEHAVIOUR'S PERSONALLY through the subcategories: 1. Knowing yourself; 2. Knowing the patient; 3. Consulting with other nurses, the team, and the patient; 4. Viewing each situation with the patient as a learning experience; 5. Imagining the patient's situation; and 6. Taking a break. Figure 1 (p. 95) illustrates the subcategories of not taking the patient's behaviour personally in the process of protective empowering.
Statement of Relationships among the Six Major Categories of Protective Empowering

During the development of the basic social process of protective empowering, statements of relationships among the six major categories keeping the patient safe, encouraging the patient's health, authentic relating, interactive teaching, respecting the patient, and not taking the patient's behaviour personally were envisioned and conceived by means of the coding paradigm in which antecedent conditions, contexts, actions, interactions, and consequences of caring were identified (Strauss and Corbin, 1990). These relationships were sought and verified in the data. Before the process of protective empowering could occur, psychiatric nurses approached the patient in accordance to: 1. respecting the patient through the subcategories (i) acknowledging the patient's concern or distress; (ii) being non-judgemental of the patient; (iii) not power-tripping; (iv) viewing the patient as knowledgeable; and 2. not taking the patient's behaviour personally as evidenced through the subcategories of (i) knowing yourself; (ii) knowing the patient; (iii) consulting with other nurses, the health care team, and the patient; (iv) viewing each situation as a learning experience; (v) imagining the patient's situation; and (vi) taking a break.
Respecting the patient and not taking the patient's behaviour personally enabled psychiatric nurses to achieve specific interactions and actions whereby they accomplished:

1. keeping the patient safe as evidenced through the subcategories (i) advocating for the patient to the team; (ii) providing reassurance to the patient; (iii) attending to the patient's self-care and treatment; and (iv) providing the patient with information and choices;

2. encouraging the patient's health evidenced through the subcategories (i) promoting patient responsibilities in increments; (ii) inviting the patient's participation in activities; (iii) bringing any changes to the patient's attention; (iv) complimenting and cheerleading the patient's efforts; and (v) drawing out the health already there;

3. authentic relating as evidenced through the subcategories (i) being consistent; (ii) being available and responsible to the patient's concerns of daily living; (iii) matching the nurse's interaction with the patient's receptivity and capabilities; and (iv) interactive teaching as evidenced through the subcategories (i) showing the patient through the nurse's example of interaction; (ii) building on the patient's interests, needs, and knowledge; (iii) giving feedback; (iv) pointing out expectations, alternatives, and patterns.

As a consequence of the psychiatric nurse's "antecedent actions and conditions" of respecting the patient and not
taking the patient's behaviour personally, psychiatric nurses were able to provide "caring" in different conditions and 'contexts' associated of protective empowering, through the categories of keeping the patient safe, encouraging the patient's health, authentic relating, and interactive teaching.

According to psychiatric nurses, their 'actions and interactions' of keeping the patient safe, encouraging the patient's health, authentic relating, and interactive teaching, were most effective when the psychiatric nurse's method was in accordance with the categories of respecting the patient and not taking the patient's behaviour personally. It was in this way that the psychiatric nurses accomplished the process of protective empowering, and achieved the 'consequence' of helping patients access their abilities to take action or accomplish their activities of daily living. Figure 2 summarizes these relationships between the six categories of protective empowering by means of the coding paradigm in which the antecedent conditions, contexts, actions, interactions, and consequences of protective empowering are identified (Strauss and Corbin, 1990; 1994). The protective features of protective empowering were mainly, but not exclusively, accomplished through the main categories of keeping the patient safe and not taking the patient's behaviour personally. The empowering features of protective empowering were mainly,
FIGURE 2
Relationships Between the Six Categories of Protective Empowering According to the Coding Paradigm

Coding Paradigm Features

Antecedent Actions and Sustaining Actions of Protective Empowering

1. Specific Actions and Interactions of Protective Empowering

2. Contexts Through Which Protective Empowering Changed

Consequences of Protective Empowering

Categories

- respecting the patient
- not taking the patient's behaviour personally
- encouraging the patient's health
- authentic relating
- interactive teaching
- keeping the patient safe
- Patient access ability to take action or accomplish activities of daily living

Protective Empowering
but not exclusively, accomplished through the categories of respecting the patient, encouraging the patient's health, authentic relating, and interactive teaching. Therefore, there was an interplay between the protective and empowering features of caring within, and between, each of the six main categories and are encompassed by the main theme of protective empowering.

The protecting and empowering actions of protective empowering (i.e., keeping the patient safe, encouraging the patient's health, authentic relating, interactive teaching, respecting the patient, and not taking the patient's behaviour personally), are viewed as part of a process in which protective and empowering features are interwoven, to varying degrees, both within and between the categories of protective empowering. In the descriptions provided by the psychiatric nurses, a tension or dilemma did not emerge in the interplay between protecting and empowering actions, because the actions associated with the category of not taking the patient's behaviour personally, when accomplished, were used by the nurses to get perspective on situations that were challenging, threatening, and difficult for the nurse. The category of not taking the patient's behaviour personally was the category of protective empowering that represented how psychiatric nurses developed, sustained, and re-established protective empowering and its other categories.
Given that protective empowering did not happen all the time (not within the scope of this study), the finding that no tension or dilemma existed in the interplay between protecting and empowering may relate to the difference between the meaning and description of caring in situations in which protective empowering actually occurred (focus of this study), from situations in which there were factors that interfered or impeded caring from occurring in a protective empowering way.
Limitations of the Study

One of the purposes of this qualitative research was to specify the conditions under which "caring" existed, and the actions associated with "caring". Consequently, as conditions for caring change, I expect that the theoretical formulation presented here will need also to change in order to meet those new conditions, different settings, and diverse samples. Therefore, what cannot be found in the actual data, at this time, can become one of the limitations of the study (Strauss and Corbin, 1990; 1994).

Although the psychiatric nurses' demographic characteristics were basically similarly distributed across the three psychiatric settings, the study was limited by the composition of the sample. The theory was developed based on the descriptions of psychiatric nurses that were mostly Caucasian and female. It is possible that another sample or group composed mainly of visible minorities and males may identify a different experience or may accentuate different aspects of the theory generated. Although the research was conducted on acute psychiatric units in one psychiatric hospital and two general hospitals, the theory developed was based on the descriptions of nurses who worked in three urban teaching hospitals. It is possible that the meaning and experience of caring may be different for nurses working in the community or in hospitals in rural or isolated areas, in which the psychiatric nurse may be the primary, if not
the sole, health professional involved in the patient's care.

It is acknowledged that the interaction of diverse contextual and internal factors that may influence the actual practice of caring cannot always correspond to the described and espoused practice of nurses as represented in the theory of protective empowering. Moreover, in that regard, looking at the practice of caring from different vantage points, such as the patient's perspective or a nurse observer's perspective may enrich and shed further light on the understanding of the theory of caring.

Although generalizations to a larger population was not the purpose of this grounded methodology study, the transferability of this theory is determined by the reader. The reader makes the judgement regarding its transferability based on the reader recognizing or knowing the theory and context as relevant, to his or her experience. This means the theory is not meant to be used blindly as a template for all situations, because the sample is context specific.
INTEGRATION OF FINDINGS WITH RESEARCH LITERATURE

Once the basic social process was formulated, a review of the literature was conducted related to the categories and subcategories which emerged. Data pertaining to the six categories of protective empowering were compared and contrasted with concepts existing in the present psychiatric nursing, ethics, and psychological research literature. The following is a presentation of the literature as it relates to the theory of protective empowering. This discussion will attempt to integrate the findings from this study into the existing literature (Strauss and Corbin, 1990; 1994).

Viewing the literature through the lens of protective empowering, there were concepts and findings identified in the literature, to be discussed subsequently, that reflected and corresponded to the individual categories of protective empowering, (i.e., keeping the patient safe, encouraging the patient's health, authentic relating, interactive teaching, respecting the patient, and not taking the patient's behaviour personally). Although there are concepts which pertained to caring and empowerment in the literature surveyed, which had individual aspects that corresponded to various individual categories and subcategories of protective empowering, the way in which the theory of protective empowering is different from the literature surveyed is that the psychiatric nurse's meaning and
experience of caring is encompassed and integrated according to an interplay between protective and empowering actions within its categories and subcategories, which is represented by the main pattern of protective empowering. Therefore, the relationship of protective empowering encompasses concepts related to caring and further expands the concepts, in the literature, that pertain to caring. It is in this way that the understanding of caring is further expanded and enriched. Therefore, the relationship of protective empowering encompasses concepts that pertain to caring and is one more lens through which to understand caring. The fact that elements of protective empowering can be extracted from the theoretical and empirical literature is indication of the credibility of the theory, albeit it is secondary to the credibility given to the theory by the actual participants of this study and readers. Therefore, in the subsequent section on the integration of findings, the literature is discussed to show that the process of protective empowering can be extracted from the literature, by bringing together familiar concepts in new ways and by examining individual concepts through the lens of protective empowering. That is, the main pattern of protective empowering makes it possible to extract protective and empowering aspects from the existing literature and provides another vantage point for understanding and integrating the existing literature. It is from this stance that the
integration of findings from this study with the literature is discussed.

Literature Pertaining to the Basic Social Process of Protective Empowering

Psychiatric nurses described the process of protective empowering as central to caring with patients in the hospital setting. Psychiatric nurses described "caring" as a process of empowering the patient while at the same time described "caring" to have a protective nature.

A similar interplay between the empowering and protecting discovered in this study, was evident in an ethnographic study conducted by Kavanagh (1988). Kavanagh (1988) examined the psychiatric nurses' experience of psychiatric nursing in the hospital setting. Kavanagh (1988) collected her data on three psychiatric units within one urban general hospital that managed actively suicidal, homicidal, and gravely disabled adults. Kavanagh (1988) interviewed and observed registered nurses who had practiced psychiatric nursing for a minimum of four years and as much as 30 years. The psychiatric nurses in Kavanagh's study (1988) reported an "ongoing intra-staff debate over levels of control versus patient's rights and self-care" (p.244). This debate is parallel to the process of protective empowering in this study. However, in the theory of
protective empowering there is a different emphasis from the literature surveyed. In the theory of protective empowering, protecting and empowering actions are not conceptualized as a debate. Rather, in the theory of protective empowering, the interplay between protective and empowering actions are described as interwoven within a harmonious interplay.

While Kavanagh (1988) based her findings regarding the debate over level of patient control versus patient's rights within the domain of nursing practice, other authors (Fisher, 1995; Forchuk, 1991; Garritson, 1988; Lutzen and Nordin, 1993; 1994) have presented similar findings within the domain of nursing ethics. These studies identified the ethical principles of: 1. "doing good" or beneficence and 2. autonomy, as the most important moral concepts related to psychiatric nurse's decision making.

Rumbold (1993) recognizes that some patients (i.e., unconscious patients or mentally handicapped patients) may be incapable of making informed decisions, however he states that effective care is implemented when the duty of beneficence (the duty to do good) and non-maleficence (the duty not to harm patients or clients) is tempered by the duty of respect for patient choice and autonomy. This theme of tempering the duty to do good with respect seemed parallel to the tempering of empowering with protecting in the process of protective empowering.
Rumbold (1993), quoting Gillion, defines autonomy as "the capacity to think, decide, and act on the basis of such thought and decide freely and independently and without... hindrance" (p.198). Rumbold (1993) argues that autonomy does not mean the freedom to do as one wants, or to act in accordance with one's desires. He argues, referring to the major schools of ethical thought of categorical imperative (ie., Kant) and the utilitarians (ie., Mills), that the principle of autonomy is not absolute. For example, Kant argued that respect for the person's autonomy had to be viewed within the context of respect for the autonomy of all. Mills (as cited in Rumbold, 1993), a utilitarian, supported respect for the person's autonomy but the obligation to respect people's autonomy holds only as long as it does not cause harm to others. Similarly, in the process of protective empowering, each of the categories and subcategories were considered in context of whether the patient was a harm to themselves and/or others. Therefore, the theory of protective empowering through its interplay between protecting and empowering in the categories of keeping the patient safe, respecting the patient, not taking the patient's behaviour personally, encouraging the patient's health, authentic relating, and interactive teaching may provide insight into the principles of the duty to do good and no harm (ie., beneficence and non-maleficence) and respect for a person's right to self-
determination (ie., autonomy) within the specific context of nursing practice.

In studies conducted within psychiatric nursing (Fisher 1995; Forchuk 1991; Garritson 1988; Lutzen and Nordin, 1994), authors stated that psychiatric nurses reported the need to balance beneficence with autonomy as the most important ethical concept. For example, the psychiatric nurses in Fisher's (1995) grounded theory study described the ethical problem of balancing support for patient autonomy with the need to maintain unit control. Fisher (1995) found that nurses described "a tension between their desire to give patients latitude to manage their own behaviours and their simultaneous responsibility for maintaining unit safety" (p.199). This finding is akin to the protecting and empowering actions in the process of protective empowering. That is, protective empowering involves protecting the patient from physical harm while at the same time allowing the patient the freedom to access his/her own abilities to accomplish their activities of daily living. In contrast to the literature reviewed, supporting the patient's autonomy was described as interwoven with the nurse's duty to maintain safety on the unit and was described as a harmonious interplay in protective empowering.

In the nursing literature surveyed, there were three studies that pertained to the idea of caring and the idea of
the empowerment of patients (Benner 1984; Gibson, 1991; Malin and Teasdale, 1991).

Malin and Teasdale (1991) presented four case studies, and within these case studies they discovered that empowering did not emerge as part of caring. Malin and Teasdale (1991) found that caring and empowerment were conceptualized as separate, in which nurses at different times viewed their role primarily in terms of caring or empowering. This is in contrast to this study in which protective empowering emerged as a consistent pattern where a discussion of any one of either empowering or protecting would eventually incorporate the other.

Furthermore, Gibson (1991) conducted a concept analysis of empowerment to define empowerment and to determine whether the concept had utility for nursing practice. Although Gibson's (1991) concept analysis revealed many characteristics which defined empowerment, the concept of "caring" was not among them.

Benner (1984) examined the notion of "the power of caring" (p. 208) by interviewing nurses from a variety of clinical areas including, but not limited to, intensive care nursing, emergency nursing, palliative care nursing, maternity nursing, cardiac care nursing, psychiatric nursing, and medical-surgical nursing. Benner (1984) used a "descriptive research" design, (p. xvii)... ethnographic and interpretative strategies" (p. 4) to identify the levels of
competency in nursing practice. From Benner's (1984) dialogue with nurses she identified five levels of nursing competency: novice; advanced beginner; competent, proficient; and expert. Based on the interviews with nurses, Benner (1984) "identified six different qualities of power associated with caring" (p. 209). The six different qualities of power associated with caring were: 1. transformative power; 2. integrative caring; 3. advocacy power; 4. healing power; 5. participative /affirmative power; and 6. problem-solving. These qualities of power associated with caring emerged from the actual narratives of nurses that Benner (1984) referred to as the "expert" nurse (p.209).

The idea of empowering the patient is evident in Benner's findings as she states nurses use "their power to empower patients" to gain self-determination (p. 209). This is akin to some aspects of the theory of protective empowering in which one of the goals is to help the patient access his/her ability to act or accomplish their own activities of daily living so that self-determination is facilitated. The theory of protective empowering expands on Benner's finding regarding the notion of self-determination, because self-determination in this theory is facilitated and encompassed by a harmonious interplay between protecting and empowering.
There are elements of protective empowering as expressed through the individual categories of keeping the patient safe, encouraging the patient's health, authentic relating, interactive teaching, respecting the patient, and not taking the patient's behaviour personally that can be extracted from Benner's (1984) six qualities of power associated with caring.

According to Benner (1984), transformative power is associated with caring and is manifested when the nurse informs the patient of his/her "power to choose...in effect it [power] transforms[s] his world into one that he could once again participate in" (p. 210). According to Benner (1984), informing the patient of his/her power to choose is important to transforming the patient's world into a place in which they can participate, as the following quotation from Benner's (1984) study shows: "I'm going to choose to be here and let all of you help me get well as fast as I can" (p. 210). Using the main pattern of protective empowering as lens, the interplay between protecting and empowering can be extracted from Benner's concept of transformative power. The concept of transformative power which includes the ideas of informing the patient of his/her power to choose, corresponded to the subcategory of providing the patient with information and choices from the category of keeping the patient safe. Moreover, Benner (1984) discovered that informing patients of their power to choose, occurred even
when the patient was unable to care for themselves and corresponded to the subcategory of attending to the patient's self-care and treatment from the category of keeping the patient safe. Together these ideas reflect the interplay between the protective action of attending to the patient's self-care and treatment with the mainly empowering action of providing the patient with information and choices.

Although Benner's notion of transformative power, in which its qualities were represented individually, corresponded to various individual categories and subcategories of protective empowering, the way in which the theory of protective empowering is different from transformative power is that the psychiatric nurse's meaning and experience of caring is encompassed and integrated according to an interplay between protective and empowering actions within the categories and subcategories, which is represented by the main pattern of protective empowering. Therefore, the relationship of protective empowering encompasses Benner's notion of transformative power and further expands concepts in the literature that pertain to caring. It is in this way that the understanding of caring is further expanded and enriched.

their ability to continue with meaningful life activities despite their limitations" (p. 201). The main theme of protective empowering, can be extracted from the following description of integrative caring. In the following description of integrative caring the interplay between protecting and empowering is indicated in parentheses:

"patient care situations where a prolonged or permanent disability is inevitable, the nurse is often instrumental in helping patients maximize their ability to continue with meaningful life activities [the empowering actions of protective empowering] despite their limitations [protective actions of protective empowering] " (Benner, 1984, p. 211).

In the above description of integrative caring one can see that actions directed at helping the patient access his/her own ability to act and accomplish his/her activities of daily living occurs in close relationship to situations in which there is an on-going attentiveness to the patient's safety. Furthermore, Benner's (1984) notion of "helping patients maximize their ability to continue with meaningful life activities despite their limitations" (p. 211) seems to correspond to individual subcategories such as drawing out the health already there in the category of encouraging the patient's health and the subcategory of building on the patient interests, needs, and knowledge in the category of interactive teaching, while at the same time, corresponds
to the individual subcategory of attending to the patient's self-care and treatment from the category of keeping the patient safe.

Although Benner's notion of integrative caring, in which its qualities were represented individually, corresponded to various individual categories and subcategories of protective empowering, the way in which the theory of protective empowering expands Benner's notion of integrative caring is that there is an interplay between protecting and empowering expressed through the main pattern of protective empowering. This main pattern accounts for the behaviours seen in such concepts such as integrative caring, and helps to further integrate qualities that pertain to empowering the patient and those that relate to actions which are protective in nature. Therefore, the relationship of protective empowering encompasses Benner's notion of integrative caring and further expands the concepts in the literature that pertain to caring.

A third quality of power that resided in caring which was discovered by Benner (1984) was called advocacy power. Advocacy power is "the kind of power that removes obstacles or stands alongside and enables" (p. 212). Advocacy power is associated with the "belief that an individual's life has possibilities even though it falls short of perfect wellness and adjustment (p. 106)...[and] once nurses are convinced of their assessments, they are obligated to act as the
patient's advocate in terms of that assessment or else reassess[es] the situation" (p. 107).

Benner's notion of advocacy power corresponds to some of the individual categories of protective empowering. For example, the notion of the individual having possibilities is indicative of mainly empowering subcategories such as pointing out expectations, alternatives, and life patterns in the category of interactive teaching. Moreover, advocacy power also has protective elements because it occurs even when the patient's life "falls short of perfect wellness and adjustment" (p. 106). Furthermore, advocacy power "removes obstacles or stands alongside and enables" and corresponds to such subcategories in which there is an interplay between mainly protecting actions such as attending to the patient's self-care and treatment, and reassuring the patient, with mainly empowering actions such as advocating for the patient to the team within the category of keeping the patient safe. These individual categories represent some of the ways in which the interplay between protecting and empowering occurs.

Although Benner's notion of advocacy power, in which its qualities were represented individually, corresponded to various individual categories and subcategories of protective empowering, the way in which the theory of protective empowering is different from advocacy power is that the psychiatric nurse's meaning and experience of
caring is encompassed and integrated according to an interplay between protective and empowering actions within the categories and subcategories. This interplay is represented by the main pattern of protective empowering. Therefore, the relationship of protective empowering encompasses Benner's notion of advocacy power and further expands the concepts in the literature that pertain to caring.

In addition to transformative power, integrative caring, advocacy power, the nurses in Benner's (1984) study also described healing power as a fourth quality of power that resided in caring. Healing power involved creating "a healing relationship and a healing climate [despite the patient's limitations] by...mobilizing hope...finding an interpretation or understanding of the situation that is acceptable and clarifying to the patient; and...assisting the patient to use social, emotional, and spiritual support" (p. 213). According to Benner (1984) healing power "solicits the patient's internal and external resources and empowers the patient by bringing hope, confidence, and trust" (p. 213). These qualities of healing power correspond to the individual categories and subcategories of: interactive teaching and encouraging the patient's health in which the patient's hope and confidence are mostly promoted, through the subcategories of building on their own interests, needs, and knowledge (empowering nature of protective empowering),
and giving the patient feedback (protective nature of protective empowering) in interactive teaching. Moreover, the patient's hope and confidence, as articulated in the quality of healing power, also corresponded to the subcategories of promoting the patient's responsibilities in increments (protective nature of protective empowering) and complimenting and cheerleading the patient's efforts (empowering nature of protective empowering). Although Benner's notion of healing power corresponds to various individual categories of protective empowering, the way in which they are integrated can be understood as encompassed by the main pattern of protective empowering.

The nurses in Benner's (1984) study also described participative/affirmative power as a fifth quality of power that resided in caring. In Benner's (1984) study participative/affirmative power was identified as a quality that allows the nurse to protect himself or herself from burnout, and to empower the patient. The interplay between protecting and empowering can also be extracted from Benner's notion of participative/affirmative power as Benner discovered that "the best antidote to burnout in the work setting...[is] engagement and involvement that enables the nurse to draw on the resources of the demanding situation" (p. 214). In the relationship encompassed by the main theme of protective empowering, caring in a protective empowering way was established and sustained through the
interaction of the mainly protective action of not taking the patient's behaviour personally with the mainly empowering action of respecting the patient. That is, not taking the patient's behaviour personally was important to helping nurses protect themselves and the patient by getting perspective on situations that were challenging, threatening, and difficult for the nurse; and, was also a way of remaining engaged with the patient through the mainly empowering category of respecting the patient. The correspondence between Benner's notion of participative/affirmative power to the individual categories of not taking the patient's behaviour personally and respecting the patient represents one of the ways in which the interplay between protecting and empowering is manifested.

According to Benner (1984) problem-solving was another quality of power that resided in caring. In problem-solving, expert nurses in Benner's (1984) study described an "attentiveness" (p.214) to anticipating deterioration and breakdown of the patient and an attentiveness to the nurse's own emotions in caring. Benner (1984) also discovered that the power which resided in caring through problem-solving was manifested by nurses taking "the distress of their patients seriously" (p. 219). These qualities of power associated with caring corresponded to the individual categories of keeping the patient safe and respecting the patient. Benner's (1984) notion of attentiveness to
recognizing pending deterioration and breakdown in the patient is akin to the subcategory of attending to the patient's self-care and treatment (protective nature of protective empowering) in the category of keeping the patient safe. The attentiveness to the nurse's own emotions in caring corresponded to the category of not taking the patient's behaviour personally, in which the nurse attends to herself or himself through the subcategory of knowing yourself (protective nature of protective empowering).

Furthermore, the nurse taking "the distress of their patients seriously" (Benner, 1984, p. 219) corresponded to the subcategory of acknowledging the patient's concern or distress (empowering nature of protective empowering) in the category of respecting the patient. It also corresponded to the subcategory of being available and responsive to the patient's concerns of daily living (empowering nature of protective empowering) in the category of authentic relating. However, when the different qualities associated with problem-solving are examined through the lens of protective empowering, the interplay between protecting and empowering actions can be seen when the categories are viewed in a relationship encompassed by the main pattern of protective empowering.

Although Benner's (1984) notion of problem-solving corresponds to some of the individual categories of protective empowering, the interplay between protecting and
empowering can be extracted from the qualities associated with problem-solving. The main pattern of protective empowering accounts for the pattern of behaviour in which the mainly protective actions in the categories of keeping the patient safe and not taking the patient's behaviour personally interrelate with the mainly empowering actions within the categories of respecting the patient and authentic relating.

In addition to these ideas akin to the protecting and empowering actions evident in the ethics and research literature, an examination of the historical development and etymology of the words "care" and "caring" revealed an exclusive focus on attending to others and protecting the other from harm or worry (Simpson and Weiner, 1989, p. 893). These conceptualizations of 'care' and 'caring' were expanded by this theory of protective empowering, in which caring was expanded to include empowering patients to access their own abilities to take action and accomplish their activities of daily living. Interestingly, an examination of the historical development and etymology of the verb "to nurse", seemed to encompass both protecting and empowering. For example, on the one hand, the verb 'to nurse' was said to mean "to wait upon, attend to [a person who is ill]" (Simpson and Weiner, 1989, p. 604). On the other hand, the verb 'to nurse' also involved "taking care of oneself" (Simpson and Weiner, 1989, p. 604). Furthermore, 'to nurse'
was also described as "to foster, tend...take care of...but also was described as "promoting growth and development" (Simpson and Weiner, 1989, p. 604). This interplay between attending to the patient, and encouraging growth, development, and self-care were the prevalent themes in the process of protective empowering. The theory of protective empowering provides the reader with one more view from which to understand caring. In the theory of protective empowering, caring is not separate from, or does not compete with, empowering. Rather, caring is expressed as a harmonious interplay between empowering and protecting actions.

**Literature Pertaining to the Category Keeping the Patient Safe and Its Subcategories**

During the process of protective empowering, nurses described an attentiveness to the actions and interactions which occurred in keeping the patient safe. This was because patients admitted to hospital were assessed as being of a harm to self, others, and/or of neglecting self care to the point of imminent bodily harm.

Nurses focussed on keeping the patient safe as evidenced through the subcategory attending to the patient's treatment and self-care and reassuring the patient, while at the same time respecting the patient's autonomy through the
subcategories of advocating for the patient to the team, and by providing the patient with information and choices.

The purpose of presenting the literature in relation to the main category of keeping the patient safe is to show that nursing interventions of safety have traditionally been associated with protecting, reassuring, and attending to the patient's self-care and treatment (Ellis and Nowlis, 1994; Kanak, 1992). The category of keeping the patient safe in this study expands the conceptualization of safety by not only including protective actions of attending to the patient's treatment and self-care and reassuring the patient, but also by including empowering actions, in which the patient's autonomy was respected through advocating for the patient to the team, and by providing the patient with information and choices.

Ideas akin to the keeping the patient safe category were identified by Lowe (1992). Using a combination of semi-structured interviews and participant observation, 33 psychiatric nurses were interviewed in the hospital setting about the interventions psychiatric nurses used when faced with aggressive and or manipulative behaviour. In Lowe's (1992) study, nurses identified a dilemma between the duty to recognize the patient's need for security and safety, while trying to provide care in a manner that the patient is allowed to take responsibility for herself or himself. Lowe's (1992) findings are parallel to the interplay between
the protective actions of the subcategories attending to the patient's treatment and self-care and providing reassurance to the patient with the empowering actions of advocating for the patient to the team, and by providing the patient with information and choices in keeping the patient safe. However, as discussed in the statement of relationships section, protective empowering, and by association keeping the patient safe category, has a different emphasis than described in the literature, because protecting and empowering actions in this study are viewed as part of a process in which each of protecting and empowering features are interwoven, to varying degrees.

In the following sections, ideas in the literature which were akin to the individual subcategories of keeping the patient safe are presented and the differences are highlighted.

In this study, psychiatric nurses described keeping the patient safe as evidenced through the subcategory attending to the patient's treatment and self-care, when the patient was not capable of accomplishing his/her own self-care activities. A concept akin to attending to the patient's treatment and self-care was Lowe's (1992) category of 'monitoring'.

Psychiatric nurses in Lowe's (1992) study described 'monitoring' as the nurse's ability to recognize patterns in behaviour and to anticipate impending difficulties. This
idea of mastering this recognition of scenarios was also discovered by Benner (1984) in her phenomenological study with expert registered nurses, and was discussed according to the theme of 'diagnostic and monitoring function'.

The recognition aspect of the subcategory attending to the patient's treatment and self-care in keeping the patient safe implies providing the patient with different levels of protection based on the extent to which the nurse anticipated the patient deterioration and breakdown. The nurse's skills of recognition reported in other studies (Benner, 1984; Lowe, 1992) also helped to illuminate the subcategory of attending to the patient's self-care and treatment, and in turn contributes to this literature. For example, psychiatric nurses in Lowe's (1992) study differentiated between the patient's need to 'let off steam and express their feelings' and 'mounting aggression' (Lowe, 1995, p.1230). In the case of mounting aggression, if the nurse did not de-escalate the mounting aggression, nurses described that this could result in severe incidents to the patient or others. Akin to the psychiatric nurses in this study, the psychiatric nurses in Lowe's study cited the example of giving the patient medication as needed. This was a preventative measure for helping the patient remain in control when aggression appeared to be mounting. Therefore, the category of 'monitoring' discussed in other studies (Benner, 1984; Lowe, 1992) illuminates the subcategory of
attending to the patient's treatment and self-care discovered in this study.

Furthermore, the psychiatric nurses in Lowe's study described the category of 'monitoring' as involving being alert to the atmosphere on the psychiatric unit. Similar to attending to the patient's treatment and self-care from this study, the psychiatric nurses in Lowe's study described having a "protective attitude" (Lowe, 1992, p.1230) to other patients within the vicinity of aggressive and or manipulative patients. This finding was corroborated by Kavanagh (1988) in her ethnographic study with 36 registered psychiatric nurses, on three psychiatric units within a hospital.

In Kavanagh's study (1988), the psychiatric nurses reported: "one must always remember that it is their rationality and/or emotionality that is impaired, not their physical strength" (Kavanagh, 1988, p.245). Kavanagh (1988) reported an on-going need for 'attentiveness' to such basics as physical defense of others and oneself. This 'attentiveness' to anticipating deterioration and breakdown of the patient, was described in studies by Kavanagh (1988), Lowe (1992), and Benner (1984). These studies corroborated the different levels of protection discovered in the subcategory attending to the patient's treatment and self-care in keeping the patient safe.

In addition to these studies, Dorothea Orem (1980;
1985) wrote that there are three basic nursing systems: 1. the wholly compensatory system, 2. the partly compensatory system, and 3. the supportive-educative system, which further illuminates the different levels of protection inherent in attending to the patient's treatment and self-care.

The wholly compensatory system is when the nurse performs all the self-care activities for the patient, and the nurse compensates for the patient's total inability to initiate and accomplish his/her own self-care. This is similar to the 'taking control for the patient' strategy in attending to the patient's self-care and treatment. In contrast, the partly compensatory system involved both the nurse and the patient taking action in meeting self-care activities. This is similar to the strategy of 'opposing' in the category of attending to the patient's self-care and treatment, in which the patient and the nurse negotiated mutually acceptable behaviour that did not pose a potential harm to the patient and others. Finally, the supportive-educative system of nursing characterized situations where the patient was able to perform or can learn to perform self-care, but cannot do so without assistance. This is similar to the strategy of 'explaining'. Within the category of attending to the patient's self-care and treatment, in which the nurse provided the patient with the necessary information to understand, predict, or perform his/her own
self-care. Orem (1980; 1985) discussed these systems of
nursing care as overlapping in patient care, and do not
necessarily move along in linear fashion. These nursing
systems of care illuminate the different degrees of
protecting discovered in the subcategory attending to the
patient's self-care and treatment of keeping the patient
safe.

According to Orem (1980; 1985), as the patient and the
nurse move along the nursing systems, the patient
increasingly participates in his/her own self-care
activities. This increase in patient action is parallel to
the three types of protecting that occurred during the
subcategory of attending to the patient's self-care and
treatment. That is, there were varying degrees of patient
participation, as the nurse moved between implementing
'taking over for the patient' actions, 'opposing' actions,
and 'explaining' actions.

Furthermore, the psychiatric nurses in this study
described keeping the patient safe as evidenced by the
subcategory of providing reassurance to the patient. Similar
to the subcategory of attending to the patient's treatment
and self-care, the subcategory of providing reassurance to
the patient was relatively protective in nature compared to
the other subcategories in the category of keeping the
patient safe. In this study, the psychiatric nurses
described providing reassurance to the patient as associated
with orienting and redirecting the patient to behaviour that was safe and not a harm to themselves and others. The subcategory of providing reassurance to the patient was mostly used when patients were fearful or suspicious of their environment and others. Through the subcategory of providing reassurance to the patient, the psychiatric nurses described that they were able to maintain the safety of the person emotionally so that the patient felt comfortable and felt safe physically and emotionally. It was in this way that providing reassurance to the patient was associated with the protective nature of protective empowering.

Teasdale (1989; 1995) explored the concept of reassurance in clinical practice and helped to illuminate the subcategory of providing reassurance to the patient discovered in this study. In Teasdale's (1995) study, reassurance was defined as an "attempt to communicate with people who are anxious, worried or distressed with the intention of inducing them to predict they are safe or safer than they presently believe or fear" (p. 79). Teasdale (1995) conducted a survey which analyzed how a sample of 85 student nurses, 51 patients and 168 qualified nurses from general medical, surgical, psychiatric, and learning disability settings, tried to calm anxious patients. Data was collected in the form of tape-recorded and written descriptions of critical incidents from both patients and nurses. The participants in Teasdale's (1995) study reported
that the concept of reassurance in health care involved
"giving information predicting a safe outcome, plus the use
of personal support to help clients feel secure" (p.79).

The nurses in Teasdale's study (1989; 1995) described
providing the patient with safety-oriented factual
information, frequently supplemented by verbal assurances of
safety, such as 'you'll be alright'. The psychiatric nurses
in this study concurred with Teasdale's (1995) finding of
providing the patient with safety-oriented information.
However, the psychiatric nurses in this study not only
included, 'you'll be alright' but also "we are here to help
you", "we are looking after you", "we will make sure you are
okay".

Teasdale (1995) also discovered that reassurance was
accomplished by 'giving the patient support'. The nursing
actions of giving support were revealed to be mostly non-
verbal. While Teasdale (1995) described giving support as
involving the non-verbal actions of moving close to the
patient and using touch to reassure the patient, in contrast
the psychiatric nurses in this study described the
importance giving the patient adequate physical space. That
is, the psychiatric nurses in this study concurred with
Kavanagh's (1988) ethnographic study with psychiatric
nurses, in which she observed, "touch cannot be used as it
is in most interpersonal situations. One patient may be
comforted by human contact; another might respond with
screamed accusations and remain agitated for the rest of the day. In short, every day rules for interaction are not to be trusted" (p.244).

Having presented the research that supports and pertained to the mainly protective subcategories of attending to the patient's treatment and self-care and providing reassurance to the patient, I will now present specific concepts from the literature which illuminates the mainly empowering subcategories of keeping the patient safe: advocating for the patient to the team and providing the patient with information and choices.

Within the keeping the patient safe category, patients were frequently described by the participants as distracted by hallucinations and delusions, or by their anxiety and irritability. Nurses described the importance of advocating to the team about the patient's preferences, and concerns. Advocating for the patient was corroborated by the guidelines for professional behaviour for registered nurses in Ontario (College of Nurses of Ontario, 1995), and in discussions of power within mental health nursing practice (Sines, 1994).

Sines (1994) writes that a major part of advocacy is "the extent to which the nurse succeeds in empowering her clients. This is to enable them to take an active role in determining their own futures (which include decisions about their health status and the provision of care)" (p.899).
This is similar to the notion discovered in this study, that although keeping the patient safe was associated with the protective nature of protective empowering, empowering was the focus and goal of all the six categories of protective empowering. Gadow (1980) seems to concur with Sines' (1994) link between empowering and advocacy when she writes about the nurse advocate as one who helps "persons become clear about what they want to do. [This is done] by helping them discern and clarify their values in the situation and on the basis of that self-examination, to reach decisions which express their reaffirmed, perhaps recreated, complex of values" (Gadow, 1980, p.85). While patients may not always find themselves as capable of self-examination, Gadow (1980) brings forward an ethic of helping the patient become clear, about what they want to do.

The commitment to empowering patients to access their abilities to act or decide, is also reinforced by the recent code of conduct for nurses in Ontario, which states: "Clients who are not competent in all areas may still be capable of sound choice in some areas of their lives and need to be allowed an opportunity to make decisions in those areas" (College of Nurses of Ontario, 1995, p.8). The subcategory of advocating for the patient contributes to the further articulation of this code of conduct in nursing.

Gadow (1980) distinguishes clearly between paternalism, consumer protection, and advocacy. These distinctions are
helpful in illuminating the subcategory of advocating for the patient to the team. Gadow (1980) writes that advocacy "is not based on the paternalistic assumption of what individuals "should" (p.85) want to do for their own good, regardless of the patients own values and unique meaning of their experience of illness, health, suffering and dying. Nor is advocacy based on the assumption of consumer protection, where the nurse would protect the individual's right to do what they want, once the person has been informed of all of his/her options. In contrast advocacy, according to Gadow (1980), is helping the patient become clear about what they want to do.

Furthermore, advocacy has been cited as an important concept to nursing (Copp, 1986; Gadow, 1980; Neilson, 1992; Nelson, 1988; Rumbold, 1993). Neilson (1992) and Sines (1994) maintain that "caring for psychiatric patients in secure or locked unit conditions is not incompatible with attempts to involve them in decision making" (Neilson, 1992, p. 31).

The subcategory of advocating for the patient can contribute to the further articulation of this compatibility between maintaining patient safety and respecting the patient's choices, by expanding the view of what keeping the patient safe entails with interventions that include empowering actions, in which patient choices and preferences are advocated.
Another subcategory of keeping the patient safe was providing the patient with information and choices and is now discussed in relation to the literature. A similar concept to providing the patient with information and choices was "the least restrictive alternative" (LRA) principle (Garritson, 1983a; 1983b; Morales and Duphorne, 1995).

A recent three month inservice project initiated on an acute psychiatric unit in a hospital further elaborated on the LRA principle (Moralis and Duphorne, 1995). The project was conducted on a thirty bed unit. The patients were chronically mentally ill with diagnoses of depression, schizophrenia, bipolar affective disorder, and organic brain syndrome. The average length of stay on the unit was two weeks. The project goal was to decrease the use of restraints and seclusion by using least restrictive measures (Moralis and Duphorne, 1995). In Moralis and Duphorne's study (1995) nurses determined that the use of limit setting, verbal interaction for de-escalation, giving medications as needed, and "quiet time" were the most effective interventions for decreasing the patient's anxiety before the patient lost control. The psychiatric nurses, in Moralis and Duphorne (1995) study, stated that they were comfortable using least restrictive alternatives and were more comfortable about offering patients choices, and did not wait until restraints and seclusion were the only
options. Patients in this study were offered choices commensurate with the patient's capabilities such as choosing between medication or "quiet time". In the Moralis and Duphorne (1995) study "quiet time" or "time out" was conceptualized as an extension of seclusion "where patients may either request or be asked to go voluntarily to a designated room: to spend a specific period of time away from others, to help them think about their behaviour or regain control over their thoughts or feelings in a less stimulating environment " (Moralis and Duphorne, 1995, p. 13). Moralis and Duphorne (1995) also discovered that it was beneficial to provide information about the rationale for use of seclusion and restraints to patients. These findings are akin to providing the patient with information and choices described by the nurses in this grounded theory study.

The subcategory of providing the patient with information and choices can contribute to the further articulation of the compatibility between maintaining patient safety and respecting the patient's choices, by expanding keeping the patient safe with interventions of safety that include empowering actions, in which the patient is provided with information and choices.

In summary, the category of keeping the patient safe and its subcategories are all identified in the previous literature. Unique to this study is that these familiar
findings in the literature are not presented in isolation. Rather, in this study, the subcategories of attending to the patient's treatment and self-care, advocating for the patient to the team, providing reassurance to the patient, and providing the patient with information and choices are presented in a relationship encompassed by the main theme of protective empowering. The way in which the category of keeping the patient safe is different from the literature surveyed is that the subcategories of keeping the patient safe in this study are described as having a harmonious interplay between protecting and empowering. Protecting and empowering are part of the process for accomplishing keeping the patient safe. Consequently, the category of keeping the patient safe expands present conceptualizations of caring, by not only focussing on the protective aspects of keeping the patient safe through attending to the patient's self-care and treatment and providing reassurance to the patient, but also focussing on the empowering aspects of keeping the patient safe, which include advocating for the patient to the team and providing the patient with information and choices.
Literature Pertaining to the Category Encouraging the Patient's Health and its Subcategories

During the process of protective empowering, nurses described, encouraging the patient's health as evidenced through the subcategories: promoting the patient's responsibilities in increments, inviting the patient's participation in activities, bringing any changes to the patient's attention, complimenting and cheerleading the patient's efforts, and drawing out the health already there.

In this study, psychiatric nurses described promoting the patient's responsibilities in increments as helping the patient do activities that will show them they can accomplish things. The ideas within this subcategory are similar to the behavioral techniques discussed in the psychological literature.

In the psychological literature, behavioural techniques have been cited as helpful to restoring the patient's functioning, and in engaging the patient's interest in activities (Beck, Rush, Shaw, and Emery, 1979). Similar to the subcategory of promoting the patient's responsibilities in increments, Beck et al., (1979) have shown that by allowing the patient to experience mastery, success, or pleasure in carrying out activities of daily living, this can help reverse discouragement, and prevent the patient from drifting into a deeper state of immobility.
Mastery is defined as "a sense of accomplishment when performing a specific task [and] pleasure refers to the pleasant feelings associated when performing a specific task" (Beck et al., 1979, p.128). The nurses in this study, similar to the observations by Beck et al., (1979), found that by encouraging patients to do some activity within their repertoire (i.e., walking, participating in group, getting dressed), this invited patients to experience partial successes and/or small degrees of pleasure that lead the patient to do more of that behaviour. Inherent in the subcategory of promoting the patient's responsibilities in increments are protective and empowering aspects of caring in which there can be varying degrees to the type of responsibilities undertaken by the patient, and the degree to which the patient is invited to participate in activities.

Psychiatric nurses in this study encouraging the patient's health through the subcategory bringing any changes to the patient's attention. A similar action was described by psychiatric nurses in Mason, Breen, and Whipple's (1994) account of their use of solution-focussed therapy. Mason et al., (1994) conducted their study on an inpatient psychiatric unit within a large teaching medical centre. In Mason et al's (1994) study, the psychiatric nurses described "acknowledge [ing] patient competence" or instances of patient success (p. 47). Similar to the
findings of this study, Mason et al's (1994) study reported that acknowledgement of patient competence involved complimenting the patient on her or his ability to perform a simple task, to complimenting the patient on the accomplishment of a more complex task. In Mason et al's., (1994) study, the nurses brought changes in the patient to the patient's attention through verbal statements such as 'I am amazed at your ability to'...or 'I'm impressed with how you...', or 'You have been through harsh conditions how did you manage to survive'. These approaches accentuated the positive and the patient's abilities that the patient may not recognize. Psychiatric nurses in this study also accomplished encouraging the patient's health through the subcategory complimenting and cheerleading the patient's efforts. Complimenting, as discussed above, was associated with helping patients recognize that they were responsible for effecting any changes in their situation. Moreover, cheerleading in solution focussed therapy seems to be akin to the cheerleading in encouraging the patient's health. Walter and Peller (1992) defined cheerleading as the emotional support and encouragement for any changes made by the patient because "small changing leads to larger changing" (p. 106).

In the subcategory of complimenting and cheerleading the patient's efforts are protective and empowering aspects in which there can be varying degrees of complimenting the
patient on her or his ability to perform a simple task, to complimenting the patient on the accomplishment of a more complex task.

Psychiatric nurses described encouraging the patient's health through the subcategory drawing out the health already there. Similar to this subcategory was a category called 'confirming messages' identified by 33 psychiatric nurses interviewed in a study by Lowe (1992). The category of 'confirming messages' illuminates the subcategory of drawing out the health already there, as it emphasized accentuating the positive and involved addressing the part of the patient that is not ill. These findings were corroborated by Mason et al (1994) and Webster (1990).

In the subcategory of drawing out the health already there are protective and empowering aspects in which the nurse uses protecting mainly to address the patient's illness and uses empowering to mainly address the patient's health.

In summary, the category encouraging the patient's health and its subcategories are identified in the psychological and nursing literature of behavioural techniques and solution-focused therapy concepts. Although there is limited research on the use of solution focussed therapy concepts in psychiatric nursing, encouraging the patient's health and its subcategories contributes to the further development of a knowledge base in this area. The
way in which the category of encouraging the patient's health contributes to, and is different from, the literature surveyed is that the subcategories of promoting the patient's responsibilities in increments, inviting the patient's participation in activities, bringing any changes to the patient's attention, complimenting and cheerleading the patient's efforts, and drawing out the health already there expand present conceptualizations of caring, by viewing encouraging the patient's health as a harmonious interplay between protecting and empowering. Protecting and empowering are viewed as interwoven in the process of accomplishing encouraging the patient's health.
The literature as it pertains to the category of authentic relating and its subcategories is addressed in three parts. In the first part, John Bowlby's (1991a) concept of \textit{availability} from his theory of attachment is used to illuminate the nature of authentic relating and its subcategories. In the second part, the nursing literature in relation to authentic relating and its subcategories is presented. In the third part, only the subcategory of being available and responsive to the patient's concern of daily living is addressed in relation to the literature, because there were divisions between the psychiatric nurses about whether this subcategory should be retained within the caring done within nursing or delegated outside of nursing.

In the literature surveyed the harmonious interplay between protecting and empowering was corroborated by the literature surveyed in relation to authentic relating and its subcategories of being consistent, being available and responsive to the patient's concerns of daily living, and matching the nurse's interaction with the patient's receptivity and capability. The category of authentic relating in the theory of protective empowering has a different emphasis than what is presented in the literature. The difference being that authentic relating and its
subcategories are presented in a relationship encompassed by the main theme of protective empowering in which protecting and empowering are interwoven within the subcategories.

Part One: John Bowlby's Concept of Availability and the Category of Authentic Relating

Bowlby's (1991a) concept of availability is an effective vantage point for illuminating the vicissitudes of the category of authentic relating described by the psychiatric nurses in this study. Although Bowlby (1982) wrote about attachment in the relationship between the infant and the mother, he extended his theory to include situations of loss and separation in which attachment behaviours were reawakened in adult life. Bowlby (1991a) wrote about the importance of having attachment figures or a "trusted companion" at times of need (p.234). Bowlby based his thinking largely on his experience with patients.

According to Bowlby (1982), attachment behaviour is "any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. It [attachment behaviour] is most obvious whenever the person is frightened, fatigued, or sick, and is assuaged by comforting and caregiving" (p.668-669). This implies that hospitalization is one of those events that increases the
patient's susceptibility to fear, and that potentially reawakens attachment behaviours in people.

According to Bowlby (1982), the concept of availability is based on the premise that the presence of a trusted person or attachment figure, decreases a person's fear of situations; and, that the absence of a trusted person magnifies fear. According to Bowlby (1991a), "presence [of a trusted person] is to be understood as implying ready accessibility, rather than actual and immediate presence" (p.234). This means the trusted person(s) is available when wanted by the person in need.

The idea of accessibility to, and the presence of, one or two trusted persons, in Bowlby's concept of availability, is similar to the subcategory of being consistent in this study. The similarity lies in the contention that care coming from a succession of different people with different approaches to the patient, prevents the patient from developing trust. Being consistent with a patient in this study, like Bowlby's notion of accessibility within the concept of availability, involved having one or two nurses follow the patient throughout the hospitalization as opposed to the patient being exposed to a different nurse each day of the hospitalization. This means the patient has a person they deal with on a consistent basis. Furthermore, in this study being consistent not only meant the individual nurse was consistent, it also meant the entire nursing staff,
during spontaneous or on the spot interactions with the patient, followed a similar approach so that expectations were consistent.

These features of availability, such as being consistently accessible to the patient, reflect the interplay between protecting and empowering. That is, the nurse is accessible to the patient in protective situations in which the patient may become fearful, worried, disabled, or a potential harm to themselves or others, while at the same time the nurse is accessible patients in empowering situations, in which patients take action to explore their environment.

"Accessibility" to a trusted person is only one aspect of the concept of "availability" in Bowlby's theory of attachment, the "responsiveness" of the nurse is also important. Bowlby (1991a) wrote that the trusted person or attachment figure is only truly available if the trusted person (s) is "both accessible and responsive" (p.235). Therefore, in addition to accessibility, the attachment figure or trusted person "must be willing to respond in an appropriate way" (Bowlby, 1991a, p.234). To Bowbly, being responsive means being receptive to, and following the patient's "lead" and "initiative" (Bowlby, 1991b, p. 356-357). While the nurses in this study were divided on the issue of what patient concerns of daily living they
'should' be available and responsive to, they all concurred with following the patient's initiative and lead.

The idea of following the patient's lead and initiative in Bowlby's concept of 'availability' is akin to the subcategory of matching the nurse's interaction with the patient's receptivity and capability to interact. Following the patient's lead and initiative involves being perceptive to the person's "signals and responding promptly and appropriately to them... it is when she [health professional] is not perceptive or responsive, or when she gives him not what he wants but something else instead, that things go wrong" (Bowlby, 1991b, p. 357). Furthermore, matching the nurse's interaction with the patient's receptivity and capability to interact was akin to Bowlby's idea of responsiveness, as it involved the nurse's "ability to time" his/her interventions in harmony with the patient's rhythms (Ainsworth cited in Bowlby, 1991b, p.346).

Furthermore, Bowlby (1991a) writes that availability involves "a willingness to act as comforter and protector" (p.234), when someone is afraid or does not feel safe. These qualities of availability, such as allowing the patient to take the lead and the initiative while at the same time comforting and protecting the patient, are akin to the interplay between protecting and empowering in the process of protective empowering and run parallel to the category of authentic relating and its subcategories.
Part Two: Authentic Relating and the Nursing Literature

Teasdale (1995) found, in a grounded theory method study with 253 nurses and 51 patients, that the presence of a trusted person during times of need diminished the patient's fear of a situation. Bowlby (1991a) stated that "of the many fear arousing situations that a child, or older person, can foresee, none is likely to be more frightening than the possibility that an attachment figure [trusted person] will be absent or, in more general terms, unavailable when wanted" (p.234).

Taylor (1994) wrote that psychiatric nurses are involved in at least three types of therapeutic interactions with patients. In the first situation, the nurse and the patient do not know each other, in the second the nurse and the patient have an association but no on-going relationship, and in the third type of interaction the nurse and the patient have an on-going relationship (ie., the nurse is designated to follow the patient for the duration of the hospitalization).

The subcategories of authentic relating are supported by Taylor's (1994) comments about the nurse's responsibility to behave in a thoughtful, goal-directed manner when interacting with a patient, even with those patients that the nurse does not have an ongoing relationship with (ie., the nurse's non-primary patients). According to Taylor
(1994), an on-going relationship with a patient is not possible with all the patients on the psychiatric unit, therefore, each nurse will have an on-going relationship with a few patients for the duration of their hospitalization. She points out that for those patients that the nurse has an association with, but does not have the major responsibility for their treatment, it is still important for the nurse to interact with the patient in a manner that enhances the nursing care plan of other nurses working primarily with that patient. This idea is similar to the subcategory of being consistent with patients discovered in this study.

Although Taylor (1994) recognizes that every nurse cannot have a thorough knowledge base of all the patients with whom they are likely to come into contact, she supports the nurse being available and responsive to the patient as she says:

unlike many persons with physical illness, persons with mental illness usually are mobile and are able to approach the nurse whenever they choose. Sometimes a client seeks out one to validate the statements of another or otherwise engage the two nurses in a power struggle. The client's motivation may or may not be conscious and may be a manifestation of the stage of the relationship in which the client and the nurse are engaged (p. 112).
This implies that interactions with patients on a psychiatric unit are generally not planned or predicted, but are important when they occur (Hummelvoll and Da Silva, 1994; Taylor, 1994). These different types of interactions discussed by Taylor (1994) were also corroborated by Kavanagh's (1988) ethnographic study with 36 psychiatric nurses, in which they described their experience with patients in the hospital setting. The psychiatric nurses in Kavanagh's (1988) study reported the existence of these different types of interactions as the following excerpt illustrates: "some patients, severely depressed, isolate themselves in their beds or rooms most of the time. Others are out and about, often agitated and agitating, creating a roller coaster of interactive highs and lows" (p. 244). This finding corroborates the interplay between protecting and empowering as the nurse attempts to accomplish the subcategory of matching the nurse's interaction with the patient's receptivity and capability. Within this subcategory there are protective and empowering features. That is, there can be varying types of interactions between the nurse and the patient. For example, there are interactions in which the nurse protects patients when patients are a potential harm to themselves, or others, to empowering interactions in which patients take action and accomplish their own activities of daily living.
Part Three: The literature pertaining to the subcategory of 'Being Available and Responsive to the Patient's Concerns of Daily Living' Debate

In this study, nurses were divided on the subcategory of being available and responsive to the patient's concerns of daily living. In this study, some nurses described meeting the patient's ordinary needs as menial, others described these as occupying too much of the nurse's time and taking time away from developing and working with the patient in an on-going relationship. Then there were other nurses that believed that being available and responsive to the patient's concerns of daily living was important to developing trust and a relationship with a patient.

This difference of opinion regarding this subcategory is noted in some of the nursing literature. Some authors (Dunlop, 1986; Hall, 1986; McFarlane, 1976; Orem, 1980; 1985; Peplau, 1982) believe that the physical care of the patient and responding to the patient's ordinary needs of living such as those related to hygiene, grooming, nutrition, elimination, and clothing, all provide the nurse access to the patient and a means for developing some sort of a relationship or interaction with a patient.

In a literature review on the conceptualizations and theories of caring (Morse, Bottoroff, Neander, and Solberg, 1991), the authors stated that there was a tendency of some contemporary nursing theories of caring to ignore the body
and its associated physical care. Furthermore, a decrease in research dealing with the physical aspect of care was noted in a five year review of nursing research from 1970-1975 (McConnel and Duffey as cited in Dunlop, 1986). Similar observations were made by McFarlane (1976), and point out that these divisions found amongst the nurses are longstanding in the nursing literature.

McFarlane (1976) wrote that nursing focusses on the effects disease has on the patient's activities of daily living. The nurse's focus is on daily activities rather than disease. McFarlane (1976) described nursing as helping patients accomplish their own activities of daily living and maintaining wellness, such as nutrition, elimination, hygiene and grooming. McFarlane (1976), quoting Florence Nightingale, stated that nursing was initially conceptualized as primarily concerned with the use of fresh air, light, cleanliness, warmth, quiet, and proper selection of and administration of diet. Attending to medically derived tasks such as the administering medication and procedures was conceived as secondary. McFarlane (1976) stated that unless nursing promotes the primary aspect of nursing as assisting patients with their activities of daily living, nursing will be impoverished and taken over by others.

Although McFarlane (1976) wrote about nursing in general and not psychiatric nursing in particular, the
literature in psychiatric nursing corroborates McFarlane's contention that nursing focuses on the effects disease has on the patient's activities of daily living. For example, Peplau (1982) and others (Loomis, O'Toole, Brown, Pothier, West, and Wilson, 1987) contend that the focus of psychiatric nursing interventions is with human response patterns to disease, illness, treatment, daily experiences, and life-threatening events. These authors indicated that psychiatric nurses focus on human response patterns such as grief, anxiety, loneliness, hallucinations, thought disorder, and negative self-concept. Loomis et al (1987) and Peplau (1982) suggested that psychiatric nurses also focus on the self-care limitations and impaired functioning in the areas of nutrition, elimination, hygiene, grooming, sleep, activity, rest that may emanate from disease, illness, treatment, daily experiences, and life threatening events. The subcategory of being available and responsive to the patient's concerns of daily living is unique to this study, as it may be helpful to nurses when considering their position in political arenas.

Interestingly, there are some studies in which patients were asked to rank, in order, the nursing activities considered most important by patients and reflective of "caring". These studies are presented in order to illuminate the debate inherent in the subcategory of being available and responsive to the patient's concerns of daily living.
For example, in a study of 300 medical and surgical patients (White, 1972), patients ranked the following nurse activities as most important to the patient. Giving or assisting the patient with physical care and its associated activities was identified as one of the top five nursing interventions. Assisting the patient with physical care included the following: providing the patient with a clean, comfortable bed; making sure that the patient has the necessary equipment, glass, towel, soap, blanket, etc; providing the patient with a comfortable, pleasant environment with proper temperature and free from odours; and ensuring that the patient's area is clean and tidy (Larson, 1984; Mayer, 1987; von Esseen and Sjoden, 1991). While the patient samples for these studies reviewed above, were mostly from medical-surgical and palliative settings, these patient needs were similar to the activities of daily living cited, by the psychiatric nurses, in this study.

In summary, the category of authentic relating and its subcategories are supported in the previous empirical and theoretical literature in nursing and through the theoretical concept of availability from Bowlby's theory of attachment. The harmonious interplay between protecting and empowering was corroborated by the literature surveyed in relation to authentic relating and its subcategories of being consistent, being available and responsive to the
patient's concerns of daily living, and matching the nurse's interaction with the patient's receptivity and capability.

The category of authentic relating in the theory of protective empowering has a different emphasis than what is presented in the literature. The difference being that authentic relating and its subcategories are presented in a relationship encompassed by the main theme of protective empowering in which protecting and empowering are interwoven within the subcategories.

Moreover, unique to this study is that the subcategory of being available and responsive to the patient's concerns of daily living points out the divisions between psychiatric nurses about whether nurses should retain or delegate these activities. This division between psychiatric nurses within the subcategory of being available and responsive to the patient's ordinary needs of daily living may be an indication of the on-going debates within the nursing profession about what nurses should be doing and not doing in practice. This subcategory may be helpful in debating and examining McFarlane's cautionary note of twenty years ago, that unless issues are discussed, "specialization will be built on the shaky foundation of accepting all that comes our way...[or] that nursing will be impoverished and taken over by others" (McFarlane, 1976, p. 196). The category of authentic relating provides a vantage point to view and debate these divisions in nursing.
Literature Pertaining to the Category of Interactive Teaching and Its Subcategories

During the process of protective empowering nurses described interactive teaching as evidenced through the subcategories: building on the patient's interests, knowledge, and needs; showing the patient through the nurse's example in interactions with others; giving feedback; pointing out expectations, alternatives, and life patterns to the patient; and helping the patient anticipate how they will manage in the community.

Unique to this study is that the subcategories of interactive teaching are expressed as a harmonious interplay between protective and empowering actions. The protective features of interactive teaching were encompassed mainly by the subcategory of giving feedback while the empowering aspects of interactive teaching were reflected mainly through the subcategories of building on the patient's interests, knowledge, and needs; showing the patient through the nurse's example in interactions with others; pointing out expectations, alternatives, and life patterns to the patient; and helping the patient anticipate how they will manage in the community. The category of interactive teaching in the theory of protective empowering has a different emphasis than what is presented in the literature. The difference being that interactive teaching and its
subcategories are presented in a relationship encompassed by the main theme of protective empowering in which protecting and empowering are interwoven within the subcategories. This is in contrast to the literature in which the subcategories of interactive teaching were individually supported. In the following section the literature pertaining to the category of interactive teaching and each of the subcategories is reviewed.

As the name of the category of interactive teaching suggests, nurses in this study described the teaching with patients as interactive. Joyce Travelbee's (1971) concept of `interaction' from her human to human relationship model seemed parallel to the meaning of the `interactive' from interactive teaching. Travelbee (1971) defined interaction as referring to "any contact during which two individuals have reciprocal influence on each other and communicate verbally and/or non verbally" (p.120). Each of the above subcategories of interactive teaching imply the nurse and the patient influence each other through each individual's participation in building on the patients strengths, interests, knowledge, and needs; showing the patient through the nurse's interactions; giving feedback; pointing out expectations, alternatives, and life patterns; and helping the patient anticipate how they will manage in the community. Furthermore, Travelbee's (1971) definition of
`interaction' implies participation on both the part of the nurse and the patient in teaching situations. Other theories of nursing, such as the Philosophy and Science of Caring (Watson, 1979), Self-Care Deficit theory (Orem, 1980), From Novice to Expert theory of Clinical Nursing Practice (Benner, 1984), and Interpersonal Relations Model (Peplau, 1952), all speak to a type of teaching with patients that is interactive. For example, according to Watson (1979), one of the factors of caring is the `promotion of interpersonal teaching-learning'. Watson's concept of `interpersonal teaching and learning' is facilitated by the nurse and is designed to shift the responsibility for self-care and well-being to the patient.

Orem (1980) discussed three different types of approaches to nursing care which depended upon the patient's capabilities. One of these approaches included the `supportive-educative system' in which the approach is interactive as the nurse and the patient both influence each other (Orem, 1985).

In Peplau's Interpersonal Model of Nursing (1952; 1982), she described six nursing roles that emerged in different phases of the relationship between the patient and the nurse. Peplau (1952; 1982) described the teaching role as "always proceed[ing] from what the patient knows" (p.48). Similar to the subcategory of building on the patient's interests, needs, and knowledge, Peplau (1952; 1982) viewed
the nurse's teaching role as developing around the patient's "interest" (p.48). Furthermore, similar to the subcategory of pointing out life patterns and alternatives, Peplau (1952; 1982) stated the purpose of the interpersonal techniques in the teaching role was to assist "the patient [to] remember and understand fully what is happening to him [her] in the present situation, so that the experience can be integrated rather than dissociated from other experiences in life" (p. 64). The nurses in this study described this type of intervention as limited in the hospital setting because of the short admissions. Rather the nurses in this study focussed more on empowering patients to access their abilities to take action or accomplish their activities of daily living by showing the patient through the nurse's example and giving feedback by using interactions with the nurse, as examples from which patients could modify their own patterns and ways of coping and interacting.

The category of interactive teaching expands conceptualizations of caring, because the subcategory of giving feedback also had protective features in situations in which limit-setting on the patient's behaviour was necessary. Moreover, the subcategory of giving feedback was tempered with the empowering features of building on the patient's interests, needs, and knowledge, showing the patient through the nurse's example in interactions, pointing out expectations, alternatives, and life patterns,
and helping the patient anticipate how they will manage in the community.

In a phenomenological study designed to determine the domains of expert practice, Benner (1984) reported that one of the domains of expert nurse caring was the teaching-coaching function. The teaching-coaching function involved capturing the patients readiness to learn and helping patients to maximize their ability to continue with life activities that were meaningful to the patient. These features of the teaching-coaching function are akin to the subcategories of building on the patient's interests, needs, and knowledge.

Other ideas akin to the subcategories of showing the patient through the nurse's example, giving the patient feedback about their impact on others, and helping the patient anticipate how they will cope in the community was further conveyed in the teaching-coaching function "by demonstration, attitudes, and reactions [of the nurse]" (Benner, 1984, p. 90).

In summary, the category of interactive teaching in the theory of protective empowering has a different emphasis than what is presented in the literature. The difference being that interactive teaching and its subcategories are presented in a relationship encompassed by the main theme of protective empowering in which protecting and empowering are interwoven within the subcategories. This is in contrast to
the literature in which the subcategories of interactive teaching were individually supported.

Literature Pertaining to the Category Respecting the Patient and its Subcategories

Carl Rogers (1986) concept of unconditional positive regard from his theory of client-centred or person-centred therapy is akin to the category of respecting the patient and its subcategories of: acknowledging the patient's concern or distress, being non-judgemental of the patient's situation, not power-tripping, and viewing the patient as knowledgeable.

According to Rogers (1986), "unconditional positive regard" is evident "when the therapist is experiencing a positive, non-judgemental, acceptant attitude" toward the client (p. 198). Rogers' (1986) concept of unconditional positive regard, is similar to the subcategory of acknowledging the patient's distress. Rogers asserted that unconditional positive regard "involves the therapist's [nurse's] willingness for the client to be whatever immediate feeling is going on—confusion, resentment, fear, anger, courage, love or pride" (p.198). The nurses in this study expressed their concern to the patient and a willingness to listen to the patient. The nurses showed their concern for what the patient cared about by
acknowledging the patient's distress, regardless of whether the origin of the patient's distress was internal or external. The nurses viewed the patient's feelings and perceptions as real and important to the patient. Similar to the nurses in this study, Rogers (1986) said that "when the therapist prizes the client in a total, rather than a conditional way, forward movement is likely" (p. 198).

Unconditional positive regard, similar to the subcategories of being nonjudgemental of the patient situation and not power-tripping or imposing on the patient involves experiencing a positive, nonjudgemental, accepting attitude and is associated with terms, such as warmth, caring, prizing, and nonpossessiveness (Raskin and Rogers, 1989, p.171). Furthermore not power-tripping seems close to McGee's (1994) discussion of the concept of respect, in nursing. McGee (1994) stated that a lack of respect may be associated with patient abuse and dehumanized care.

The concept of unconditional positive regard, similar to the notion of respecting the patient and its subcategories, is based on the guiding value of viewing the patient as knowledgeable. In Rogers' (1986) client-centred therapy, the therapist does not view himself/herself as responsible for arriving at a solution for the problem presented, or changing the client's attitudes, or determining which problem will be focussed on in therapy. In client-centred therapy, the therapist sees the client as
having these responsibilities and "respects" the client's capacity to fulfil them (Raskin and Rogers, 1989, p. 177). This respect for the patient's capacity to fulfil responsibilities is parallel to the subcategory of viewing the patient as knowledgeable, in which the patient is acknowledged as a knower or having knowledge about what needs to be done.

Related to the value or belief of the patient as knowledgeable was the quality of the patient as having abilities already present, and as having the best knowledge about what is needed, and what can be maintained (Raskin and Rogers, 1989). In addition to Rogers' concept of unconditional positive regard, Annette Browne (1993), in her conceptual clarification of respect, compared the concept of respect to other concepts in nursing. Brown (1993) noted that respect served as the basis for the nurse's attitudinal, cognitive, and behavioural orientation toward people. Furthermore, Browne's (1993) comparison of the concept of 'respect' to other nursing concepts revealed 'respect' both as a component of caring and an antecedent to caring. This corroborated the finding in this study that respecting the patient was an action that preceded caring in a protective empowering way, and was also an action that sustained and maintained the process of protective empowering. Psychiatric nurses described they were most
effective at "caring" when they had a respecting the patient orientation toward the patient.

Lancee, Gallop, McCay and Toner (1995) examined the influence of six limit setting styles used by nurses in four common patient situations, within a psychiatric inpatient setting. These four situations included: 1. where the patient refused to participate in what was required; 2. when the patient wanted something that was not possible; 3. when the patient demanded instant gratification; and 4. when the patient demanded immediate emotional attention. The limit setting style of 'affective involvement with options' was reported as the least likely to generate anger in patients (Lancee et al., 1995). The limit setting style of 'affective involvement with options' was akin to the category respecting the patient and its subcategories, because the participants in this study said that a respectful approach was the approach most likely not to generate anger.

According to Lancee et al (1995), the limit setting style of 'affective involvement with options' involved the nurse attending to the patient's subjective experience and expressing concern and care. This is akin to the subcategories acknowledging the patient's suffering or distress, not power-tripping; and viewing the patient as knowledgeable. 'Affective involvement with options' involved offering the patient useful suggestions, and tailoring the nurse's response to the patient's specific
experience. Although Lancee et al (1995) did not explicitly refer to the themes of power and patient knowledge; nevertheless, by offering the patient suggestions and tailoring the nurse's response to the patient's specific experience in the affective involvement with options style, the nurse is acknowledging the patient's concern or distress, not power-tripping, and the patient is viewed as knowledgeable. However, in this study psychiatric nurses described situations similar to the four patient situations described in Lancee et al., (1995), in which the patient's refusal to participate in what was required (for example), could mean that the patient or others on the unit could be potentially harmed. Consequently, the subcategory of acknowledging the patient's concern and distress in situations had protective features, in which the patient's concern or distress could be of potential harm to the patient or others. Unique to this study, is the interplay between protective and empowering actions of caring. In this study, the subcategory of acknowledging the patient's concern and distress in situations, mainly protective in nature, was expressed in relation to, and interwoven with, the empowering subcategories of respecting the patient: being non-judgemental of the patient's situation, not power-tripping, and viewing the patient as knowledgeable. Although each of these subcategories of respecting the patient were, individually, addressed in the empirical and theoretical
literature discussed below, the subcategories in this study are presented as a collective encompassed by the main theme of protective empowering.

Lancee et al., (1995) corroborated the importance of the subcategory of not power-tripping by identifying the limit setting styles that caused patients to defend their position, such as belittlement and generic styles. Belittlement and generic styles were not effective as they gave little attention to the specific circumstances of the patient's situation. These styles involved the nurse telling the patient what to do, or explaining rules without providing options (Lancee et al., 1995). Lancee et al's (1995) findings pointed to the importance of not imposing on the patient, and providing the patient with options. This lends support to the importance of the subcategories of not power-tripping and viewing the patient as knowledgeable.

The importance of addressing the nurse's power in interactions with patients was further studied by Hewison (1995), in a participant observation and grounded theory study, in which she observed 103 interactions between nurses and elderly patients within a small hospital. Hewison's (1995) findings further supported the subcategory of not power-tripping.

The purpose of Hewison's (1995) study was to understand the nurses' power in interactions with patients by examining how nurses use language to exert power over patients.
Hewison (1995) used a grounded theory approach in order to arrive at key concepts of power and language in interactions between the patient and the nurse. The concept of power identified by Hewison (1995) further illuminated and supported the subcategory of not power-tripping.

Hewison (1995) reported that nurses exert power over patients through overt power, persuasion, controlling the agenda, and through praise. According to Hewison (1995) overt power involved ordering the patient to do something or preventing the patient from doing something. Hewison's example of power are akin to the examples associated with the subcategory of not power-tripping. For instance, Hewison (1995) provided the example of a patient that wanted to return to bed, but is prevented from doing so due to established routines on the ward such as meal times. Persuasion was another category identified in Hewison's study (1995). Persuasion involved persuading patients to go against their original stance. Persuasion also involved getting the patient to do things the nurse wanted by providing the patient with suggestions of what the patient can do. These suggestions were usually stated in the form of a question and were repeated and persistently offered until the patient agreed.

Another category pertaining to the nurses' use of power in interactions with patients was controlling the agenda (Hewison, 1995). Nurse's controlled the agenda by providing
the patient with a limited range of choices to ensure that the choice made by the patient was the one desired by the nurse. Hewison (1995) stated that the patients were sensitive to the nurse's agenda and usually recognized there were expectations of them. Hewison (1995) also pointed out situations in which the nurses 'take over' the interactions with patients completely, by the nurse asking the questions and providing the responses for the patient. That is, nurses used closed questions, leading questions, and persistence, to control the agenda. Hewison's study findings, which encourage nurses to be aware of their own power in interactions, further lends support to the importance of the subcategory of not power-tripping.

Furthermore, the subcategory of not power-tripping appeared similar to the concept of authentic care in the theoretical literature (Benner and Wrubel, 1989; Bishop and Schudder, 1991). Bishop and Schudder (1991) wrote that when people are unable to care for themselves, caring from others becomes necessary. Moreover, these authors asserted that the necessity of care "gives the caregiver much power over the person receiving care" (Bishop and Schudder, 1991. p. 56).

Authentic care involves helping the other to care for her or his own being (Benner and Wrubel, 1989; Bishop and Scuddler, 1991). Bishop and Scuddler (1990) wrote that authentic care "attempts to restore self-care to those who have lost it due to illness or debilitation" (p. 57). In
authentic care, "the nurse focusses...on the possibilities for increasing the patient's self-care" (Bishop and Schudder, 1991, p. 59). Furthermore in authentic care, similar to the subcategory not power-tripping, care for the patient is provided only when the patient is unable to care for themselves, so that the nurse is taking "care of [the patient]" (Bishop and Scudder, 1991, p. 59) rather than taking "care from [the patient]" (Bishop and Scudder, 1991, p. 59). Similar to the subcategory of not power-tripping in this study, patients are "empowered to continue their quest for full humanity" (Bishop and Scudder, 1991, p. 62).

Similar to the subcategory of not power-tripping in this study, Benner and Wrubel (1989) recognized that there were situations in which the patient cannot care for themselves, such as after surgery or in extreme distress. In such situations, Benner and Wrubel (1989) stated that "when patients are extremely ill and dependent, there is no choice but to "leap in" and take over, but the problem is that this kind of taking over can extend past the point of necessity either on the part of one caring or the one cared for" (p. 49). In contrast, the psychiatric nurses in this study did not associate leaping in or taking over with protective empowering even when the patient was extremely ill. Rather within a protective empowering approach psychiatric nurses described not power-tripping as similar to another concept Benner and Wrubel (1989) discussed, referred to as a
`leaping ahead' type of caring. In `leaping ahead', the nurse gives back his or her care to the patient authentically by facilitating and advocating with the patient to take up his/her own care. According to Benner and Wrubel (1989) `leaping ahead' is a type of caring that "empowers the Other to be what he or she wants to be" (p. 49). Therefore, different from Benner and Wrubel (1989), in this study nurses focussed on a `leaping ahead' type of care as present even when the patient was extremely ill. This finding may relate to the potential gap between what the meaning and description of caring is in situations when protective empowering occurs, to situations in actual practice where factors emerge that interfere or impede caring from occurring in a protective empowering way. That is, this finding may relate to the fact that in this study psychiatric nurses were asked to describe their meaning and experience of caring with patients, according to when it actually occurs in clinical practice in a way that has meaning for them. The psychiatric nurses in this study were not asked to describe their meaning and experience of caring when caring does not happen in a way which has meaning for them.

In summary, the category of respecting the patient and its subcategories are supported in the empirical and theoretical literature within nursing and psychology. Unique to this study is that the subcategories: acknowledging the
patient's concerns or distress, being non-judgemental of the patient's situation, not power-tripping, and viewing the patient as knowledgeable represent the antecedent actions necessary for sustaining caring in a protective empowering way. Moreover, the category of respecting the patient represents the values and world view associated with caring in a protective empowering way. Furthermore, respecting the patient contributes to the further articulation of the ethic of care which underpins the nurse's actions in psychiatric nursing. The way in which the category of respecting the patient is different from the literature surveyed is that the subcategories are expressed as a harmonious interplay between protective and empowering actions. In respecting the patient, the mainly protective action of acknowledging the patient's concerns and distress is tempered with the subcategories of being non-judgemental of the patient's situation, not power-tripping, and viewing the patient as knowledgeable, which are mainly empowering in nature.
Literature Pertaining to the Category of Not Taking the Patient's Behaviour Personally and its Subcategories

During the process of protective empowering psychiatric nurses described not taking the patient's behaviour personally, as evidenced through the subcategories: knowing yourself, knowing the patient, viewing each situation as a learning situation, consulting with other nurses/the team/the patient, imagining the patient's situation, and taking a break.

Knowing yourself and knowing the patient have been cited as important in the psychological literature (Bollas, 1987; Fromm-Reichman, 1960; Gill, 1982; Racker, 1968; Sandler, 1987), and in the nursing literature (Travelbee, 1971; Gallop, Lancee, Garfinkel, 1989; Gallop, Lancee, and Garfinkel, 1990; Jones, 1986; Purtilo, 1984; Smith and Hart, 1994). Within the literature on psychology, there is the underlying assumption of the client and the therapist as continually and mutually influencing each other, and as such, imply the importance of the subcategories of knowing yourself and knowing the patient as two ways of accomplishing not taking the patient's behaviour personally. For example, Racker (1968) stated that the patient and the therapist express their total responses to each other, individually and together. Gill (1982) stated that the
patient has a selective attention, adaptation, or interpretation of the therapist's behaviour and style. This suggests that the therapist needs to become aware of the patient's selective attention in interactions, and is akin to the subcategory of knowing the patient. In addition, to the patient having a selective attention, the same was implied of the therapist, by Sandler (1987). Sandler (1987) wrote about the therapist's free-floating attention and responsiveness to the patient. This suggested that the therapist needed to become aware of his or her own free-floating attention and responsiveness to specific patient interactions. This idea is akin to the subcategory of knowing yourself. Therefore, becoming aware of the patient's selective attention (Gill, 1982) and the therapist's free-floating attention (Sandler, 1987) is akin to the subcategories of knowing yourself and knowing the patient. The importance of knowing yourself and knowing the patient to accomplishing not taking the patient's behaviour personally, and maintaining protective empowering was implied and corroborated by Fromm Reichman (1960) in the following quotation: "unless the psychiatrist is widely aware of his [her] own interpersonal processes so that he [she] can handle them for the benefit of the patient in their therapeutic dealings with each other, no successful psychotherapy can eventuate" (p. 3).

Furthermore, Joyce Travelbee's (1971) concept of
'therapeutic use of self' is akin to the subcategory of knowing yourself discovered in this study. According to Travelbee (1971) the therapeutic use of self is:

the ability to use one's personality consciously and in full awareness in an attempt to establish relatedness...[it] requires self insight, self understanding, an understanding of the dynamics of human behaviour as well as the behaviour of others, and the ability to intervene effectively in nursing situations (Travelbee, 1971, p. 19).

Erich Fromm's (as cited in Purtilo, 1984) concept of 'knowledge' was akin to the subcategory of knowing the patient. Fromm (as cited in Purtilo, 1984) stated that having knowledge about what another person cares about was one of the important elements on which to build a caring relationship.

In a grounded theory study with registered nurses working in a variety of settings, a pattern of connecting emerged (Smith and Hart, 1994). This connecting pattern was akin to the category of not taking the patient's behaviour personally and its subcategories of the nurse knowing yourself, knowing the patient, viewing each situation as a learning situation, consulting with other nurses, the health team, and the patient, imagining the patient's situation, and taking a break.
The nurses in Smith and Hart's (1994) study defined the connecting pattern as "the ability to associate mentally, physically, and emotionally with the angry patient" (p. 649). The nurses in Hart and Smith's study (1994) described connecting patterns as occurring even when the patient was appraised as threatening. The connecting pattern illustrated how the nurses managed the threat of being the recipient of different types of intense anger. The nurses in the Smith and Hart (1994) study were able to establish and maintain a connecting pattern with the patient by: (i) taking charge of one's own anger; (ii) non-personalizing the anger; (iii) having a holistic understanding of the patient situation; (iv) taking time out; (v) seeking peer support, and (vi) talking with patient after an emotional incident in order to understand what led to the incident; and how to prevent future incidents. These strategies within the connecting pattern identified in Hart and Smith study (1994) are parallel to the category of not taking the patient's behaviour personally and its subcategories of knowing yourself, knowing the patient, viewing each situation as a learning situation, consulting with other nurses/the health team/the patient, imagining the patient's situation, and taking a break. The way in which the category of not taking the patient's behaviour personally differs from Smith and Hart's study is that the category is expressed in a relationship encompassed by the main theme of protective
empowering. Although the category of not taking the patient's behaviour personally is mainly protective in nature, it is interwoven with the category of respecting the patient, whose subcategories primarily focus on empowering the patient. The categories of not taking the patient's behaviour personally and respecting the patient are both antecedent and sustaining actions of protective empowering, except that the category of respecting the patient is predominately concerned with empowering actions to help the patient access his/her abilities to act or accomplish their own activities of daily living through the subcategories of: acknowledging the patient's concern or distress, being non-judgemental of the patient's situation, not power-tripping, and viewing the patient as knowledgeable. In contrast, the category of not taking the patient's behaviour personally is concerned with protective actions taken to circumvent situations in which caring is threatened, compromised, challenged, interrupted or curtailed and is accomplished through the subcategories of: knowing yourself, knowing the patient, viewing each situation as a learning experience, consulting with other nurses, the health care team, the patient, imagining the patient's situation, and taking a break. Therefore, the interplay between protective and empowering actions is expressed through the interaction of the subcategories within each of the two antecedent and sustaining categories of protective empowering which are:
respecting the patient and not taking the patient's behaviour personally. The category of not taking the patient's behaviour personally in the theory of protective empowering has a different emphasis than what is presented in the literature. The difference being that not taking the patient's behaviour personally and its subcategories are interwoven within the subcategories of respecting the patient and their interplay is represented through the main theme of protective empowering. This is in contrast to the literature in which the subcategories of not taking the patient's behaviour personally were individually supported. In the following section the literature pertaining to the category of not taking the patient's behaviour personally and each of the subcategories is reviewed.

Joyce Travelbee's (1971) concepts of empathy and sympathy appeared similar to the subcategory of imagining the patient's situation. Travelbee (1971) wrote that empathy and sympathy were important to the psychiatric nurse's work with patients. Empathy according to Travelbee (1971) is characterized by the nurse sharing in the patient's experience. According to Travelbee (1971) empathy is facilitated by the nurse's desire to understand the other person and share in their experience. That is, the nurse imagines what it must be like for the patient to be admitted into hospital for a mental illness (ie., life situations in which the nurse might have felt fear and then using this as
one of the driving forces for helping the patient).

Travelbee (1971) also believed that sympathy was important in psychiatric nursing care. According to Travelbee (1971) sympathy goes beyond the nurse's action of empathy. Sympathy involves the nurse's desire to help the patients alleviate their distress. Travelbee (1971) wrote that "when one sympathizes one is involved but not incapacitated by the involvement" (p. 138). Furthermore, Travelbee (1971) described sympathy as "a desire to help individuals undergoing stress (p.68-69) ... [sympathy] requires a combination of the disciplined intellectual approach combined with the therapeutic use of self" (p.149). This was similar to the subcategory of imagining the patient's situation in conjunction with the other subcategories of not taking the patient's behaviour personally.

The idea of imagining the patient's situation was also corroborated by R. May (as cited in Purtilo, 1984). May defined caring as "an energy that one is willing to expend on another because one can remember, or 'vividly imagine', what it feels like not to be cared for" (as cited in Purtilo, 1984, p. 151). It is important to note the similarity between May's conceptualization of caring as involving 'imagining' and the psychiatric nurse's conceptualization in this study as also including imagining the patient's situation.
In summary, the category of not taking the patient's behaviour personally and its subcategories are supported in the empirical and theoretical literature within nursing and psychology. Unique to this study is that the subcategories: knowing yourself, knowing the patient, viewing each situation as a learning experience, consulting with other nurses, the health care team, the patient, imagining the patient's situation, and taking a break represent the antecedent and the sustaining actions that maintain caring in the process of protective empowering. The way in which the category of not taking the patient's behaviour personally differs from the literature surveyed is that the category is expressed in a relationship encompassed by the main theme of protective empowering. Although the category of not taking the patient's behaviour personally is mainly protective in nature, it is interwoven with the category of respecting the patient, whose subcategories primarily focus on empowering the patient.
SIGNIFICANCE FOR NURSING

Protective empowering is a theory of caring, which provides insight and a framework for affirming, proposing, challenging, and for enhancing the visibility of psychiatric nursing practice. A grass-roots theory of caring, such as the theory of protective empowering provides a rationale on which to base lobbying efforts for the maintenance, reallocation, and/or expansion of the specific psychiatric nursing interventions. The implications of the theory of protective empowering are discussed in terms of both its clinical and political significance to nursing.

Clinical Significance

The theory of protective empowering is a grass-roots theory of caring, and as such, it represents categories and relationships that explain what "caring" is. Moreover, caring occurs through a process of protective empowering. Since protective empowering is a process, no one category can capture it completely but each category of protective empowering in a particular context adds to the understanding of what caring is. Consequently, the theory of protective empowering implies the following two points for clinical practice: 1. that there is value in examining each of the categories of protective empowering, individually; and 2.
that there is value in examining the relationships among the six main categories of protective empowering.

The clinical value of examining each of the individual categories of protective empowering, is that each category outlines what psychiatric nurses working with patients think about, do, consider, and include in their "caring" in hospitals. Caring is accomplished by a process of protective empowering. The process of protective empowering involves respecting the patient, not taking the patient's behaviour personally, keeping the patient safe, encouraging the patient's health, authentic relating, and interactive teaching. The outcome of protective empowering is manifested by the patient's ability to take action towards accomplishing his/her activities of daily living. The six categories of protective empowering serve as criteria for accomplishing "caring". The theory of protective empowering with its six categories and their associated subcategories has two major implications. The first is that protective empowering provides nurses with a framework for interacting with patients. Second, the psychiatric nurse can also use this framework as a feedback tool on how they are providing "caring".

Since these six categories represent what psychiatric nurses do, and include, in caring, they can be especially useful when the psychiatric nurse perceives that he or she is "stuck" or at a stand still with a patient's care.
Protective empowering does not happen all the time, because of the interaction of patient, nurse, workplace, and societal variables which interfere with caring. Consequently, the theory of protective empowering can be used by the nurse to get on track, or back on track, with the patient. In the theory of protective empowering, caring is expressed as a complex process in which the nurse reflects on practice with a patient in a deliberate way. The theory of protective empowering provides a guideline on how two aspects of caring, protecting and empowering, interweave and translate into what nurses do in caring. The implication of this is that the theory of protective empowering provides an inclusive and hands-on model for looking at how protecting and empowering are expressed in each decision of caring and allows for an explicit consideration of caring in clinical practice. For example, the theory of protective empowering can help the psychiatric nurse to become aware of the situations in which the nurse may be "over or under attached" to, or "challenged" by the patient. That is, if the nurse is "stuck" in the care with a patient and does not know what to do next, the theory of protective empowering implies what the possible deficits and strengths in the nurse's approach are, specifically in terms of each of the individual categories of protective empowering. For example, one of the categories of protective empowering is respecting the patient. The category of respecting the patient is
accomplished by its subcategories of: not power-tripping, being non-judgemental of the patient's situation, acknowledging the patient's distress and acknowledging the patient as a knower of what needs to be done. Referring to this individual category of protective empowering helps the nurse to develop interventions in which he or she is respecting the patient. For example, in relation to the subcategory of not power-tripping, the psychiatric nurse develops interventions that would give the patient control. Moreover, with this subcategory, the psychiatric nurse reflects on whether he or she has taken over for the patient rather than helping the patient access abilities in which they can take action and/or accomplish his/her own activities of daily living.

Another subcategory of respecting the patient is being non-judgemental. This subcategory helps the nurse to reflect on his/her own beliefs about the patient so that the psychiatric nurse can confront his or her possible prejudices. These prejudices and biases may influence the care provided to the patient. For example, the nurse would consider whether the patient that has molested children, or who is a drug addict, is treated with the same respect as the mother or father of three children who is diagnosed with depression.

Also, the subcategory of acknowledging the patient's distress and concerns from the category of respecting the
patient directs the psychiatric nurse to consider whether they have validated the patient in terms of what the patient cares about. Thus, the psychiatric nurse considers what actions she or he can take that acknowledges the patient's distress and concerns. For example, if the patient is concerned about his/her food being poisoned the psychiatric nurse would acknowledge the patient's concern or distress about the food and explore alternatives with the patient such as prepackaged food or what the patient thinks needs to be done.

Lastly, the psychiatric nurse can draw on the subcategory of viewing the patient as knowledgeable as a way of respecting the patient. The subcategory of the patient as knowledgeable involves the psychiatric nurse examining whether the patient has been treated as someone who is able to make decisions and as someone who has knowledge about what needs to be done in his/her care. This means that even for patients who are not able to help themselves in some areas are still viewed as able to participate and make decisions in others. Psychiatric nurses viewed patients as capable of making choices in some areas of their lives, even for patients legally declared as not competent in their self-care. Therefore, the psychiatric nurse guided by the subcategory of the patient as knowledgeable will formulate interventions that will allow the patient to make decisions in areas in which they are still competent (i.e., personal
food preferences, routes for administering medications, and ways of accomplishing self-care). Therefore, each subcategory of respecting the patient is geared towards drawing patients out to participate in their own care, and to take action for themselves.

The implications of viewing caring as a complex and deliberate process, as described above, points to the necessity of educating institutions and government about the complexity of caring. This involves recognizing that caring is a reflective and deliberate process that takes time and knowledge. Recognizing the complexity and the time required to accomplish caring points to the needs for formal time allocation for nurses to discuss issues in caring and educational support for instituting protective empowering, so that caring can be maintained. In addition, this time allocation for discussing issues in caring, which emerge in daily clinical practice, need to be part of the formal accounting systems used by the institution or agency to document the nursing services provided to patients.

Although it is suggested above that the theory protective empowering be used as framework for nursing services, it is important to note that the clinical usefulness of the theory is that it is specific, yet not dogmatic. That is, each nurse will define and modify each of the categories and their associated subcategories within the context of his or her experience with a patient. Thus, the
use of this theory can facilitate the psychiatric nurse's own modification of the theory as contexts, categories, and descriptions, and criteria of caring, expand or change.

Having discussed the clinical value of examining each of the categories individually, the clinical value of examining the relationships among the six major categories of protective empowering is now discussed.

Examining the relationships among the six major categories of protective empowering provides a method for interacting with patients. That is, the theory of protective empowering guides the psychiatric nurse in his or her approach, stance, and actions taken with the patient. For example, according to the theory of protective empowering, the goal of caring is to help patients access their abilities to take action and accomplish their activities of daily living. In the hospital setting, this means that the goal for the patient is to be able to take action. This action can be in the form of the patient accomplishing his/her self-care and/or the patient accessing the ability to take action in the form of seeking assistance from support services in the community. By examining the relationships between the categories of protective empowering, patients are helped to access their abilities to take action for themselves through the: 1. antecedent and sustaining actions of caring; 2. specific actions and interactions of caring; and through 3. the contexts in
which caring with patients change. Coincidentally, this consequence or outcome of protective empowering is useful to present day health reform mandates, in which short hospitalization stays and returning the patient to the community as soon as possible are encouraged.

Although the theory of protective empowering can help the nurse when she or he is experiencing difficulty in caring, the theory of protective empowering represents the psychiatric nurse's approach and methods with the patients, which occurs irrespective of whether the nurse is experiencing difficulty in "caring". For example, the stance the psychiatric nurse takes with the patient in order to achieve protective empowering is:
1. always respecting the patient;
2. always not taking the patient behaviours personally;
3. keeping the patient safe when the patient is afraid, worried, unable to care for themselves, or is a harm to themselves or others;
4. encouraging the patient's health when the patient does not see the health they already possess or can develop;
5. authentic relating is when patients do not trust or understand the people and things in their environment; and
6. interactive teaching is when the patient shows interest in learning or unlearning ways of interacting with others or accomplishing his/her own activities of daily living.
Political Significance

In order to understand the significance of this grass-roots theory of caring, protective empowering, in the political arena, it is necessary to briefly comment on the invisibility of "caring" in the history of nursing.

Caring in nursing has historically been economically invisible. The problems nurses have experienced in making "caring" economically visible have been reflected historically in the broader problem of "caring" as unpaid work in society, usually associated with the work of women (Larsen and George, 1992). This has meant that caring was absent from written accounts of events or productive work in society. Nursing grew out of a societal demand for knowledgeable care-givers. By the late nineteenth century, people in society began to delegate their own care, and the care of family members to nurses (Lynaugh and Fagin, 1988).

Furthermore, another factor which contributed to the invisibility of "caring", provided by nurses, was that historically, nursing care in hospitals was provided by student nurses. The students were minimally paid and provided services so that they could receive the title of graduate nurse. These graduate nurses worked in private duty nursing in people's homes. The cost of the care that nurses provided was not calculated directly. Instead hospitals tracked the cost of renting hospital beds by the day. Diers
(1986) asserted the invisibility of nursing when she stated that "for way too long nursing has been buried in the hospital bill along with brooms, breakfast, and building mortgage" as opposed to a separate service.

Given that caring is a devalued and simplified construct, and that information pertaining to the work of caring has traditionally not counted as knowledge, it is important to articulate the work that psychiatric nurses call "caring". Moreover, the tendency for the work of caring to not be regarded as equally valuable as other kinds of work in society is another important reason for clarifying what caring is from the perspective of the psychiatric nurse. That is, since caring has been undervalued and simplified in society, it is important to describe the complexity, knowledge, expertise that is involved in caring within nursing. One way in which to describe the complexity, expertise, and knowledge of caring is through the theory of protective empowering.

In protective empowering, caring is more than the sum of its individual categories and subcategories. According to the theory of protective empowering, caring has many actions that are in relationship to one another. This means each of the individual categories and subcategories includes more than each subcategory and category indicates, because it is part of an overall process of protective empowering. Therefore, no one action in the categories and subcategories
of protective empowering can capture caring completely. The political significance of this idea is that the theory of protective empowering does not support replacing registered nurses in hospitals with less skilled or unskilled staff; because, when the nurse is giving a patient a bed bath for example, the nurse is also doing other actions, as indicated in the theory of protective empowering.

Therefore, giving a voice to the nurse's description of the meaning and experience of caring gives a political aspect to the research, because the theory generated can be used as a framework for articulating to organizations about the work nurses refer to as "caring". The theory of protective empowering is offered as one explicit way, not the only way, of considering caring. The theory of protective empowering explains what "caring" is, how caring is accomplished, and the consequences of caring.

The theory of protective empowering implies that the clinical and political focus of nursing be on revaluing and supporting "caring". Within the theory of protective empowering, the emphasis is on articulating what caring is and the valuing of caring from within nursing itself.

Understanding caring as protective empowering can conceivably be used to facilitate further debates and discussions within nursing about the future direction of psychiatric nursing in the hospital setting. For example, in the theory of protective empowering, psychiatric nurses
identified "attending to the patient's self-care and treatment" subcategory and "being available and responsive to the patient's concerns" subcategory as important to accomplishing caring in the hospital.

The psychiatric nurses in this study espoused caring as including the physical care and self-care of the patient and was one of the subcategories of keeping the patient safe. The significance of this finding needs to be considered in context of Dunlop's (1986) and Morse's et al (1991) concerns that contemporary nursing theorists tend to espouse a concept of caring that ignores the patient's physical body and self care. In identifying the relevance of physical care and self-care in the subcategory of "attending to the patient's self-care and treatment" in the theory of protective empowering, nurses can debate the political consequences of emphasizing or de-emphasizing physical and self-care in their conceptualizations of patient care.

Furthermore, psychiatric nurses also identified being available and responsive to the patients concerns of daily living as important to caring. This was one of the subcategories of the category of authentic relating. Although the psychiatric nurses discussed the subcategory of being available and responsive to the patient's concerns as part of their caring, they were divided on whether this subcategory should be retained as part of the psychiatric nurse's caring in hospitals (ie., providing food trays,
locating towels, socks etc). That is, there were divisions regarding the extent to which the psychiatric nurses felt they should attend to the patient's activities of daily living. Having identified this division, psychiatric nurses can debate and discuss each of the nurse-identified behaviours associated with these activities of being available and responsive to the patient's concerns of daily living. In so doing, psychiatric nurses can consider the political consequences of retaining or delegating these activities of being available and responsive to the patient's concerns of daily living.
The theory of protective empowering represents the categories and subcategories of caring that existed in the actual data, collected in three hospitals. Moreover, one of the assumptions of grounded theory methodology is that the social world is always changing. Therefore, as conditions change, the theoretical formulation also changes in order to meet those new conditions of the situation, that were not come across in the three hospital settings in this study.

The goal for asking about the psychiatric nurse's experience and meaning of caring was to reconnect with what caring means to nurses. With the understanding obtained from this study, further research can be conducted which looks at how contextual factors such as oppression disrupt the process of caring as expressed through protective empowering. Since the actual practice of caring cannot always correspond to the described and espoused practice represented in the theory of protective empowering, due to the contextual, organizational, societal and internal factors that may interfere with caring, looking at the practice of caring from different vantage points, such as, the patient's perspective or a nurse observer's perspective are areas for further research that may enrich and shed further light on the understanding of caring. Given that the psychiatric nurses in this study stated that protective
empowering did not happen all the time, investigations into the contextual factors which may disrupt or impede protective empowering in actual practice is another area for further research.

The use of other methodologies, such as an experimental design, can be used to compare and contrast patient outcomes in places that follow the practice of protective empowering with places that do not seem to follow the practice of protective empowering. Research in this area can further specify the theory of protective empowering and determine how the theory relates to patient outcome.

The theory was developed based on the descriptions of psychiatric nurses that were mostly Caucasian and female that worked in urban teaching hospitals. The confirmation of the theory of protective empowering in other diverse samples and from different vantage points can further make caring explicit and visible. For example, studies conducted in rural hospitals or in isolated areas in which the psychiatric nurse may be the primary or sole health professional involved in the patient's care may identify a different experience or may accentuate different aspects of the theory generated. Similarly, studies conducted with diverse samples in which the psychiatric nurses are male, or that belong to visible minority cultural groups, or that work in clinical areas other than psychiatric nursing, such as medical-surgical, pediatric, geriatric, and community
nursing may also identify different meanings or may accentuate different aspects of the theory generated.

Furthermore, the theory of protective empowering outlined here pertains to what protective empowering of patients entails on an individual level in the relationship between the patient and the nurse. It is possible that the meaning and experience of protective empowering, as an expression of caring, may be different at the community or macro level. This difference is highlighted in a discussion paper on nursing and empowerment (Skelton, 1994). In this discussion paper, Skelton (1994) draws a distinction between the meaning of empowerment at the individual or micro level between the patient and the nurse, and the meaning of empowerment at the community or macro levels of organizations and society. This indicates that the meanings associated with empowering patients is different than the type of empowering that occurs at the community level.

Furthermore, research into the transferability of protective empowering at the macro level or community level is suggested by a study in which public health nurses' perceptions of power and powerlessness experienced in their work was investigated (Rafael, 1996). Rafael (1996) reported that public health nurses experienced discomfort with notions of power and recommended that caring be conceptualized in terms of societal or macro levels, according to a notion of empowered caring. According to
Rafael (1996) empowered caring occurred at the macro level and involved recognizing women's oppression while at the same time valuing the experiences and characteristics of women through the equal valuing and respecting of a nurse's credentials, association between nurses and organizations, research, and valuing of nursing expertise. It is for this reason that research into the transferability of protective empowering at the community or macro level be further investigated.

Furthermore, in this study, six main categories of caring were identified in the process of protective empowering. Further research is needed in other settings. For example, other grounded theory studies conducted with nurses in geriatrics, pediatric, community, education may support, refute, expand, or further specify the main categories of caring identified in this theory.

Moreover, the nurses in this study were divided on whether nurses should remain or continue to be available and responsive to the patients' concerns in terms of their ordinary needs of daily living (i.e., requests for towels, meal menu changes etc). Some nurses advocated delegating the patient's ordinary needs to unskilled workers because responding to patient's requests for meal changes, settling disputes regarding meals was not perceived as requiring advanced skills and education. Other psychiatric nurses advocated the importance of nurses remaining available and
responsive to the patient's ordinary needs. That is, there was no need that the patient had that was considered too trivial for the psychiatric nurse to address. These psychiatric nurses believed that advanced education and skills are required in knowing how to respond to patients in an effective manner. That is, these nurses believed that experience, skills, and education were needed in order to understand how to respond to a patient even for so-called simple requests such as the patient needing a towel, a door opened, a meal tray, or socks. Further research in this area can help to further clarify the divisions identified in the study that pertained to the practice of being available and responsive the patient's concerns of daily living. This type of research is important in this time when registered nurses are being replaced with less skilled or, in some cases unskilled personnel.

This type of study could contribute to the development of priorities and goals for nursing practice, research, and education, and would also be a step towards developing a practice-based theoretical rationale for "caring" for the purposes of affirming and/or challenging what is done in caring and how caring is provided in hospitals.
The psychiatric nurses accomplished protective empowering of patients through six categories as evidenced through keeping the patient safe; 2. encouraging the patient's health; 3. authentic relating; 4. interactive teaching; 5. respecting the patient; and 6. not taking the patient's behaviour personally. All six categories appeared throughout the process of protective empowering, except that each category represented a different feature of protective empowering. The two main categories of respecting the patient and not taking the patient's behaviour personally were the antecedent and sustaining conditions of protective empowering. The other four categories keeping the patient safe; encouraging the patient's health; authentic relating; and interactive teaching represented the actions and contexts through which protective empowering changed. The protective features of protective empowering were mainly, but not exclusively, accomplished through the categories of keeping the patient safe and not taking the patient's behaviour personally. The empowering features of protective empowering were mainly, but not exclusively, accomplished through the categories of respecting the patient, encouraging the patient's health, authentic relating, and interactive teaching. There was an interplay between protecting and empowering within, and between, each of the
six main categories which was encompassed by the main theme of protective empowering. The results suggest a practical and grass-roots theory of protective empowering that could be used as a valuable guide for articulating and reflecting on what psychiatric nurses do in their caring with patients on general psychiatric units; and, could be useful for both the clinical and political purposes of affirming and/or challenging the way in which the psychiatric nurses' "caring" with patients is practiced, organized, or prioritized in the hospital setting.
References


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APPENDIX A

Letter to the Director of Nursing

Dear : 

This letter is to request permission to conduct a research study on the psychiatric unit with the psychiatric staff nurses in your hospital. I am a psychiatric/mental health nurse (R.N., BSc.N., MSc.N) currently registered in the Doctoral program in the Faculty of Education, Department of Applied Psychology and Counselling. The study is a requirement for the degree of Doctor of Education in Counselling.

Please refer to the attached Study Information Sheet and Study Consent Form for details about what is proposed as expectations of the psychiatric staff nurses at your setting and from the department of nursing.

Only about four nurses from your psychiatric unit will be interviewed as psychiatric nurses from other hospitals will also be interviewed. I plan to interview one nurse a week, however I am allotting six months for data collection to account for any difficulties that may be encountered due to nurse/researcher availability and room vacancies. At the end of the study the psychiatric nurses who participated in the study will be sent a postcard requesting them to indicate whether they agree or disagree with the results of the study and provide comments as necessary. The nurses can reply with the self-addressed stamped envelope or they may call the researcher personally, whatever the nurse chooses. No information is required from the patient's chart.

The assistance of the Nursing Unit Administrator or Patient Care Coordinator or delegate will be sought, in order to attend the end of nursing staff meetings in order to introduce the study to all full-time and part-time psychiatric nurses on the unit (nurses will be provided with study information sheet and consent form).

Enclosed are copies of the proposal. This proposal has been approved by the Scientific Review Committee (Thesis Committee) and Ethical Review Committee at the Ontario Institute for Studies in Education at the University of Toronto. (Please refer to attached documentation).

I appreciate your time and consideration of this doctoral study. I look forward to hearing from you at your earliest convenience. If you should require further information, please do not hesitate to contact me at my home number (905) 566-5716 (answering machine).

Sincerely,

Rosalina Chiovitti, R.N.
The criteria used for participant selection:

The participant:

1. must be a registered nurse with the College of Nurses of Ontario.

2. must have an employment status of full-time or regular part-time psychiatric staff nurse in the setting.
Hello, my name is Rosalina (Rose) Chiavitti. I am a nurse doing my doctoral thesis on psychiatric nurses' experience of their caring role with patients, and I am interested in talking to you!

The purpose of this study is to explore with psychiatric staff nurses, their experience of their caring role with patients in the hospital setting. The benefits of this study is that it provides staff nurse accounts of what the psychiatric nursing caring role is, what works, what needs to be improved, and what changes need to happen in the hospital setting or nursing education that will better facilitate the psychiatric nurses' caring role with patients in the hospital setting. Why you? Psychiatric staff nurses are in a unique front-line position to provide insight into the contemporary issues relating to the nurse's role and patient care. Therefore, a study based on grass-root accounts of staff nurses may point to recommendations for future program planning on hospital units and nursing education. Also the findings of this study may further assist in aligning psychiatric nursing care with the staff nurses' vision of psychiatric nurses in context of current trends in health care and the nursing profession (i.e., shorter hospitalization stays, changes in patient populations admitted into hospital, decreased funding for hospital and nursing staff, nurse job satisfaction issues and effective patient care outcomes, Regulated Health Professions Act and Nursing's Scope of Practice).

This study is a doctoral thesis project. The data collected in this project will be used in for my doctoral dissertation as a requirement for my degree. I am psychiatric/mental health nurse and doctoral student in the Faculty of Education, Department of Applied Psychology and Counselling at the University of Toronto. My Thesis Supervisor is Dr. Niva Piran (Faculty of Education) and my thesis committee members are Dr. Ruth Gallop (Faculty of Nursing) and Dr. Vivian Darroch Lozowski (Faculty of Education)

What is expected from you, times of interviews, and questions explored? I will be talking with you about your experience of your psychiatric nursing caring role with patients in hospital by using semi-structured interviews. The interview will take approximately 60 to 90 minutes in total and can be done in 20 minute intervals or as the your staff nurse schedule dictates in order to accommodate nursing coverage on the unit. For practical reasons (i.e., high volume of individuals/ programming on the unit during the day etc), the interviews will be conducted on evening or nights shifts during the weekday or weekends in order to assist with the availability of nurses and rooms for interviewing on the unit. The interviews will be tape recorded, then transcribed, and then erased. The questions that you will be asked are designed to help you tell..............page 1 of 2
your own story about what you think the psychiatric nurses' caring role is, and your experience of it with patients in the hospital setting (i.e., what works, what needs to be improved, how can these improvements be made in your setting or through nursing education, and how the meaning of your psychiatric nursing role has developed over your career).

I want to emphasize the information you give in this study will be kept completely confidential. Your name will never be used in the findings reported from this study. Each person's names will be disguised using codes and the list of code numbers and the identities will be stored separately. You will be asked to sign the attached consent form.

Your participation in this study is voluntary and you may refuse to answer any questions during the interview or withdraw from the study at any time. Since the basis of this study is on the nurse's experience, each nurse participant interviewed, from different hospitals, will be asked to review the study results, and comment on whether the results are accurate in reflecting their experience of their caring role with patients in hospital. This can be done verbally or in written form, whatever the nurse chooses.

Thank you for taking the time to read this information sheet and I look forward to talking to you! If you would like more information please do not hesitate to contact me at (905) 566-5716 (local number from Toronto; please call collect if calling from Hamilton).

Sincerely,

Rosalina (Rose) Chiovitti, R.N.
I, __________________, consent to participate in a study designed to better understand the psychiatric nurse's experience of their caring role with patients in hospital setting. This is a study that Rosalina Chiavitti is conducting for her doctoral dissertation in the Faculty of Education, Department of Applied Psychology and Counselling, at the University of Toronto.

I understand that my participation will contribute to better understanding of, what the psychiatric nurses' caring role is, what is it about psychiatric nurses' caring role with patients that works, what needs to be improved, and what changes staff nurses, from different hospitals, believe need to happen in the hospital setting/nursing education that will better facilitate the nurses' experience of their caring role with patients in the hospital. This study may provide recommendations for future program planning in hospitals and nursing education.

I consent to, and understand that I will be interviewed by Rosalina Chiavitti during one of my evening or night shifts on the unit. The semi-structured interview will take approximately 60 to 90 minutes if done in one session; however, the interview can occur in 20 minute intervals or as my schedule on the unit dictated, in order to accommodate my nursing coverage on the unit.

I agree to the following procedure concerning the confidentiality of my interview data:

This interview will be tape recorded and then transcribed. I agree that only Rosalina Chiavitti will hear the interview tapes and that it will be subsequently erased. I agree that transcripts will only be viewed by Rosalina and thesis committee (Dr. Piran, Dr. Gallop, Dr. Darroch-Lozowski). Transcripts will be kept in locked storage. I understand that an identification number will accompany my transcripts, the list of code numbers and the identities will be stored separately, and will be known to Rosalina Chiavitti only. I understand that data about me and the hospital will be disguised and will never be directly attributed to me or the hospital (ie., by name).

I understand that my participation in this study is voluntary and I may refuse to answer any questions at any point in the interview or withdraw from the study at any time.

I understand I will be asked to review and comment whether the results of the study are accurate in reflecting the processes at work in the psychiatric staff nurse's experience of caring role with patients in the hospital setting. I understand this can be done verbally or on a follow-up form which can be mailed in a self-addressed envelope, whatever I choose.

I consent to the data obtained from this interview being used in the preparation of Rosalina Chiavitti's dissertation and subsequent derivative materials, such as scholarly papers, intended for publication.

Participant (signature/print) ..................... Date .........
Initial Interview Guide Questions For In-Depth Interviews

**Principle Questions Asked**

1. Please describe what you do on a day to day basis in your psychiatric caring role with patients in this setting? (Pause) Perhaps think back to today or yesterday what did you do with patients?

2. How do you feel about these things you do?

3. How does your employer feel about what you do?

4. Please describe an actual experience you have had with a patient in this setting that will help me understand what "caring" with patients means to you?

   or

Please describe an actual experience with a patient that stands out in your mind, in this setting, that reflects "caring".

**Probe Questions derived from the literature**

5. Please describe which factors in the hospital setting influence how you do your work with patients?

6. What is your experience of your nursing caring role in team meetings? with other professionals on the team?

7. Please describe to what extent the patient classification and documentation instruments, used daily in this setting, supports your caring role with patients?

8. Please describe the extent to which the leadership style in the setting supports your psychiatric nurse caring role with patients?

9. Please describe the extent to which your nursing school/ instructors/ clinical colleagues supported your psychiatric nurse caring role with patients as you see it?

10. Please describe the extent to which the nursing approach in this setting (ie., primary/team nursing, patient assessment and documentation procedures) supports your caring role with patients?

11. Is your caring role with clients different/same here at------(hospital name) than other places you have worked? How?
Modified Interview Guide Questions based on Data from In-Depth Interviews

Principle Questions Asked

1. Please describe what you do on a day to day basis in your "caring" with patients in this setting? (Pause) Perhaps think back to today or yesterday what did you do with patients?

2. How do you feel about these things you do?

3. How does your employer feel about what you do?

4. Please describe an actual experience you have had with a patient in this setting that will help me understand what "caring" with patients means to you?

or

Please describe an actual experience with a patient that stands out in your mind in this setting that reflects "caring”.

Probe Questions derived from interviews with the nurse participants

5. Please describe what you mean by "safety" in your day to day work with the patient. Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

6. Please elaborate on what you mean when you say you "protect that patient from themselves and others on the unit.”
Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

7. Please elaborate on what you mean by "advocating" for the patient. Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

8. Please elaborate on what you mean by "reassuring” the patient. Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.
Probe Questions derived from interviews with the nurse participants

9. Please describe what you mean by "teaching" in caring with patients on a day to day basis. Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

10. Please elaborate on what you mean when you say that you were able to "empower" the patient. Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

11. Please elaborate on what you mean by being "consistent"? Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

12. Please elaborate what you mean by "drawing out the health that is already there in the patient"? Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

13. Please describe what you mean by "encouraging"? Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

14. Please describe what you mean when you say you use" your own example to show the patient alternative ways of doing things". Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

15. Please describe what you mean when you say you are "available" to the patient. Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

16. Please describe what you mean when you say you are "responsive" to the patient. Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

17. Please describe what you mean when you say you try to be "authentic" with the patient? Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.
Appendix F-Continued

Probe Questions derived from interviews with the nurse participants (Continued)

18. please describe what you mean when you say that teaching is "interactive"? Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

19. please describe what you mean when you say you try to "relate" to what the patient says or the situation they are in. Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

20. please elaborate what you mean when you say that caring with patients is about "respect". Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.

21. please elaborate what you mean when you say that caring with patients is about "not taking the patient's behaviours personally". Please provide specific situations with a patient(s) in your day to day practice with patients that will help me understand what you mean.
APPENDIX G

INTERVIEW FACE SHEET

Respondent Identification Number..............

Date/Time of Interview..........................

Place of Interview............................

Respondent's sex..............................

   age...........................................

employment status............................

length employment on ward.....................

years of experience

   in nursing...................................

   in psychiatric nursing.....................

position title................................

education.....................................

year of graduation...........................

Primary/Team Nursing.........................

Patient Classification System..............

Recruitment requirements for position........(ie., special training)

Length of Patient Stay Average......Range.....

Theoretical Model used on unit...............
APPENDIX H

POST-INTERVIEW COMMENT SHEET

1. Note the time of day of the interview.

2. Note the emotional tone of the interview (ie., relationship with participant; personal reactions to participant accounts).

3. Note any difficulties (methodological/personal) encountered during the interview. (ie., note any doubts about quality of the data, researcher difficulties, participant difficulties).

4. Describe own feelings during and about the experience. Note any insights or reflections (ie., Note any observations or responses to informant verbal or nonverbal behaviour; insights regarding relationships between different parts of the data.)
Appendix I

Example of Coding Transcript using Open Coding

1 I see my caring role with all my patients as
2 empowering them so that, for example a patient
3 with multiple personality disorder I empower
4 the alters so they can negotiate and work
5 things out themselves so they are not
6 dependent on somebody else to set things
7 straight or whatever. I am helping them to help
8 themselves. I am helping them learn to develop
9 the skills to help themselves. You are always
10 ensuring safety, but I think that empowerment
11 starts right from the minute that they walk in
12 the door. Even for somebody who has very little
13 control because they are psychotic, there are
14 small ways that you can empower them by maybe
15 giving them choices, or two choices to choose
16 from. For example if they are out of control
17 and you are giving them a choice between taking
18 medication liquid or injection. I think that is
19 empowering to them because it gives them a
20 choice, and if they can't make a choice you do
21 it for them. You are always ensuring safety
22 but I think there are many ways you can empower
23 the patient that starts from the beginning.
Appendix J

Example of Coding a Transcript using the Coding Paradigm

1 I think as human beings,
2 respect is absolutely essential,
3 and giving back to the person
4 something that they may have
5 been stripped away of, they may
6 have been very damaged and may
7 not have been respectfully treated,
8 whether as children, as adults,
9 as teenagers, whatever. I find
10 them to be damaged to their
11 person's self-image and tied up
12 with lack of respect. I find that
13 over and over again that people even
14 with severe personality disorders respond
15 to a respectful approach, rather than
16 trying to come on in a controlling
17 way or responding in a demeaning way,
18 using sarcasm. It is a collision course,
19 people can just fight it because they
20 have learned to, that is part of how they
21 learned to cope, but in the real world we
22 don't always get treated respectfully but
23 for people with psychiatric illness very
24 often they have been made fun of, they

Action/Interaction:

"respecting"?
"giving back"?

Context and conditions in which the action of respect is embedded:

Respect is effective with all patients including personality disorders?
Example of Coding a Transcript using the Coding Paradigm

25 have been treated badly, and if they have
26 learned to cope with that by being
27 belligerent or arrogant then
28 for us [in nursing] to come
29 on the same way, to be sarcastic,
30 argumentative, or power-tripping, we
31 are going to get that reaction,
32 because they learned it over
33 and over again.
34 We are going to get that reaction,
35 because they have learned it over
36 and over again in the real world.
37 All we are doing is antagonizing,
38 and getting a reactive stance rather
39 than getting the person to work with you
40 on developing the skills necessary to
41 care or act for themselves and that
42 is what you get with a respectful, calm,
43 caring approach. It sounds simple
44 but it works. Respect is necessary
45 before we can work with the people,
46 and respect continues during our work
47 with people in the hospital setting.