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Feature

How patients and nurses experience the acute care psychiatric environment

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How patients and nurses experience the acute care psychiatric environment
The concept of the therapeutic milieu was developed when patients' hospitalizations were long, medications were few, and one-to-one nurse–patient interactions were the norm. However, it is not clear how the notion of 'therapeutic milieu' is experienced in American acute psychiatric environments today. This phenomenological study explored the experience of patients and nurses in an acute care psychiatric unit in the USA, by asking them, 'What stands out to you about this psychiatric hospital environment?' Three figural themes emerged, contextualized by time, which was a source of stress to both groups: for patients there was boredom, and for nurses, pressure and chaos. Although they shared some themes, nurses and patients experienced them differently. For instance, nurses felt caged-in by the Plexiglas-enclosed nursing station, and patients felt caged-in by the locked doors of the unit. The findings from this US study do not support the existence of the therapeutic milieu as described in the literature. Furthermore, although the nurse–patient relationship was yearned for by nurses, it was nearly absent from patients' descriptions. The caring experienced by patients was mainly derived from interactions with other patients.

Key words: acute care psychiatry, mental health nursing, therapeutic milieu.

Researchers have infrequently studied the physical space of the psychiatric unit and its effects on the experiences of the nurses and patients therein (Andes and Shattell 2006). However, theories of mental health-care emphasize the importance of design for psychiatric patients and nurses. Shrivastava, Kumar and Jacobson (1999), for example, suggest that psychiatric hospital designs should provide protection from negative internal and outside forces; hospitals should be places for therapy as well as containment. Also, the ideal setting for mental health-care 'maintains the social skills which the patient possesses, restores lost or damaged social skills ... [and] encourages and reinforces the acquisition of good social skills' (Izumi 1968, 44). Schweitzer, Gilpin and Frampton (2004) noted that the physical elements of the psychiatric unit (such as sound, complexity, fresh air, light, exposure to nature, music, and color) can be detrimental or a healing environment. They pointed to the 'noisy, cluttered, and institutional' nature of the modern hospital environment in the USA and its potential negative impact on 'behaviours, actions, and interactions' of people who enter that setting (Schweitzer, Gilpin, and Frampton, S-72).

In a British study, McMahon (1994) identified types of space, such as 'patient space' and 'staff space', and noted the values of each, such as personal respite for nurses in nurses' space, and maintenance of patients' personal identity in patient space (McMahon 1994). In an Australian study, nurses' satisfaction with their work environment and positive nurse–patient interactions increased with structural changes to the unit that included more private space for nurses (Tyson, Lambert and Beatty 2002).

Although a central goal of psychiatric nursing is to create therapeutic relationships with patients, 'there has been little empirical examination of patients' experience' of the environmental context in which therapeutic relationships are formed (Thomas, Shattell and Martin 2002, 99). A few studies have examined aspects of the psychiatric unit (such

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as 'ward atmosphere'), but most of these investigations focused on either patients' or nurses' experiences.

Patient perceptions of the acute psychiatric unit were assessed by Middleboe et al. (2001), who found that the atmosphere was an important factor in patient satisfaction. In a Swedish study conducted in a forensic psychiatric setting (Brunt and Rask 2007), staff were perceived as the primary contributors to ward atmosphere. Curiously, no distinguishing characteristics of the atmosphere were attributed to patients, leading the researchers to conclude that patients were peripheral, almost invisible figures on the ward.

Moyle (2003), who interviewed patients in Australia about the experience of being nurtured while hospitalized for major depression, found that patients reported feeling cared about at some times and being treated like objects at other times. Forchuk and Reynolds (2001) looked at hospitalized Canadian and Scottish patients' experiences of their relationships with nurses. All the patients described being listened to by the nurses as beneficial, but elements of separation between nurses and patients were exacerbated by patients' feelings that nurses did not care about them, or held judgmental opinions of them (Forchuk and Reynolds 2001). Examining patients in the UK, regarded as 'difficult' by nurses, Breeze and Repper (1998) asked those who met this description about their experiences while hospitalized. These 'difficult' patients described being controlled and coerced and having little say about their treatment (Breeze and Repper 1998).

A somewhat different view was reported by patients in the USA interviewed by Thomas, Shattell and Martin (2002): they saw the hospital as a refuge. Rather than constricting them, the hospital freed the patients from their self-destructive impulses and opened the possibilities for a future. For example, a man who called the hospital his 'fortress' was relieved that he was being protected from 'an evil stress factor that is within myself' (Thomas, Shattell and Martin 2002, 102). Patients also spoke positively of the freedom they experienced in the 'inner sanctuary' of the patient smoking room, where they could connect with other patients without staff oversight (Thomas, Shattell and Martin 2002). Lacking satisfying connections with staff, they deemed this peer-administered 'therapy' as the most beneficial aspect of their hospitalization.

Mental health nurses in the UK surveyed by Dickens, Sugarman and Rogers (2005) about the quality of their work environment reported that their autonomy was not respected, and rules and procedures were overemphasized in caring for patients. Deacon, Warne and McAndrew (2006) noted that despite the focus in psychiatric nursing on the nurse–patient relationship, nurses' work in the psychiatric unit is not well understood or described even by psychiatric nurses themselves.

These studies of the acute care psychiatric environment were conducted in countries with different types of healthcare systems, patient populations, staffing levels, education, and skills. However, they all illustrate the effects of the atmosphere for psychiatric nurses and psychiatric patients. According to Norton (2004, p. 282), there is 'value in conceiving of the ward environment as a whole'. Only two studies, however, have compared nurses' and patients' views. A Norwegian study that compared the opinions of nurses and patients on the atmosphere and working conditions of the psychiatric unit found that staff generally thought more highly of the 'treatment environment' than did patients (Rossberg and Friis 2004). Alexander (2006), who conducted an in-depth study of the relationship between psychiatric ward rules, rules enforcement and patients' and nurses' experience of them in the UK, found separation and mistrust between staff and patients and a psychiatric hospital environment that was potentially harmful to patients (Alexander 2006). The study described in this paper explored the acute care psychiatric environment in the USA, eliciting descriptions of psychiatric nurse and patient experiences of their shared space. The aim was to understand elements of the inpatient unit that nurses could focus their energies on to better satisfy both the needs of those who work in and those who seek help from the psychiatric hospital.

METHODS

Existential phenomenology

Since it was the lived experience of the acute psychiatric unit that was of interest here, an existential phenomenological approach was employed. The existential phenomenological approach used was based on the philosophy of Maurice Merleau-Ponty (1962). Perception is primary in Merleau-Ponty's phenomenology because perception (unlike thinking) affords direct experience of the phenomena of the world. According to Merleau-Ponty, a perceived phenomenon always has a certain figure or form, contextualized by a background; the figure and the ground co-constitute one another. During data analysis, the phenomenologist strives to understand both the figural aspects and the grounds of the human experience under investigation. In order to illuminate human existence, therefore, the researcher must seek a 'rigorous description of human life as it is lived and reflected upon in all of its first-person concreteness, urgency, and ambiguity. For existential phenomenology, the world is to be lived and described, not explained' (Pollio, Henley and Thompson 1997, 5).

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Setting and sample

The setting for the study was a large (> 30 bed) inpatient adult psychiatric unit in the southeastern USA. The psychiatric unit was in a free-standing psychiatric hospital that was part of a large, public, non-profit healthcare system. The unit was a locked unit. There were two sets of locked doors between entry and exit from the hospital building; the adult psychiatric unit was beyond the inner locked doors and had three wings (in the shape of a 'T') with a large locked, enclosed nursing station in the middle. Each wing had patient bedrooms (two persons/room), a small medication room, a small consultation room (desk and two chairs) and one large room with a television, couches, and small table and chairs. The large rooms were used for patient-to-patient recreation and socialization, and staff-to-patient therapeutic activities (e.g. group therapy and psycho-educational groups). (These rooms are called 'dayrooms' in the USA and 'living rooms' in other countries.)

The sample included 10 patients and 9 nurses. Patient participants were six women and four men; three were black people, one was Latino, and six were white people. Psychiatric diagnoses included borderline personality disorder ($n = 1$), depression ($n = 5$), substance abuse ($n = 5$), bipolar disorder ($n = 4$), anxiety disorder ($n = 2$), and post-traumatic stress disorder ($n = 1$) (some patients had multiple diagnoses). These diagnoses were fairly representative of non-psychotic patients in this and other acute care psychiatric facilities in the USA. Patients who were actively psychotic were excluded from the study. Diagnoses were used only to describe the sample. At the time of the interview, they had spent from 2 to 11 days in the facility (mean = 4). The number of their admissions to this facility ranged from 1 to 9 (mean = 2), and the number of psychiatric hospitalizations in any acute care psychiatric facility ranged from 1 to 11 (mean = 3).

The nurse participants were all women. One was African American/Indian and eight were white people, which is fairly representative of nurses in the USA. Their ages ranged from 46 to 76 years (mean = 57); their psychiatric experience ranged from 1 month to 26 years (mean = 18), and tenure at the facility ranged from 1 month to 17 years (mean = 5 years). Educational levels ranged from an associate degree to a master's degree in nursing; the majority had baccalaureate degrees ($n = 6$). Three nurses held certifications: two were board certified in psychiatric nursing and one was certified in critical incident stress debriefing.

The study was approved by the university and hospital institutional review boards, and written informed consent was obtained from all participants. Individuals were given a $10 gift card for participation. Names and references to places were changed to protect the identity of participants.

Data collection

Phenomenological interviews were conducted to obtain rich descriptions of the experience of the acute care psychiatric environment. Before the interviews, participants were reminded that the study was about the acute care psychiatric hospital environment and told that nothing was too trivial or unimportant to mention (Fall-Dickson and Rose 1999). The term 'environment' was purposefully not defined. Participants were asked to describe in as much detail as possible what stood out for them or what they noticed about the acute care psychiatric setting where they worked or were patients. The opening interview question was, 'What stands out to you about this psychiatric hospital environment?' This question was crafted as broadly as possible, rather than limiting participants to descriptions of specific aspects of the environment. Follow-up probes such as 'Tell me more about that' were used to clarify descriptions. All patient interviews took place on the psychiatric unit in a private location. Some nurse interviews took place at the hospital while others took place in the authors' on-campus offices. Interview lengths ranged from 10 minutes to 2.5 hours (mean = 75 minutes). Interviews were audio taped and transcribed verbatim.

Data analysis

The researchers analyzed each transcript for meaning units (Thomas and Pollio 2002). Transcripts also were read from the part (meaning units) to the whole (entire transcript). Meaning units were then aggregated into themes (recurring patterns that constituted important aspects of participants' descriptions of their experiences). A thematic description was developed for each transcript, and an overall structure was then developed and presented to a research group to enhance rigor. Interpretations from the group were considered in addition to the re-reading of all transcripts to finalize the thematic structure.

FINDINGS

Patients' and nurses' experiences of the acute care psychiatric hospital environment were parallel in many respects. Both patients and nurses felt they were confined in a prison-like world, in which moments of connection with others occurred mainly within groups (patient-to-patient, nurse-to-nurse) rather than between groups. Yet their experiences of time differed dramatically. Time stood still for patients but moved

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quickly for nurses. Patients were bored and nurses were busy. Patients complained of not having enough to do to occupy their minds. They found time between group therapy sessions detrimental to their well-being. As one patient said:

> Sometimes when you sit and you don't want to do anything or there's nothing to do, your mind kind of works too much, you know? ... It gives you anxiety. Because you're thinking, 'I want to go outside' or you're thinking of the things you want to do but can't.

Another patient said, 'Folks start getting jittery in the down time because you are sitting there waiting for the next meeting ... We got a lot of down time in between meetings. We've got a whole lot of down time.' All the patients who discussed boredom or empty time described its negative effects on them. Some spoke of previous hospitalizations, or other hospitals, where they were able to engage in activities like movement therapy or reading books to occupy their time. At the time of the study, this hospital provided neither of these things.

Nurses were aware that time moved slowly for patients. According to one nurse participant, 'The patients don't do anything. They're bored out of their gourds. They'll tell you that.' Another nurse said, 'I ... don't think we have enough diversity to give these people. There's like music therapy, art therapy. Their biggest recreation is to take them outside when it's a nice day. They entertain themselves.' As noted by another nurse: 'It's very boring. I think we don't provide our patients with enough activities during the day'. For nurses, in contrast to patients, time was fast, frenetic, and in short supply. They described with frustration the many time-consuming activities that impeded their real work — for example, searching or waiting for patient charts (medical records), online documenting that 'no one looks at', 'hunting down' patients for medications, and looking for a private place to talk with patients. For example, one said:

> You have to walk up and down the hall, check the different day rooms, check the different consult rooms, check all the different places the patient could be in order to find the patient you may want to talk with ... You go and look for them and they are talking with someone else in the consult room. So, then you've got to go back and re-plan.

The figural themes of patients' and nurses' experiences were 'Imprisoned and confined', 'Like a Band-Aid on an open wound', and 'Here, we care about each other'. The themes were interconnected and interdependent, not mutually exclusive.

Imprisoned and confined

Patients described the acute care psychiatric environment as a place where they were imprisoned and confined 'like a caged-in animal'. Their descriptions were dominated by feelings of powerlessness, intimidation, harassment, suffocation and control. Powerlessness and mistrust of those who held power were described by one participant: 'I feel like we're in a place almost like a cult, being controlled. We're at their mercy.' Another patient participant said, 'It's a little small. It's a little confining ... Just a little bit suffocating.' Another patient said, 'I feel like I'm in jail. I am enclosed here. I can't go out. and I get agitated. I get so panicked.'

Patients yearned for the outside, which they experienced as freedom. Yet patients told of not being able to go outdoors for days at a time. They described the benefit of the windows on the unit, through which they looked at the sunshine, trees and other features of the outside world. As one patient said: 'Luckily there are windows. Because God forbid if there wasn't ... I see a lot of people just staring out the windows to look at the sunshine.' According to another patient:

> I just look at the window outside and I wish I was outside. And I've never appreciated freedom as I do now. Because yesterday we went out. Oh, my God. I was like a little kid running around and playing. I never appreciated freedom like I did yesterday.

Fresh air was an aspect of the outside that helped ward off the suffocating feeling of the acute care environment. As one patient said, 'I would open the window just a little tiny bit ... You can smell the air ... I have hunger of fresh air'. The imprisoning and confining hospital environment was exacerbated by unit rules, which were often poorly understood, arbitrarily assigned, and unpredictably enforced. One patient described the inconsistency between the rules and the rationale:

> I like to drink sodas. But ... as of today or yesterday, I don't think your family members can bring you any more in. But they said we could bring them up from the cafeteria. But they're like $1.25 [USD]. And that's just outrageous. And they say, 'Well, it's because we had an ant problem.' Well, how can you bring them up from downstairs? What difference does it make?

Nurses seemed to understand patients' need to go outside, although they did not necessarily relate this to the freedom the outside world provided, or the intense imprisonment and confinement experienced by patients. According to one nurse, 'They may or may not go out ... Most of the time we can't spare the staff to go with them. We aren't staffed well enough.'

Both patients and nurses felt intimidated. Patients were intimidated by the unit rules, controlling environment, and some staff interactions. They described staff members who bullied them and other patients: 'Sometimes some of them do something just so you can say something so they can write

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you up [a report of behavior to persons in authority].' Patients described consequences for 'having an attitude'. One patient told of a time when a fellow patient got upset because a staff member rushed him to finish his meal. As this participant told it:

> This guy [another patient], he got up a petition and everybody signed it and the next thing I know they put him out ... I don't know if [his] time ended or not. But I know after he got that petition and everything, they put him out... So, we had to just go in there and gobble up our food right quick because that shift wanted to go home. It was close for them to get off from work.

The participant thought the patient who 'got up a petition' to complain about not being provided enough time to eat was possibly discharged as a result of the petition and his complaints about the staff.

This patient also thought that the staff person on that shift wanted to go home. The nurses described a possible reason for this — an intense pressure from administration 'to punch out on time' in order to avoid overtime. As noted by one nurse participant, 'I always leave that place in a dead run ... I come out of there gasping, trying to get out the door because they'll get all over you if you work overtime.' Patients understood that nurses and mental health technicians (non-professional aides) wanted to leave work, but the patients did not see the pressure staff members were under from administration. As a result, patients resented staff for not valuing their need to eat without feeling hurried, and their resentment certainly carried over into the milieu, possibly hindering therapeutic processes. Nurses and mental health technicians seemed to be caught in a double bind: if they provided ample time for patients to eat, they risked running into overtime. Yet in order to clock out on time, they hurried patients. It was a no-win situation.

In another case, a patient told of a woman who was found with a cigarette (smoking and cigarettes were not allowed on the unit). A security guard was called, as well as 'six or seven' staff people, to deal with the situation.

> The patient said, 'Well, I only had that one cigarette.' and she [the staff person] kept saying, 'No, you got more. You got more. Give me the rest of them. Give me the rest of them.' Then they grabbed her [the patient] and put her in a restraint thing, and gave her some kind of shot that knocked her out. So, they were able to subdue her ... So, I just felt like that was, it was too much.

This story conveys the patients' perception of how those who broke unit rules were treated: they were intimidated, overpowered and medicated to enforce rule compliance.

Nurses also described an atmosphere that was intimidating and punitive. They painted a discouraging picture of attempts to change the way the unit was run, describing a 'disconnect' between nurses and leadership. They mentioned negative consequences for those who criticized: 'I keep my head low. Anybody that has complained or gone up and spoke their mind ... They put their money where their mouth was. Well, they got burnt.' Nurses also described the detrimental effect this intimidation had on their ability to function: 'People, especially that have direct experience being punished for negativity, feel very guarded. And they are just going through the motions of doing their job. They're not sharing themselves with the patients or their coworkers because they feel so guarded.'

Like a band-aid on an open wound

The second theme was participants' shared pessimism about the efficacy of the treatment provided in this intimidating and punitive world. Nurses and patients alike questioned the ability of the hospital to help patients. The patients described being assigned to group therapy that did not address their illnesses. For instance, a patient admitted for alcohol abuse was placed in a group for people with depression and suicidal thoughts. Another patient, seeking help for bipolar disorder, was assigned to a group for people dealing with substance abuse. One patient described the atmosphere of a group session he attended:

> [Group] yesterday was supposed to be at 9. She [the group counselor] showed at 9:20. And because of [a] meeting she was late. She said she was going to allow the television to be left on ... during the meeting. And it was loud. And it came around to me and I tried to make my point. And I'm looking at the people watching the television and listening to the television and I'm thinking, 'This is crazy. This is insane.'

Constraints related to organizational and personal finances were mentioned by both nurses and patients. The amount of time a patient or caregiver thought a patient should remain in the hospital had little effect on how long the patient actually stayed. Short lengths of stay were attributed by patients and nurses to minimal insurance coverage for mental illness. When the insurance stopped, patients were discharged. One patient wondered if substandard patient care created supply and demand — if patients were not helped, they would inevitably be admitted again, creating a steady flow of revenue from patient readmissions. Other patients described the dread of pending discharge from a hospital stay that did 'nothing':

> When you walk out of here ... you walk out on that edge, like that edge you were ready to fall off when they brought you in here. And when you walk out of here, you walk back out on that edge again. So, what's happened that made it any better? Nothing.

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Some patients expressed a lack of faith in the ability of professionals to help them at all with their illness: 'Nobody knows how to nurse our conditions, really.'

Nurses expressed anger and feelings of impotence: 'I *hate* the fact we don't take care of these patients. When they come in, it is crisis intervention. You stick a Band-Aid on them and you send them right back out the door.' They lamented the fact that their work had become oriented towards 'task nursing:' 'Ever seen cattle going through the line? ... That's what it's like.' They felt they were not able to focus on patients' needs. The high number of patients assigned to each nurse was a prominent topic of discussion, as were the effects on their work and the care that patients received. One effect of these low nurse-to-patient ratios was lack of time for one-on-one interactions: 'We don't have time to talk to them. And that's the cornerstone of what we do.' Nurses also spoke of the lack of basic supplies for medical needs of their patients, such as diabetic supplies, automated external defibrillators and hoppers to clean bedpans.

The locked and glassed-in nurses' station made it difficult for nurses to see and speak directly with patients. Nurses said the unit included 'too much nursing station space and not enough patient interaction space'. Nurses felt stuck doing tasks in the station, which included hunting for charts in which to document, and lengthy charting on computers. A nurse described the effects of the large, enclosed nurses' station on potential nurse–patient interactions:

> If you're separated to such a degree that you're not even ... able to visualize each other, know what's going on, then out of sight, out of mind. Your reality becomes what you see in front of you ... staff starts interacting with each other more than they interact with patients. Because that's who you're seeing. That's who's in your world.

Here, we care about each other

Participants did describe caring and support they received in the hospital, but mostly from members of their peer groups; patients supported patients and nurses supported nurses. In patient interviews, there was a notable absence of descriptions of caring from nurses, even when the topic of caring surfaced. Patients mostly described the support they received from other patients. This was sometimes intentional and direct; for example, one said,

> I feel like I'm in a family now ... If we see a patient in distress we try to, Are you okay? How can I help you? They give me a hug, or I give them a hug ... So, I feel pretty good. Here, we care about each other.

Patients also described how their experiences with their own mental illness allowed them to teach other patients ways of coping with their illness. And they said that simply hearing stories from people who also had mental illness was comforting: 'You hear it, you think, "Wow, that's not that far from what I'm going through." So, I'm not a freak. It's the illness. And you feel better.'

Nurses recognized the help patients received from one another and often tried to facilitate relationships between patients. This inadvertently served two purposes — patients could connect with and receive guidance from someone who had 'been there', and nurses could focus on accomplishing tasks that did not involve direct patient care. Although nurses expressed a desire to care more directly and individually for patients, they also described being unable to do so because of organizational constraints. These constraints included low nurse–patient ratios, heavy administrative focus on documentation that 'nobody looks at', and performing time-consuming patient admissions that took them off the unit. Yet, despite difficulties with staffing and management of duties, almost all the nurses had a strong teamwork mentality. They described supporting each other with patient care, covering for each other if something needed to be done, and providing patient support whether it was 'their' patient or not.

There were some stories of caring between groups. One patient told this story:

> The first day I come here, I'm usually not altogether there. So I ask some pretty strange questions ... I ask them [the nurses] ... especially the ones that know me, I say, 'Am I a burden to you?' I mean, 'You know me. You've seen me before. Am I taking advantage of this facility?' And they always say, 'No. This is what it's here for.' ... They comfort me, 'No, definitely not. You're always welcome here.' And that makes you feel really good.

Patients said the help they received from staff came in the form of 'saying hello' and simple reassurances. As one patient said, 'Some just talk to you, want to know a little bit about you. And they try to give you ... positive motivation.' Providing toiletries and giving medications were other acts that patients identified as helpful. Nurses' descriptions of care they provided for patients revealed that they often engaged in thoughtful actions that patients may not have known occurred, or 'invisible caring.' For instance, one nurse described how she sometimes called the medical unit a patient had been transferred to, to see how the patient was after leaving the psychiatric unit. Another nurse described bringing items and giving them to patients anonymously, such as providing a winter coat to a patient who had no winter clothing.

DISCUSSION

This phenomenological study paints a disturbing picture of everyday existence in a prison-like inpatient psychiatric unit.

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Nurses and patients in the study failed to achieve meaningful closeness. The environmental milieu described by participants hindered rather than facilitated the development of therapeutic relationships. Time was a tyrant for all, passing too slowly for patients and too quickly for nurses. In an atmosphere of intimidation, both patients and nurses had to be on their guard. Both questioned the ability of the hospital to truly help patients, epitomized in the theme, 'Like a Band-Aid on an open wound.' Basic human needs of the patients, such as eating an unhurried meal, were unmet. And basic needs of the nurses, such as sufficient staff and resources to do their jobs well, were also unmet.

The separateness between nurses and patients in the study echoes that found in previous studies by Alexander (2006) and Thomas, Shattell and Martin (2002). The achingly slow progression of time for patients was also noted in Shattell's (2002) study of patients hospitalized for medical illness and in RadLey and Taylor's (2003) study of medical and surgical patients. To capture the part that the ward setting played in patients' recovery, Radley and Taylor provided cameras to patients and asked them to photograph spaces and objects that they found salient. One participant photographed the ward clock to show that 'time stands still' (Radley and Taylor 2003, 90).

The poignant longing for freedom expressed by patients in this study brings to mind Goffman's (1961) classic analysis of life in a mental hospital. Patients in that early study managed to find 'free places' where they could elude staff surveillance; these places also permitted communion with the natural world: 'the patch of woods behind the hospital ... the shade of a large tree near the centre of the hospital grounds' (Goffman 1961, 230). Patients who were not allowed to go outdoors engaged in 'vicarious consumption of free places' (237), such as securing a coveted seat on a window sill.

More than 50 years after Goffman's observations, the window view of the inaccessible outside world is still important for patients. A window permits temporary escape from oppressive ward atmosphere. One patient in the Radley and Taylor (2003) study said the view from the dayroom window offered her hope of leaving the hospital. Regular opportunities for patients to walk outdoors, perhaps in settings such as the serene and soothing 'healing garden' developed by one urban medical centre (Geary 2003) would afford patients experiences of fresh air and undoubtedly lessen their feelings of being 'caged-in'. All humans desire freedom, a central concern in existential philosophy. Although deplored as a pessimistic philosophy, existentialism actually promotes an 'optimistic toughness' (Sartre 2001, 356). Speaking of freedom, Merleau-Ponty (1962, 442) asserts that 'as long as we are alive, our situation is open'. Individuals in a locked psychiatric unit have been 'thrown' (as described by Heidegger (1962) into a situation of *unfreedom*. Yet both the patients and the nurses could take a different stance towards their unfreedom, envisioning new possibilities (Thomas and Pollio 2002).

The environment portrayed by participants in this study badly needs changes, for both patients and nurses. Both groups wanted a milieu of mutual respect with ample time to forge relationships. Both groups described patient hospitalization as ineffective and even possibly harmful. They agreed that patient stays are too short, staff members do not do enough for patients, and the milieu is not conducive to healing. Nurses and patients wish for change, but feel powerless to create it. One potentially empowering intervention could be the implementation of solution-focused therapy, which Stevenson, Jackson and Barker (2003) found helped patients and empowered nurses in acute care psychiatric settings.

In our view, it is a moral imperative that nurses project themselves beyond their 'thrownness' (Heidegger 1962) and work to create humane hospitals that promote healing. Merleau-Ponty (cited in Watson 2001) exhorts us to shoulder the responsibility of 'actively being what we are by chance, of establishing that communication with others and with ourselves for which our temporal structure gives us the opportunity and of which our liberty is only the rough outline' (201). The question is how to create opportunities to transform nurses' concern for patients into actions that benefit patients. Nurses, counsellors, and other hospital staff can provide more activities to combat the boredom that patients have experienced. Group therapies and education groups can be more focused and individualized to a particular patient population (e.g. depression or substance abuse). Nurses and other hospital staff should not minimize the importance of simple reassurances and friendly interactions to get to know their patients. Physical barriers such as doors and Plexiglas-enclosed nurses' stations can be removed in order to facilitate more staff-to-patient interactions.

The nurses in this study described being ignored and even punished by administrators when they criticized how the unit was managed. This conflict between nursing staff and administrative staff is consistent with findings from Hazelton (1999). Nurse staffing in contemporary US hospitals is a problem in almost all specialties due to the fee-for-service health care delivery system (see Wiener 2003). However, the frustration expressed by nurses in our study was not simply about the number of patients they were asked to care for. Their dissatisfaction was exacerbated by the time they felt they wasted doing unnecessary tasks (e.g. documenting skin integrity every shift on perfectly mobile patients) and hunting down

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patients because the design of the unit did not allow visualization of patients in common areas. Clearly, the design of the hospital and the operations within it could be improved to decrease wasted time. Also, space could be allocated for nurses and patients to engage in one-on-one interactions.

As in the study by Thomas et al. (2002), nurses in this study were not the source of most therapeutic interactions for patients. Patients were a valuable resource for each other. Perhaps nurses should encourage, rather than discourage, these peer relationships, while monitoring them. Peer relationships formed during hospitalization could lead to involvement in consumer advocacy and self-help groups following discharge.

CONCLUSION

To Maurice Merleau-Ponty (1962), the perceived world was the real world. These psychiatric nurses and patients eloquently described their perceptions of their shared world. They did not describe an 'atmosphere conducive to recovery' recommended in classic psychiatric literature (Peplau 1989). Although the findings are not generalizable in the traditional sense, 'each specific reader who derives insight from ... the study may be thought to extend its generalizability' (Thomas and Pollio 2002, 42). According to Pollio, Henley and Thompson (1997, 34), 'Existential–phenomenological philosophy provides grounds for believing that reflections emerging in one dialogic context will *not* be incommensurate with, even if different from, those emerging in another context'. Thus, readers who recognize commonalities between the environment of this inpatient unit and their own may be moved to engage in remedial modifications.

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