

EXPLORING THE ONE-TO-ONE

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Dedication

To Nana and Granda, for teaching me what it means to be a “survivor”;

To my family, for their ongoing love and support;

To Mr. CT, for believing that I could do it;

To my son, Zach, for his patience during my “busy times”, his hugs during my “frustrated times”, and the endless cups of coffee in between.

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Abstract

The purpose of this study was to explore the experiences of mental health nursing instructors and students regarding the one-to-one in mental health contexts. Using person-centered interviewing, nursing instructors and students were asked to share their views related to the one-to-one, the skills and techniques used to conduct the one-to-one, and the teaching and evaluation strategies used in clinical settings. Findings indicate ambiguity surrounding the one-to-one for both instructors and students. Students also feel anxious and uncertain without models to guide their one-to-ones, and instructors feel frustrated with how to teach and evaluate the one-to-one. Finally, findings indicate the need for further articulation of the one-to-one within nursing literature, and the development of guidelines to support student learning of the one-to-one in clinical settings.

Acknowledgements

I would like to express my appreciation to the participants in this study; your passion for the subject and your honesty throughout the interviews was vital to the progress of this work. I hope that these findings may contribute to the knowledge base surrounding the one-to-one and inspire further research on the one-to-one.

My sincere gratitude to my supervisor, Dr. Brad Hagen, who with patience and support allowed me to explore this topic in multiple directions as a new idea took my fancy. I am even more thankful for the multiple times he reeled me back in again and kept me on task. I have gained much from his wisdom and experience in the field of mental health nursing.

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Chapter One: Introduction

Within the literature to date, there is much discussion describing the one-to-one nurse-client relationship and the healing impact that a positive relationship may hold for the client, however the mental health “one-to-one” as a specific kind of nurse-patient relationship has not been explored. Peplau (1991) states that the nurse-patient relationship may be represented on a continuum; there are two individuals with separate goals and interests at one end, and two persons working together to solve a presenting problem at the other end of the continuum. Peplau (1991) goes on to describe that the nurse-patient relationship may fall anywhere on that continuum at any given time, but that the “functions, roles, judgments in practice, and skills that demand scientific knowledge and technical abilities of many kinds change” (p. 11) as the relationship moves along the continuum. Lego (1999) defines the individual (one-to-one) psychiatric nurse-client relationship as “the relationship between a psychiatric nurse and his/her patient, formed for the purpose of brief counseling, crisis intervention, and/or individual psychotherapy” (p. 4). Lego states that this relationship was used as a therapeutic tool long before 1946, and, in her article, describes the history of the one-to-one nurse-client relationship as well as major influences on its development.

Kent (2005) describes the implementation of Protected Therapeutic Engagement Time, during which the nursing ward is shut to visitors and other hospital staff, and the nursing staff dedicates this time to having one-to-one sessions with the clients. Kent states that this not only enables staff to have time for the one-to-one, it also sends the message that the adult wards have more to offer than simply being holding bays in which people wait for their medications to work. Lafferty and Davidson (2006) characterize

their implementation of daily one-to-one sessions between nurses and service users as part of a tidal model to develop a therapeutic, user-empowering relationship. Lafferty and Davidson studied the tidal model and its application within three initial pilot projects in separate hospitals across Glasgow. The service users in this study reported increased feelings of trust in nurses and increased feelings of involvement in their care as a result of the daily one-to-one sessions and tidal model trial.

Although the article is not research-based, Shattell (2007) describes the one-to-one as being an uninterrupted, lengthy, individual sit-down nurse-patient interaction and states that acute care psychiatric/mental health nurses were supposed to have at least one one-to-one interaction daily with every patient to whom they were assigned. However, Shattell (2007) goes on to explain that today's acute care environments do not allow for the one-to-one because of various time, organizational, and structural constraints, and this does not allow for nurses to practice as they were taught, which causes "professional role dissonance, frustration, anger, anxiety, and burnout," (p. 230).

Statement of the Problem

Background and Context

Nurses working on the inpatient psychiatric units in Lethbridge, Alberta, have a "one-to-one" with their clients each shift, and document the occurrence and content of the one-to-one in the clients' charts. This phenomenon has been a daily routine for many years, yet it has not been fully articulated in the literature. Studies relating to the purpose of the one-to-one, nurses' experiences of the one-to-one, and the skills or techniques involved in the one-to-one are not present in the current literature. The one-to-one within the context of the mental health setting has not been fully explored, and this limited

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understanding present in the literature poses a challenge for mental health nursing students. How does the mental health nursing student develop the necessary knowledge and skills to perform a one-to-one successfully? Is the one-to-one a concept that can be taught, or does experience play a greater role in the nursing students' success?

Definition of Terms

The following is a list of terms and their meanings as will be used within this study:

1. One-to-one nurse-client relationship: “four clearly discernable phases in the relationship – orientation, identification, exploitation, and resolution...nurse and patient learn to work co-operatively to resolve difficulties,” (Peplau, 1991, p. 17).
2. One-to-one psychiatric nurse-client relationship: “the relationship between a psychiatric nurse and his/her patient, formed for the purpose of brief counseling, crisis intervention, and/or individual psychotherapy,” (Lego, 1999, p. 4).
3. One-to-one: “uninterrupted, lengthy, individual sit-down nurse-patient interactions....Acute care psychiatric/mental health nurses were supposed to have at least one one-to-one interaction daily with each patient he or she was assigned to,” (Shattell, 2007, p. 229).
4. Mental Health Nursing Student: an individual registered in the Bachelor of Nursing Program within the School of Health Sciences at the University of Lethbridge, who has commenced or completed their mental health clinical rotation.
5. Mental Health Nursing Instructor: an individual registered with the College and Association of Registered Nurses of Alberta, who has the minimum credentials of

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a Bachelor's Degree in Nursing, and who teaches mental health nursing within the School of Health Sciences at the University of Lethbridge.

Rationale for the Study

The one-to-one remains one of the most difficult aspects of mental health nursing, for both the mental health nursing student and the novice mental health nurse. Additional challenges face the mental health nursing instructor in educating and guiding nursing students through their mental health clinical rotations, particularly in preparing students for their first one-to-one with a client. Further understanding of the one-to-one is needed to improve nursing students' proficiency when undertaking this particular kind of nurse-client relationship.

Purpose of the Study

The purpose of this descriptive qualitative study was to explore Baccalaureate mental health nursing students' and mental health nursing instructors' experiences and perceptions of teaching and learning how to conduct a one-to-one as it occurs within the mental health setting. Through person-centered interviewing, the researcher began a dialogue about the one-to-one with a focus on student and instructor experiences of teaching and learning the one-to-one. The researcher also explored the purpose of the one-to-one, the skills or techniques involved, and any changing trends in the usage or application of the one-to-one as a therapeutic tool. It is the intent that this exploration will help to offer increased understanding of the one-to-one, and its characteristics, along with potential barriers and challenges to its successful implementation.

Approach to Research

Philosophical Framework

The constructivist paradigm was used as a lens through which to view this study. Guba and Lincoln (1989) state that the constructivist paradigm is characterized by three main beliefs. The first is the ontological construction that there are multiple, constructed realities ungoverned by any natural laws. The second is the epistemological position that the inquirer and the subject are interconnected in such a way that the findings of the investigation are a creation of the inquiry process. The third belief is the methodology that involves a continuing dialectic of iteration, analysis, critique, reiteration, reanalysis and so on, leading to the emergence of a joint construction of a case. Guba and Lincoln go on to describe how constructivism allows for social reality to be viewed as a series of mental and social constructions derived via social interaction. It is this view that has guided the collection and analysis of data to generate themes surrounding the phenomenon of the one-to-one.

Research Method

As there is little in the literature surrounding teaching and learning the one-to-one, the researcher decided to explore the topic by conducting a Naturalistic Inquiry, outlined by Guba and Lincoln (1989).

Participants/Recruitment/Study Setting

A purposive, convenient sample of 6 instructors and 8 students (who held the role of participant throughout the study) enrolled in the study. Tuckett (2004) advises that sampling should continue until the researcher realizes no new data is forthcoming. There were no further volunteers for this study, limiting the size of the sample. The study was

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conducted in Lethbridge, Alberta. Participants from the University of Lethbridge Nursing Program were invited to participate through posters placed on the bulletin boards throughout the school, as well as presentations to both faculty and students. The participants included faculty who hold the minimum credential of a Bachelor's Degree in Nursing, and teach mental health nursing within the Faculty of Health Sciences at the University of Lethbridge. Participants also included nursing students who had either commenced or completed their mental health clinical rotation within their 3rd or 4th year of the Bachelor of Nursing Program delivered at the University of Lethbridge, Alberta.

Ethical Considerations

Bryman and Teevan (2005) list several points to address when considering the ethics of the study. They suggest the researcher read and incorporate the institution's ethical requirements for research, ensure no harm comes to the participants, ensure informed consent, attend to privacy and confidentiality, eliminate deception, and make participants unidentifiable.

Approval and informed consent. This study operated within the guidelines of research outlined by the University of Lethbridge Human Subject Research document and the researcher sought and received ethical approval from this institution. Informed consent was attained by each participant reading and signing the informed consent form. Participants were given the opportunity to ask questions to ensure their understanding of the consent form and the study. The privacy and confidentiality of each participant was strictly maintained by filing informed consent forms and participant identification lists separately from the data collected, and all paperwork has been kept in locked cupboards to which only the researcher has access.

Risk to participants. Debriefing was available following data collection to facilitate processing of upsetting thoughts and emotions identified during the sessions, and contact numbers for community resources were made available if distress was identified in any of the participants. The researcher contacted these resources (counsellors) in advance of beginning data collection to ensure that referrals could be made if needed.

Data Collection

This study utilized person-centered interviewing as the main data collection strategy. Levy and Hollan (1998) describe person-centered interviewing as a balanced combination of informant and respondent modes of interviewing that distinguishes this form of interviewing from most other types of interviews. Levy and Hollan describe the person-centered interviews as a mixture of informant questions (e.g. Please describe for me why nurses conduct a one-to-one with their clients? This type of question involves the informant as an expert witness) and respondent questions (e.g. Can you tell me about your one-to-ones with your clients? This type of question involves the respondent in exploring what he/she makes of the phenomenon in question). Levy and Hollan go on to describe how the oscillations between informant and respondent modes of questioning illuminate the “spaces, conflicts, coherences, and transformations, if any, between” the person him/herself and aspects of his/her “perception and understanding of her external context” (p. 336).

In considering the application of person-centered interviewing, Levy and Hollan outline when to begin the process. They encourage the researcher to address the following issues: linguistic competence, understanding culture, trust and respondents’

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motivations, location of interviews, interview topics, stance of interviewer while conducting the interviews, interview distortion, interventions and open and closed probes, and the number of interviews (6-20, or 1-2 for special purposes). Each participant was interviewed once.

Each interview took place in a small office space that was comfortable for the participant and conducive to the discussion of the topics at hand (quiet and private, to ensure confidentiality of discussion). Levy and Hollan also encourage the recording of interviews to allow the researcher to decrease the amount of note taking throughout the interview process, but they encourage copious note taking immediately following the interview, and recommend that the tapes be logged and transcribed to facilitate analysis of data. The data collection process included digitally-recorded person-centered interviews (n=14), along with pre- and post-interview field notes and a journal of potential bias. The transcriptionist signed an oath/understanding of confidentiality.

Data Management

The tapes and transcriptions of data have been kept in a locked cupboard to which only the researcher of this study had access. All paperwork relating to the study has also been kept in the locked cupboard. All digital and tape recordings, as well as any demographic information, will be destroyed five years after completion of the study.

Data Analysis

The strategy of person-centered interviewing generated a large amount of detailed data to analyze. This process began when all the participants had been interviewed. Morse (1989) suggests that in order to combat the myth of saturation, the researcher should compare findings with another group. Bryman and Teevan (2005) describe

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respondent validation as a means of seeking corroboration of data or themes collected during the interviews. The researcher was unable to provide each research participant with an account of what he or she said to the researcher during the interviews to confirm that the researcher's findings are congruent with those on whom the research was conducted, due to delays in the research process. The researcher was unable to contact the student participants as their contact information had changed since the interviews were conducted. However, peer debriefing with an instructor participant was used as an informal process to corroborate the development of themes during data analysis. Bryman and Teevan (2005) go on to state that it is unlikely that research participants can validate all of a researcher's analysis, since "it will include inferences made for an audience of social science peers, including concepts and theories and an appropriate social science frame for the resulting publications" (p. 151).

Regarding data analysis, Levy and Hollan (1998) state that "specific choices and emphasis in the *contents* of responses as well as the *form* of the responses are important for analysis" (p. 337). They go on to describe how in the analysis of interviews, the meaningful phenomena can be sorted into types and levels as follows: content as a meaningful story (the story and how it is told), meaning in organization of surface text (intuitive knowing or gaps in the story), disturbances of surface text (slip of the tongue, hesitations, stammerings, interruptions, incompletions, or abrupt switches to a new direction that may suggest tensions), paralinguistic phenomena (qualities of voice, breath, resonance, pitch, etc.), and visual phenomena (tension, stress, animation, excitement, relaxation, depression, etc.).

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In this study, the researcher began by finding themes and creating a codebook to analyze the free-flowing text of the person-centered interviews. The analysis of the data consisted of pencil and paper constant comparative analysis. Levy and Hollan (1998) state that it is important to analyze not only the contents of the responses but the form of the responses, and to consider such concepts as paralinguistic and visual phenomena when analyzing data.

Creating a codebook and finding themes. Ryan and Bernard (2003) state that content analysts have used key-words-in-context lists to identify different meanings in text/transcriptions. They suggest to start with general themes and to add more themes and subthemes as the research progresses. Ryan and Bernard describe the building of codebooks or an organized list of codes as follows: include a detailed description of each code, list inclusion and exclusion criteria, list exemplars of real text for each theme. The codebook is to be developed and refined by the researcher as the research progresses.

The data and themes generated from data analysis were kept in a locked cupboard to which only the researcher of this study has access.

Writing a detailed description of the phenomenon of study. The next step of the analysis was to write a detailed description of the phenomenon of study. The researcher provided a detailed written account of the transcribed person-centered interviews. Finally, the generated meanings and context of the data were outlined and described in detail, along with the connections and inter-connections between themes. The researcher also kept a detailed reflective journal recording any incidence of bias within the study.

Personal Situatedness in Relation to the Research Study

At the time the interviews were conducted, the researcher had worked on the proposed psychiatric units for many years, and had developed linguistic competence and an understanding of the culture of the units, as well as a foundation of rapport with many of the staff who work there. As well, the researcher had taught within the mental health clinical rotation for two years and had worked with a number of nursing students. This positioned the researcher appropriately to conduct person-centered interviewing with this sample of participants. However, this also brought a unique perspective to the issue of bias within this study. The researcher was aware that the working relationships with the instructor participants might influence the interviews and the data collected, or perhaps the analysis of the data. The researcher was alert to maintaining confidentiality and anonymity when continuing to work with these participants following the study, and maintained a nonjudgmental approach to conducting interviews and data analysis. The researcher was also aware that student participants who were not yet finished their mental health rotation could potentially perceive that the researcher might have influence over the students' final grade, and that this could influence the interviews and the data collected. It was imperative that the researcher clarify to the student participants that the data collected had no influence over the students' grade in their mental health rotation. The researcher kept a reflective journal of thoughts and experiences throughout the study, to acknowledge and record potential bias regarding participants or data collected.

Format of Thesis

A brief description of each of the subsequent chapters in this thesis is as follows:

Chapter Two: A Review of the Literature

As the concept of the one-to-one appears to remain unexplored, there was very little literature that mentioned the one-to-one. Therefore, the researcher explored concepts that surround the one-to-one or seem linked to concepts of the one-to-one and/or teaching and learning within the mental health setting. These concepts are described in more detail within the literature review in order to create a basis for this exploratory study of the one-to-one.

Chapter Three: Research Method

This chapter describes the research method in greater detail. The setting, participants, research method, data collection, data management, data analysis have been outlined to demonstrate the process followed within this study. Ethical considerations have also been addressed, including informed consent, confidentiality, and ethical approval. Chapter Three includes further explanation of these steps within the research method.

Chapter Four: Results - Instructor Perspectives

The instructors' perspectives of teaching the one-to-one within the mental health setting are described in great detail in Chapter Four. The instructors' views of what the one-to-one is, what strategies are helpful in teaching the one-to-one, and evaluation of students' learning of the one-to-one are only three of the nine subthemes discussed within this chapter.

Chapter Five: Results - Student Perspectives

The students' perspectives of learning how to conduct the one-to-one within the mental health setting are described in great detail in this chapter. The students' views of

what the one-to-one is, what strategies are helpful in learning to perform the one-to-one, and self-awareness are three of the eight subthemes outlined in this chapter.

Chapter Six: Discussion

The final chapter includes the comparison of the study results to the concepts presented in the literature review. This is followed by a discussion of the implications for mental health nursing education, the limitations of the study, and recommendations for further research. Plans for dissemination of the research findings are also included in this chapter.

Chapter Two: A Review of the Literature

When I began teaching mental health nursing, I had placed much emphasis on the one-to-one between my students and their patients, as my instructor did when I was a student years ago. As a new graduate I continued to refine my skills through the experience of having one-to-ones with my patients in my own nursing practice, as did many of the other nurses on the inpatient psychiatric unit where I worked for nearly a decade. When I assumed a more formal teaching role, I began to search for evidence in the literature that would support my teaching and I found few resources that related directly to the phenomenon of the one-to-one. I have used the term phenomenon because I believe that the one-to-one holds incredible power and potential for individual transformation. The terms *patient* and *client* appear somewhat interchangeably in the literature, as well as the terms *nurse-client* and *nurse-patient relationship*. However, there is a difference between the one-to-one nurse-client relationship as a whole and the phenomenon of the one-to-one that occurs between the nurse and the client in a mental health setting and it is important to keep this distinction in mind. This literature review is focused on the nurse-client relationship as a whole, due to the lack of literature surrounding the one-to-one as a singular phenomenon, however this thesis explores the one-to-one in more detail in Chapters Three to Six.

Bischko (1998, p. 149) states that “mental illness has the potential to become one of the most devastating, debilitating, life changing, and life threatening health conditions within society.” This statement argues for careful consideration of ways to effectively educate nurses so they will provide efficient, competent care to clients with mental health needs. As a student I learned that this care happened within the mental health one-to-one,

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and as a nurse I made it a priority to have a one-to-one with each of my patients on a daily basis. An important outcome of this study should be a clearer articulation of essential characteristics of the one-to-one, and its place in the teaching of mental health nursing.

The questions that have guided my literature search are: What is a one-to-one? What happens within this interaction between nurse and client? How do you conduct a one-to-one? What skills are needed? Can these skills be learned? What factors impact the effectiveness of the one-to-one? How does the experience of the one-to-one impact students' desires to become mental health nurses? More specifically: What are student nurses' perceptions of the mental health one-to-one? How do we help transition student nurses from their perceptions of the one-to-one to the perceptions held by experienced mental health nurses if these perceptions differ? While I was conducting this literature review a picture started to form in my mind of the concepts surrounding the one-to-one and how they may influence each other. I have included an overview of these concepts and their proposed influence on the one-to-one (see Appendix A).

Influences of a Nursing Theorist

Hildegard Peplau has often been described as the mother of psychiatric nursing since the 1952 publication of her book *Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing*. Within this work, Peplau (1991) describes nursing as “a significant, therapeutic, interpersonal process” (p. 16) that aims to support the individual in healing. She describes many roles of the nurse, including but not limited to: stranger, resource person, teacher, leader, surrogate, and counselor. Peplau describes the nurse-patient relationship as therapeutic when nurse and patient

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come to know each other as people and share in the solution of problems. She describes phases of the nurse-patient relationship and has created a continuum showing changing aspects of these relations. Peplau explains counseling with the purpose to help the patient remember and understand situations, and she contends that nondirective listening helps the patient to discover unknown facets of himself. She further explains that making generalizations from experiences with patients helps the nurse to develop the skill of being sensitive to patients. Peplau describes clarity and continuity as two principles of communication, and advises that word consciousness leads to improved learning for both the nurse and the patient. She cautions the nurse to be aware of indirect communication, and to consider nonverbal behavior and symbols as representations of emotions not directly expressed by the patient. Peplau (1953) describes her observations of power and powerlessness as being important in recovery, and explains that a person feels power when he learns new tools with which to address situations in life. Peplau (1960) stresses how the time of the nurse must be used purposefully in the patient's interest.

I was not aware of the influence of nursing theory on practice as a novice mental health nurse, but with further education and experience I became aware of the relevance of theory on my personal practice with patients, and I could see how portions of frameworks presented by nursing theorists, and Peplau's work in particular, provided a foundation for my work with patients. Thelander (1997) states that Peplau's interpersonal theory has relevance and usefulness in understanding patients and intervening to reduce symptoms and re-establish relatedness, while Lego (1999) describes Peplau's theory as providing a system within which the nurse can evaluate

current interpersonal experiences and improve competencies in order to benefit the patient.

Factors/Skills/Components of the Nurse-Patient Relationship for Consideration

The literature proposes the influence of many concepts on the one-to-one nurse-client relationship. I have experienced many of these myself, and in discussion with other mental health nurses, I feel that these concepts have relevance to the discussion of the one-to-one; therefore, I will briefly outline them here (see Appendix A).

Self-concept of nurse. For nurses to be able to fully understand the client, the nurses must first understand themselves. Silverstein (2006) states that nurses are expected to know themselves and Ware (2008) describes key features of self-concept as person and aspiring nurse as influencing the knowledge of the student nurse.

Roles of the newly qualified and experienced mental health nurse. Nurses' perceptions of their roles influence the care they provide to patients. Peplau (1962) states that counseling is the crux of psychiatric nursing, but Stickley (2002) asserts that nurses are not equipped for one-to-one counseling and should have more training.

Rungapadiachy, Madill and Gough (2004) found four themes among newly qualified mental health nurses: transition, role ambiguity, lack of support and theory-practice gap. This ambiguity presents a challenge for both nursing education and practice as both instructors and students struggle to seek evidence to guide their practice.

One-to-one nurse-patient relationship. The current view of the nurse-client relationship is represented extensively in the literature, but there is less research available that relates to the one-to-one relationship within mental health nursing and even less on the one-to-one itself. Bischko (1998) describes the client-nurse relationship as the heart

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and soul of the art of nursing. Lego (1999) defines the one-to-one psychiatric nurse-patient relationship as the relationship formed between the nurse and the patient for the purpose of brief counseling, crisis intervention, and/or individual psychotherapy and Stockman (2005) states the purpose is to promote experiences leading to health by supporting the individual's natural tendency toward growth and personality development. Raingruber (2003) proposes that relationship and nurturing offer promise as a paradigm for nursing while Scanlon (2004) states that the therapeutic relationship is a combination of learned experience and interpersonal skills which is redundant if the nurse has minimal life experience.

Trust, power, mutuality, self-revelation, congruence and authenticity are themes in the therapeutic relationship identified by Welch (2005). Cleary, Edwards, and Meehan (1999) identified six themes in the factors influencing nurse-patient interaction in the acute inpatient setting. These were environment, 'something comes up', nurses' attributes, patient factors, instrumental support, and focus of nursing. These studies demonstrate that it is not skills alone that influence the quality and amount of time spent in the one-to-one with patients. The preconceptions of the nurse and client most strongly relate to the development of the therapeutic relationship, as Forchuk (1994) explains. Time is essential to the nurse-patient relationship, and 'just-being' with the client is important as Evans (2001) notes.

Skills involved in the one-to-one nurse-client relationship. Although there is limited information on the phenomenon of the one-to-one as it relates to mental health nursing, there is research relating to the skills and technique involved in the one-to-one nurse-client relationship. I explored this concept to see if it would shed some light on

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some of my questions. Silverstein (2006) states that therapeutic interpersonal interactions are quintessential competencies in psychiatric nursing. Empathy has been identified as an essential skill by Bischko (1998), Perraud, Delaney, Carlson-Sabelli, Johnson, Shepard and Paun (2006), and Travelbee (1964). Bischko goes on to identify self-reflection, self-care, intentionality, being nonjudgmental, finesse, mutuality and trust as other skills and techniques in developing the nurse-client relationship. Trust, humor, conscious decision-making, and providing information have been identified as core skills by Scanlon (2004). Travelbee (1963) emphasizes the development of rapport with the client as an important skill.

Lego (1999) provides a literature review of the various techniques proposed to foster the one-to-one nurse client relationship within mental health nursing; some examples of which include: the use of touch (Mercer), the use of the learning process (Peplau), the concept of waiting, and focusing on feelings (Hays). The need to understand the client's concerns through the therapeutic relationship has been described by Mac Neela, Scott, Treacy, and Hyde (2007) and they include communication skills as a nursing strength arising from nurses' distinctive role in health care. However, Burnard and Morrison (2005) proposed the need for further training so nurses are able to move from their self-identified authoritative (prescriptive, informative, and confronting) approaches to facilitative (supportive, cathartic, and catalytic) approaches with the client.

Evaluation of one-to-one interactions. In a nursing home setting, England (2005) used process recording as an instrument to analyze the nurse-client interaction and conversation. England states that the research presented provides an enabling methodology for nurses to enhance professional development. Lafferty and Davidson

(2006) discussed daily one-to-one sessions with mental health patients as part of a tidal model to develop a therapeutic, user-empowering relationship, and in this study patients reported feelings of increased trust and participation in their care.

Use of language in mental health nursing. The use of language in mental health nursing has great influence on the one-to-one nurse-client relationship; this can be viewed in terms of limitations and barriers when negative language or terminology is used, or in terms of transition and change when positive, creative language is used. For example, Happell (2007) states in her editorial that consumers object to the term ‘mentally ill’ and that the use of this term may pose a barrier to the therapeutic relationship. Hamilton and Manias (2006) state that in their use of diagnostic and pragmatic language, as well as in pejorative language, nurses exercise normalizing judgments in a process of governing patients. Alternatively, McAllister, Matarasso, Dixon, and Shepperd (2004) list two suggestions as conversation starters with clients, discussing recovery as a departure lounge (as talking about journeys taken can evoke fond reminiscence and other emotions) and using picture cards with patients to discuss feelings. McAllister also encourages nurses to be creative in their use of language to connect in a meaningful way with clients.

One-to-one in international mental health nursing. The term one-to-one refers to the nurse-client relationship in international mental health nursing studies. Fourie, McDonald, Connor and Bartlett (2005) described therapeutic interventions and nurse-patient interaction as one of nine main themes in their study of mental health nursing in New Zealand. In a Chinese study, Arthur, Chan, Fung, Wong, and Yeung (1999) found that nurses in Hong Kong applied therapeutic communication strategies that were client-focused, but tended to lack culturally sensitive communication strategies

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despite acknowledgement that this is a problem. In Sweden, the client-nurse relationship was perceived as secure, confirming and developing and as providing companionship, but also as insecure and non-confirming according to Horberg, Brunt and Axelsson (2004). It appears that there is a need for further investigation into the one-to-one relationship within mental health nursing and its development for the benefit of the patient on a global scale.

Research issues and challenges. A number of questions surround the research of the mental health one-to-one and the nurse-client relationship. Lego (1999) lists several questions for further research: What does/should take place in the one-to-one relationship? Can this be measured? Are certain patients susceptible to change? Should all psychiatric nurses practice this modality? What variables affect its success? How does the one-to-one relationship fit into the current delivery of health care services? Chambers (1998) suggests that a pluralistic approach is necessary in order to fully understand the nature of psychiatric/mental health nursing, and discusses phenomenological and hermeneutic approaches to further research.

Disappearance of the one-to-one. Within the literature, there were several references to the lack of time to interact meaningfully with clients in the inpatient setting and there was a suggestion by Shattell (2007) that ‘one-to-ones’ are disappearing. Shattell goes on to describe the one-to-one as a lengthy, individual sit-down nurse-patient interaction and that nurses should have at least one of these per shift with each assigned patient, then she describes how today’s acute care environments no longer allow for these with increasing demands on nurses’ time. In a brief news article in the July 30, 2008 publication of Nursing Standard an unnamed author states that one in six service users

did not have a one-to-one with nursing staff during their first week of admission to hospital. In response to similar threats to one-to-one time with patients on their unit, Kent (2005) states that introducing PTET, or protected therapeutic engagement time, sends a strong message that the adult wards are not just holding bays in which we wait for people's medications to work.

Future of the one-to-one. The historical development of the one-to-one nurse-client relationship is traceable throughout the available literature, but many questions have arisen in relation to future research. Gastmans (1998) states that Peplau has made a clear ethical choice by placing relations at the center of nursing and that the *relationship* is not only the place where the practice of care takes concrete shape, but it is also the most significant source of knowledge for theory. However, O'Brien (2001) states that mental health nursing has a number of possible future directions, not all of them compatible with the same concept of therapeutic relationship. It will be interesting to see how future research and a changing health care environment will influence the practice of the one-to-one.

Factors Likely to Influence Nursing Students' Perceptions of the One-to-One

The phenomenon of the one-to-one is difficult to articulate, to research and, even more so, to teach. Therefore, it is important to consider the many factors and concepts that are likely to influence the student nurses' perceptions of the one-to-one and its use in mental health nursing (see Appendix A).

Mental health nursing education. Klisch (1990) states that there are barriers to student nurse-client one-to-one relationships including limitations of clinical placements and describes success with a solution project throughout a hospital where the students

interviewed clients with stress relating to health care situations. Melrose (2002) states that there is a serious lack of guidance for instructors in mental health and proposes a clinical teaching guide to improve mental health nursing education and provide consistency among nurse educators' approaches to instruction. According to Ware (2008), nursing instructors should be aware that they are a strong influence on professional socialization. The literature suggests that nurse educators need to set a strong example for future mental health nurses, but that the supports for them to do so are lacking. This poses a challenge for nursing educators and mental health nursing education alike.

First encounters with mental health patients/clients. The experience of the first encounter with a mental health patient can greatly influence student nurses' perceptions of the one-to-one and of mental health nursing. Granskar, Edberg and Fridlund (2001) describe two core categories of nursing students' experiences with patients with mental disorders; they are nursing student qualities (either focused on own needs or focused on patients' needs) and patient behavior (either rejecting nursing students or willing to engage in relationships with students) and the authors list the resulting feelings of the nursing students.

Students' perceptions of role of mental health nurse and nursing student. Rungapadiachy, Madill and Gough (2004) identify several areas of concern regarding the role of the mental health nurse from the students' perspective: mental health student nurses were expected to conduct more psychologically based interventions than were achievable in practice, emphasis on drug administration can lead to a conflict of interest in the nurses' advocacy role with patients, and mental health student nurses can

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sometimes observe poor role models in their placements which can have a negative impact on their views. Rungapadiachy et al. go on to list the students' perceived roles of the mental health nurse as administrator, agent of physical interventions, drug administrator, agent of psychological interventions, teacher, and agent of non-therapeutic interventions. This territory must prove to be a challenge for nursing students to negotiate.

Role competency of student. If it is so difficult to describe the many roles of the mental health nurse, how does the student determine competency in these roles? Gilje, Klose and Birger (2007) list eight undergraduate psychiatric nursing critical clinical competencies: therapeutic communication, therapeutic use of self, nursing process, safety, clinical learning, dialogue, faculty guidance and professional conduct. Lauder, Reynolds, Smith and Sharkey (2002) state that demonstrated role competency is a significant factor in predicting therapeutic commitment to clients; therefore if the students believe in their own skills then they demonstrate increased commitment to clients.

Student contributions to clinical site. Psychiatric nurses rated the contributions of nursing students significantly higher than did nurses working on perinatal units, according to Matsumura, Clark Callister, Palmer, Harmer Cox and Larsen (2004), and they go on to list five factors that influence staff nurse perceptions: student preparation, student qualities, level of students, the influence of the clinical instructor, and ways in which having students promotes professional growth in staff nurses. Gatson Grindel, Bateman, Patsdaughter, Babington, and Medici (2001) state that students allow nurses to participate in their professional development and are able to assist with care. In this

study, mental health nurses more strongly disagreed than other nurses regarding the following statements: working with students takes too much time, students threaten professional role development, students are not well received by patients, and students' participation allows staff time to do 'extras'. In my experience working with students, their performance improves if they feel supported by the nursing staff and feel that they are making a contribution to the care of the patients.

Student attitudes. Student attitudes are extremely influential on the care they provide to mental health patients. Madianos, Priami, Aleviopoulos, Koukia, and Rogakou (2005) state that lecturing and field experience are effective in changing stereotypes of persons with mental illness in undergraduate nursing students. Emrich, Cervantez Thompson and Moore (2003) state that student attitudes are more positive at the completion of an experience, and that attitudes are influenced by exposure to factual information, talking with clients with mental illness, treatment options available, and use of fear-reducing strategies. Surgenor, Dunn and Horn (2005) state that attitudes are improved through professionalism, increased competence and career identity as a health professional.

Student coping. There are differing opinions relating to the ability of nursing students to cope effectively with the challenges of the mental health nursing clinical experience. Tully (2004) utilized the Student Nurse Stress Index and describes sources of reported stress for psychiatric nursing students as: concerns about caring for dying patients, interpersonal conflicts, anxieties about professional competence, fear of failure, work overload and interpersonal relations with patients. This study also indicates increasing levels of distress as students progress through the program and describes both

positive and negative coping strategies utilized by students. However, Prymachuk and Richards (2007) present differing results; in their study, mental health nursing students scored lower on the Student Nurse Stress Index and utilized less emotion-oriented coping than other nursing students. The authors propose that it may be that the work is stressful, but mental health nursing attracts or develops robust people that perceive stressors as challenges rather than as threats. Both of these studies took place in the United Kingdom, and it would be interesting to see what results would come of studies in other countries.

Students' perceptions of role of mental health client in student learning.

What role does the client play in the student nurses' experience of mental health nursing? Moyle (2003) describes the patients' experience of being nurtured and their need for comfort within the nurse-client relationship. Coatsworth-Puspoky, Forchuk and Ward-Griffin (2006) explain how clients describe two kinds of relationships within their experiences with nurses. The authors describe the first relationship as the bright side, and state that it evolves through three phases: a glimmer of help, exploring and problem-solving, and saying goodbye. When nurses were caring and listened to their clients, they were contributing to the development of a therapeutic relationship. The second relationship, known as the dark side, is described as deteriorating through three phases: withholding, avoiding and ignoring, and struggling with and making sense of. When nurses were perceived as withholding care, or avoiding clients, the relationship digressed. Clients shared that they observed that nurses stayed behind the desk socializing with each other, and only approached clients to dispense medications. This contributed to the clients' feelings of hopelessness and frustration.

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If these are some of the perceptions of the clients, what are the perceptions of the students? Happell (2003) describes how the role of the consumer-academic made a significant contribution to nursing education and the experience would continue to have an impact on the practice of postgraduate psychiatric nursing students. In my own teaching experience, many of my undergraduate nursing students have told me that hearing the experience of the patient makes mental illness real, and allows for a greater understanding of the experience of mental illness that could not be gained from reading a book.

Conclusion

It is clear that the one-to-one nurse-client relationship within mental health nursing is a complex process with many influencing factors, and the phenomenon of the one-to-one itself requires further research. Suikkala, Leino-Kilpi, and Katajisto (2008) state that there is a lack of empirical analysis of student-patient relationships. This knowledge helped to guide the choice of method for this study to further understand the phenomenon of the one-to-one through the perceptions of nursing students experiencing their mental health clinical rotation. It is my goal to more fully understand this phenomenon, in the future, from the perspectives of the mental health nurse and the mental health client as well, in order to be able to support students through their mental health experience and help them to learn vital interpersonal skills. Mental health is an aspect of every area of nursing, and our focus should not only be on creating exceptional mental health nurses, but creating nurses who possess exceptional interpersonal skills for all areas of health care.

Chapter Three: Methods

The literature describes the one-to-one nurse-client relationship in detail, but there is little research surrounding the phenomenon of the one-to-one as it occurs within the mental health setting; the purpose, role, required skills, and nurses' views about the importance of the one-to-one have not been examined. This gap in the literature results in challenges for the mental health nursing student and the mental health nurse in performing the one-to-one with their mental health clients with the purpose of improved outcomes for the client, primarily because nurses are not sure how to perform a one-to-one and what it might entail. This calls for an exploration of the one-to-one and the context in which it is situated. This chapter describes the proposed descriptive qualitative study, a naturalistic inquiry, viewed within the constructivist paradigm. The research questions and participants will be discussed, as well as ethical considerations and data collection and analysis strategies. This chapter concludes with a discussion of the writing of the study, and trustworthiness and authenticity of the process.

Purpose of the Study

The purpose of this descriptive qualitative study was to explore mental health nursing students' and mental health nursing instructors' experiences and perceptions of teaching and learning how to conduct a one-to-one as it occurs within the mental health setting. Through person-centered interviewing, I began a dialogue about the one-to-one with a focus on student and instructor experiences. I explored the purpose of the one-to-one, the skills or techniques involved, and any changing trends in the usage or application of the one-to-one as a therapeutic tool.

Study Design

Bryman and Teevan (2005) describe aspects of qualitative research as: being focused on words and the point of view of the participant, the development of theory from the process of research, the search for contextual understanding and rich, deep data, and looking for meaning within natural settings. Bryman and Teevan go on to describe the main steps in qualitative research which has provided a framework within which to design this study. The steps are outlined as the following:

Step 1: General research questions

Step 2: Selecting relevant sites and subjects

Step 3: Collection of relevant data

Step 4: Interpretation of data

Step 5: Conceptual and theoretical work

Step 5a: Tighter specification of research questions

Step 5b: Collection of further data (return to Step 4)

Step 6: Write up findings and conclusions

These steps provide the basis for my inquiry and process of research, and choosing the paradigm through which I explored the phenomenon in question was crucial.

Philosophical Framework

Guba and Lincoln (1989) define the term paradigm as a set of beliefs or assumptions which serve as a touchstone in guiding our activities. They go on to state that the constructivist paradigm is also known as the naturalistic, hermeneutic, or interpretive paradigm, and that it is characterized by three main beliefs. The first is the ontological position that there are multiple, constructed realities ungoverned by any

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natural laws. “Truth is defined as the best informed...and most sophisticated...construction on which there is consensus,” (Guba and Lincoln, 1989, p. 84). The second belief is the epistemological position that the inquirer and the subject are interconnected in such a way that the findings of the investigation are a creation of the inquiry process (which effectively destroys the ontology-epistemology distinction). The third belief is the methodology that involves a “continuing dialectic of iteration, analysis, critique, reiteration, reanalysis, and so on, leading to the emergence of a joint...construction of a case” (Guba and Lincoln, 1989, p. 84).

The authors list the relative risks of the constructivist paradigm as follows: face-to-face contact (allows for intense and fragile relationships), difficulty maintaining confidentiality and privacy (as language used may allow for identification of the individual), violation of trust (over a short time frame, rapport and relationships may prove difficult to build and maintain), need for open negotiations (deception is forbidden because of ethical constraints and it is counterproductive to the study), and framing of case studies (may provide an inclusion, exclusion or selection problem for the researcher).

Guba and Lincoln (1989) also discuss some of the redeeming features of constructivism. They outline how the search for the ultimate truth is removed as “social reality...exists only as a series of mental and social constructions derived via social interaction,” (Guba and Lincoln, 1989, p. 137). Secondly, they describe how the use of deception is counterproductive to the inquiry process. Third, Guba and Lincoln (1989) describe how:

Both the need for control and the primacy of verification procedures disappear as

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parameters of inquiry within the naturalistic paradigm...there is nothing to verify. The object of a naturalistic inquiry is to identify and describe various *emic* constructions and place those constructions in touch - with the intent of evolving a more informed and sophisticated construction than any single one of the *emic* constructions *or*, the researcher's...*etic* construction, represents. (p.138)

Naturalists retain a need for explanation and management within inquiry. Some possibilities of a new metaphor to that end are “net”, “web”, and “pattern”. Lincoln and Guba (1985) state that the most powerful metaphor is the mass of interconnected neurons in the brain (the brain can apparently use almost any of its parts to fulfill the function of any other part). The main idea of this metaphor is *mutual simultaneous shaping*:

Everything influences everything else, in the here and now. Many elements are implicated in any given action, and each element interacts with all of the others in ways that change them all while simultaneously resulting in something that we, as outside observers, label as outcomes or effects. But the interaction has no directionality, no *need* to produce that *particular outcome*... it simply “happened” as a product of the interaction.

Lincoln and Guba (1985) state:

Naturalistic paradigm asserts that inquiry is value-bound, specifically, that it is influenced by the values of the inquirer, by the axioms or assumptions underlying both the substantive theory and the methodological paradigm that undergird the inquiry, and by the values that characterize the context in which the inquiry is carried out. All of these sources of influence may be in resonance (affirm, reinforce) or in dissonance with (conflict, reject) one another. It is not possible to sort out individual influences in any situation because the values are continuously interacting. Without the admission that inquiry is value-bounded, there is no hope of dealing with the influence of values.

These constructivist beliefs are a lens through which to view the phenomenon of the one-to-one as it occurs in the mental health setting. I believe that I am an implicated researcher as at the time the interviews were conducted, I had worked in the mental health setting as an RN for ten years, and I had been teaching mental health nursing students for two years. As such, conducting an effective one-to-one continues to be a primary focus in my work.

Research Questions

Clough and Nutbrown (2007) state the author(s) of a research study should be clear about how many research questions there are to be addressed within the study, and if there are more than three questions to state them clearly and consider the size of the study. The research questions for this study are as follows:

1. What is the experience/understanding of teaching the one-to-one as articulated by mental health nursing instructors?
2. What is the experience/understanding of learning the one-to-one as articulated by mental health nursing students?

Participants

This study used a purposive and convenient sample to investigate the phenomenon of the one-to-one. Morse (1989) describes a purposeful sample as one that is selected according to the informants' knowledge of the research topic. Bryman and Teevan (2005) state that a convenience sample is simply one that is available to the researcher by virtue of its accessibility, and that with homogeneity of the population, the amount of variation may be less. Initial invitation to the study was conducted with the circulation of a poster (see Appendix B), and secondly, participants were presented with a letter of invitation outlining the study (see Appendices C and D). The participants in this study were mental health nursing instructors that were currently teaching at the University of Lethbridge, who performed their duties teaching the students in this study during their mental health clinical rotations on the inpatient psychiatric units of Chinook Regional Hospital in Lethbridge, Alberta. Participants in this study also included baccalaureate nursing students who were completing or had completed their mental

health clinical rotation in either the third or fourth year of their program at the University of Lethbridge.

Sample Size

Many authors have written about sample size, but few seem to determine a set number or range of numbers for sample size for general qualitative inquiry. Morse (1989) states that researchers can only give approximations of sample size, as they cannot predict how long it will take to identify characteristics or themes or how much data is required. Morse also states it is important to consider budget when planning sample size. The sample in this study was purposive and convenient, and included a sample size of $n=18$ to provide for maximum variation, while allowing time to collect and analyze rich and detailed data from the participants.

Inclusion criteria. Participants in this study were mental health nursing instructors who hold the minimum credential of Bachelor of Nursing, currently teaching at the University of Lethbridge. Participants in this study also included baccalaureate nursing students who were completing or had completed their mental health clinical rotation during either their third or fourth year of study at the University of Lethbridge. Demographic variety is desired, e.g.: male and female students, a variety of ages, and views regarding treatment. Morse (1989) states that in qualitative research, demographics have little significance and that more descriptive methods of describing participants and context should be used. However, demographics in this study, such as length of time working in mental health, may reveal changes in perceptions of the one-to-one over time.

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Exclusion criteria. Undergraduate nursing students who had not yet started their mental health clinical rotation were not included in the study. Nursing instructors who had not taught the one-to-one in a mental health setting were not included in the study.

Ethical Considerations

Bryman and Teevan (2005) list several points to address when considering the ethics of the study. They suggest the researcher read and incorporate the institution's ethical requirements for research, ensure no harm comes to the participants, ensure informed consent, attend to privacy and confidentiality, eliminate deception, and make participants unidentifiable. This study operated within the guidelines of research outlined by the University of Lethbridge Human Subject Research document and the researcher sought and received ethical approval from this institution. Debriefing was available following data collection to facilitate processing of thoughts and emotions identified during the sessions, and contact numbers for community resources were made available if distress was identified in any of the participants. The researcher contacted these resources (counsellors) in advance of beginning data collection to ensure that referrals could be made if needed.

Confidentiality

The privacy and confidentiality of each participant was strictly maintained by filing informed consent forms and participant identification lists separately from the data collected, and all has been kept in locked cupboards to which only the researcher has access.

Informed Consent

Informed consent was attained by each participant reading and signing the informed consent form (see Appendices E and F). Participants were given the opportunity to ask questions to ensure their understanding of the consent form and the study.

Data Collection Method

This study used individual interviewing as the strategy of data collection. Bryman and Teevan (2005) state that qualitative interviewing is flexible and much less structured than quantitative interviewing. They describe the semi-structured interview as a list of questions on specific topics but identify that there is leeway in how the participant may reply. Bryman and Teevan (2005) include a figure outlining how to formulate interview questions. The steps are listed as follows:

- Step 1. General research area
- Step 2. Specific research questions
- Step 3. Interview topics
- Step 4. Formulate interview questions
- Step 5. Review/revise interview questions (may return to step 3)
- Step 6. Pilot guide
- Step 7. Identify novel issues
- Step 8. Revise interview questions
- Step 9. Finalize guide (p. 187)

These steps provided a foundation for formulating and revising interview questions that guided the development of questions for this study (see Appendices G and H). Bryman

and Teevan also recommend recording and transcribing interviews to allow the researcher to focus on not only what is said but how it is said. This also allows for the evaluation of original analysis, the potential for the data to be reused and helps to counter accusations of bias.

Person-Centered Interviewing

More specifically, this study utilized person-centered interviewing as the main data collection strategy. Levy and Hollan (1998) describe person-centered interviewing as a balanced combination of informant and respondent modes of interviewing that distinguishes this form of interviewing from most other types of interviews. Levy and Hollan describe the person-centered interviews as a mixture of informant questions (e.g. Please describe for me why nurses conduct a one-to-one with their clients? This involves the informant as an expert witness) and respondent questions (e.g. Can you tell me about your one-to-ones with your clients? This involves the respondent in exploring what he/she makes of the phenomenon in question). Levy and Hollan (1998) go on to describe how the oscillations between informant and respondent modes of questioning illuminate the “spaces, conflicts, coherences, and transformations, if any, between” the person him/herself and aspects of his/her “perception and understanding of her external context” (p. 336).

In considering the application of person-centered interviewing, Levy and Hollan outline when to begin the process. They encourage the researcher to address the following issues: linguistic competence, understanding culture, trust and respondents’ motivations, location of interviews, interview topics, stance of interviewer while conducting the interviews, interview distortion, interventions and open and closed probes,

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and the number of interviews (6-20, or 1-2 for special purposes). My experience working as a nurse conducting one-to-ones, and my experience teaching students how to conduct the one-to-one, has enabled me to develop the linguistic competence necessary to perform the interviews. Each participant was interviewed once, and each interview took place in a quiet office space that was comfortable for the participant and conducive to the discussion of the topics at hand (quiet and private, to ensure confidentiality of discussion). Comfortable seating and indirect lighting assisted in facilitating conversation.

Levy and Hollan also encourage the recording of interviews to allow the researcher to decrease the amount of note taking throughout the interview process, but they encourage copious note taking immediately following the interview, and that the tapes be logged and transcribed to facilitate analysis of data. The tapes and transcriptions of data have been kept in a locked cupboard to which only the researcher of this study had access, and they will be destroyed five years after completion of the study. The transcriptionist has signed an oath/understanding of confidentiality.

Data Analysis

The method of person-centered interviewing generated a large amount of detailed data to be analyzed. This process began when all the participants had been interviewed. Morse (1989) suggests that in order to combat the myth of saturation, the researcher should compare findings with another group. Bryman and Teevan (2005) describe respondent validation as a means of seeking corroboration of data or themes collected during the interviews. The researcher was unable to provide each research participant with an account of what he or she said to the researcher during the interviews to confirm

that the researcher's findings are congruent with those on whom the research was conducted, due to delays in the research process. Many of the participants had relocated since the interviews were completed. However, peer debriefing was used to help corroborate themes during data analysis. Bryman and Teevan (2005) go on to state that it is unlikely that research participants can validate all of a researcher's analysis, since "it will include inferences made for an audience of social science peers, including concepts and theories and an appropriate social science frame for the resulting publications" (p. 151).

When analysing data, Levy and Hollan (1998) state that "specific choices and emphasis in the *contents* of responses as well as the *form* of the responses are important for analysis" (p. 337). They go on to describe how in the analysis of interviews, the meaningful phenomena can be sorted into types and levels as follows: content as a meaningful story (the story and how it is told), meaning in organization of surface text (intuitive knowing or gaps in the story), disturbances of surface text (slip of the tongue, hesitations, stammerings, interruptions, incompletions, or abrupt switches to a new direction that may suggest tensions), paralinguistic phenomena (qualities of voice, breath, resonance, pitch, etc.), and visual phenomena (tension, stress, animation, excitement, relaxation, depression, etc.).

In this study, the researcher began by finding themes and creating a codebook to analyze the free-flowing text of the person-centered interviews. The analysis of the data consisted of pencil and paper constant comparative analysis. Levy and Hollan (1998) state that it is important to analyze not only the contents of the responses but the form of

the responses, and to consider such concepts as paralinguistic and visual phenomena when analyzing data.

Creating a codebook and finding themes. Ryan and Bernard (2003) state that content analysts have used key-words-in-context lists to identify different meanings in text/transcriptions. They suggest to start with general themes and to add more themes and subthemes as the research progresses. Ryan and Bernard describe the building of codebooks or an organized list of codes as follows: include a detailed description of each code, list inclusion and exclusion criteria, list exemplars of real text for each theme. The codebook for this study was developed and refined by the researcher as the research progressed.

Each transcript was read by the researcher a minimum of three times. After the first read, the researcher made notes of initial ideas within the transcript. The second read assisted the researcher with defining the concepts contained within the transcript more clearly, and organizing the concepts and their definitions into the codebook. The third read of each transcript allowed for the researcher to clearly outline categories of information which led to forming clusters of themes.

Forming clusters of themes. Boyatzis (1998) states that forming clusters of themes may be helpful as a way to organize the code, or to aid in the transformation of the data during analysis. The researcher chose to organize the themes in context of the other themes identified within the study. Searching for patterns within the themes allowed for the formation of three themes, each with subthemes, for the data generated by the instructors and also for the data generated by the students (see Appendices I and J).

The data and themes generated from data analysis were kept in a locked cupboard to which only the researcher of this study had access.

Writing a detailed description of the phenomenon of study. The next step of the analysis was to write a detailed description of the phenomenon of study. The researcher provided a detailed written account of the transcribed person-centered interviews within two chapters of results, the first focusing on instructor perspectives and the second focusing on student perspectives. Finally, the generated meanings and context of the data were outlined and described in detail, along with the connections and inter-connections between themes. The researcher also kept a detailed reflective journal recording any incidence of bias within the study.

Rigor and Trustworthiness

Trustworthiness

Guba and Lincoln (1989) have outlined four criteria (credibility, transferability, dependability, and confirmability) that they believe are meaningful within a constructivist inquiry, and these criteria parallel the conventional four criteria of rigor (internal validity, external validity, reliability, and objectivity). The criteria for trustworthiness outlined by Guba and Lincoln will be discussed in this section.

Credibility. Guba and Lincoln (1989) describe credibility as establishing a match between constructed realities of respondents and realities represented by the researcher. They list six methods of establishing credibility: prolonged engagement, persistent observation, peer debriefing, negative case analysis, progressive subjectivity, and member checks. Prolonged engagement with instructor participants had been established by the researcher in that she had worked on the proposed psychiatric units for a decade,

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and further had instructed nursing students on those units for two years. Persistent observation had been established in that the researcher had worked with the phenomenon in question for a period of twelve years, and was familiar with general concepts and themes. The researcher implemented peer debriefing with an instructor participant, as an informal method of member checking, to review findings with someone who had no contractual involvement in the research. This colleague was helpful in the phases of data collection and analysis.

The researcher kept a detailed reflective journal to address the topic of progressive subjectivity and acknowledge any bias that may arise. The researcher planned to use Guba and Lincoln's suggestion of member checks on a regular basis with the informants/respondents of the study in order to allow the evaluator to assess the intent of a given action, to give the respondent the opportunity to clarify or correct any errors or misunderstandings, to provide the informants/respondents with the opportunity to provide additional information, however the researcher was unable to contact many participants as they have relocated since the study began.

Transferability. Guba and Lincoln describe transferability as always relative and that it depends entirely on the degree to which salient conditions overlap or match. The major technique to accomplish transferability is a thick description of data. The researcher has provided details of how the detailed description will be written, and the documentation that will be included in the writing of the study.

Dependability. Dependability is described by Guba and Lincoln as being concerned with the stability of data over time, and that shifts need to be tracked and be trackable. The researcher relied on peer debriefing to verify shifts in experiences or

perceptions of the one-to-one over the various time periods the nurses had worked on the psychiatric units.

Confirmability. Guba and Lincoln describe confirmability as being concerned with assuring data, interpretations, and outcomes of inquiries are rooted in context and persons apart from the researcher (not simply figments of the researcher's imagination). Peer debriefing helped to establish confirmability within this study.

Authenticity

The criteria of trustworthiness are concerned with method, but Guba and Lincoln describe authenticity as being concerned with whether stakeholder rights were in fact honored. The authenticity criteria described in this section “spring directly from constructivism's own basic assumptions,” (Guba and Lincoln, 1989, p. 245). The authenticity criteria described in the following paragraphs are: fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity.

Fairness. Guba and Lincoln describe fairness as the extent to which different constructions and their underlying value structures are solicited and honored within the evaluation process. They go on to state that there are two techniques for achieving fairness: stakeholder identification and solicitation of group constructions, as well as open negotiations of recommendations and actions.

Ontological authenticity. Guba and Lincoln describe this concept as referring to the extent to which individual respondents' own emic constructions are improved, matured, expanded, and elaborated, in that they now possess more information and have become more sophisticated in its use. They describe two techniques for demonstrating that ontological authenticity has been achieved: the testimony of selected respondents

(instructors within this study), and the audit trail should have entries of individual constructions. The researcher ascertained that these two techniques were employed throughout the study.

Educative authenticity. Educative authenticity is described by Guba and Lincoln as representing the extent to which individual respondents' understanding of and appreciation for the constructions of *others* outside their stakeholding group are enhanced. The researcher is interested in the views of the nurses in how they will approach the one-to-one as part of their client care following participating in this study, and asked this question of the participants prior to concluding the interviews.

Catalytic authenticity. Guba and Lincoln describe catalytic authenticity as the extent to which action is stimulated and facilitated by the evaluation processes. There are three techniques for ensuring this criterion has been met: the available testimony of participants from all stakeholding groups, resolutions issuing from negotiating sessions themselves, and systematic follow-up to assess the extent of action and change. This criterion was beyond the breadth and depth of this study, given the considerations of timeframe and budget.

Tactical authenticity. Guba and Lincoln state that tactical authenticity refers to the degree to which stakeholders and participants are empowered to act and have the opportunity to contribute. They describe three ways this may be demonstrated: the testimony of participants and stakeholders, the follow-up to determine participation, and that judgment can be rendered as to the degree of empowerment during the evaluation process. This criterion was beyond the breadth and depth of this study, given the considerations of timeframe and budget.

Chapter Four: Results

Instructor Perspectives of Teaching How to Conduct the One to One

During the analysis of the data, three major themes unfolded, each with three subthemes (see Appendix I). The first theme, *Unraveling the Mystery: Defining the Elusive One-to-one* includes descriptions of what the one-to-one is, its frequency, the skills involved, and what nurses should be aware of within themselves. The second theme, *A Long and Winding Road: The Instructor's Developmental Journey* includes examples of what the instructor has learned about how to conduct a one-to-one themselves, how the instructor learned to teach the one-to-one, words/phrases that capture the experience of teaching the one-to-one, and addressing the challenges of teaching the one-to-one. The third theme, *It's Not Like a Dressing Change: Teaching and Evaluation Strategies* includes resources and strategies for building knowledge and skills and evaluating the student's learning. Table 1 illustrates the three themes and the corresponding subthemes, and detailed descriptions of each are included in the following sections.

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Table 1

Nursing Instructor Perspectives of Teaching the One-to-One

Unraveling the Mystery: Defining the Elusive One-to-One	Outlines the definition and concepts of the one-to-one
A pillar in mental health nursing: what and when	Describes what the one-to-one is, what potential it holds, how often it should occur
I don't know that there's a cookie cutter approach: skills and mental status assessment	Identifies skills involved in the one-to-one, techniques or models used to guide the one-to-one
Encourage the students to know their own selves: self-awareness	Describes self-awareness of nurse (own values, feelings), reflection and growth of process and progress
A Long and Winding Road: The Instructor's Developmental Journey	Describes the instructor's experiences of teaching the one-to-one
Define the destination: learning to teach the one-to-one	Outlines instructors' experiences of teaching the one-to-one, reflections of skills and knowledge
Learning the make the connection: experiences of teaching the one-to-one	Identifies instructors' most meaningful experiences of teaching the one-to-one
Moving towards mastery: challenges and advice	Identifies challenges faced when teaching the one-to-one and advice for other instructors
It's Not Like a Dressing Change: Teaching and Evaluation Strategies	Describes teaching and evaluation strategies used by instructors when teaching the one-to-one
It's not like a dressing change: frustrating, painful teaching of the abstract one-to-one	Describes frustrations experienced by instructors when teaching the abstract concept of the one-to-one
It's all relational: knowledge, resources, and strategies	Identifies strategies used to help students build knowledge and skills surrounding the one-to-one
Mission possible: the accurate evaluation of one-to-one interactions	Outlines the complexities of evaluating learning and performance of the one-to-one

Unraveling the Mystery: Defining the Elusive One-to-one

Participants were asked to describe their understanding of what the one-to-one is before describing how they approach teaching nursing students how to conduct a one-to-

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one. Participants each described portions of what the one-to-one entails, how often it should occur, the skills involved in the one-to-one, models or theories used to guide the one-to-one, and the self-awareness of the nurse conducting the one-to-one. Each participant added a piece to the puzzle, allowing the following description of the one-to-one to emerge from the data. Subtheme One, *A Pillar in Mental Health Nursing: What and When*, includes the instructors' perceptions of what the one-to-one is, how often it should occur, and its core elements. Subtheme Two, *I Don't Know that there's A Cookie Cutter Approach: Skills and Mental Status Assessment*, includes the instructors' perceptions of models or theories to guide the one-to-one. Subtheme Three, *Encourage the Students to Know Their Own Selves*, includes the instructors' views on enhancing student self-awareness and its importance when conducting the one-to-one.

A pillar in mental health nursing: what and when. Each of the instructors participating in the study agreed that the one-to-one is a fundamental concept within mental health nursing education. Isabelle explained, "It's like a pillar in mental health nursing. It's one of the things that we need to know how to do if we're going to provide great care." Despite its perceived importance, however, instructors still found it difficult to articulate just what a one-to-one is, what it entails, and how frequently they should occur. As Karl described:

Then there's this big mystery as to what a one-on-one entails because all the nurses do one-on-ones differently?...And even that term is weird because you can't even really find that term in the literature so I don't even know if that's something locally or if it's just something that people don't write about because it's sort of elusive I guess.

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Although there seems to be a gap in the literature surrounding how to teach the one-to-one, instructors still maintain that there are core elements to the one-to-one.

Kathy described her understanding of the core elements:

I think the core elements there are to understand the patient most importantly. Because the one to one for somebody who is suicidal is going to take a very different direction...So I think the core elements are understanding the client, the client's issues and making sure that all of those issues get addressed.

John agreed that there were core elements to the one to one, but described the fundamental element as building rapport:

I think it's hard to get anywhere in mental health without building rapport...if you're able to build rapport you're able to get a lot more from the patient, they'll be more apt to open up...thought process, communication, emotions, suicide risk assessments.

After sharing their thoughts about the core elements of the one-to-one, participants described how often they encouraged their students to conduct a one-to-one with their clients. Kathy explained:

I tell my students I need them to do a one to one at least once a shift...I encourage the students to try to get their one to ones out of the way early in the day so that they can first of all document them completely and second of all they have a chance later on in the shift to follow up on something that maybe was talked about earlier in the shift.

Karl, however, had more uncertainty and questions about the frequency of the one-to-one. He shared, "how often should they be, how long should they be, do they need to be done every shift? Once a day, every two days."

I don't know that there's a cookie cutter approach: skills and mental status assessment. Participants agreed that there was no one model or theory that they used to teach nursing students how to conduct a one-to-one in the mental health setting, and that there is "no cookie cutter approach." However, two participants mentioned using the

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mental status assessment as a basis for the one-to-one with the client. The first, John, stated that “general appearance...emotional wellbeing...communication, thought process, suicidal ideation” should be addressed. Kathy also agreed that after the first one-to-one the students can “focus on the core issues, whether it’s suicide, whether it’s hallucinations...whatever issue the client may be experiencing so they’ve established their baseline and now they can focus on key areas.”

Other participants mentioned that it is important to have a flow to the conversation, and not to focus on specific serious questions right away in the interaction. Angela, for example, cautioned students against feeling like they had to ask questions in a certain order:

Students get hung up on this...I have to ask these specific questions and then I think once they start doing it they realize that if the patient’s comfortable with you and, you know, you’re in an environment that’s comfortable, it happens...I tell them not to do it in any kind of order really because they do get hooked on the order of a mental status exam.

Isabelle also agreed that the flow of the one-to-one is important, and that both active listening and inquiry are important in this regard.

Listening and hearing and I think sometimes that...those two things are different. That they can actually listen but not necessarily hear what the client or patient is saying...That we’re not just here to ask them a checklist of questions and go back and chart our task as being done. It’s a relational building activity.

Participants also mentioned drawing on techniques or theories such as solution focused therapy, motivational interviewing, use of silence, cognitive behavior therapy, and the phases of the therapeutic relationship. Jane mentioned that she draws from several theories, as “it’s...kind of finding what you’re comfortable with and maybe it’s drawing things from...different approaches to fit your own approach...I don’t know that there’s a cookie cutter approach.”

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Encourage the students to know their own selves: self-awareness. The participants agreed that since there seems to be no step by step approach to the one-to-one, it is beneficial for the students to have or attain a certain amount of self-awareness when approaching and performing one-to-ones. Participants discussed the anxiety that conducting one-to-ones within the mental health setting may cause for nursing students entering their first mental health setting.

Karl mentioned that “the students are insanely nervous and so if you don’t give them some kind of structure or purpose they get really freaked out and they don’t know what they’re supposed to be doing.” Kathy agreed that anxiety about the one-to-one can be an issue. She explained:

They have to be prepared for their kinds of reactions to these things. And that’s a challenge for people too because...**nobody** myself included can possibly come up with every possible scenario...But I do encourage the students...to know their own selves and their own reactions to things... how are you going to deal with it in a professional manner.

Self-awareness is vital in maintaining professional boundaries, as Jane discussed, the students need “to be professional and to have boundaries, being aware of that... and certainly not telling them oh...me and my boyfriend are having a fight or you know those kinds of things.” The participants agreed that students need to be aware of their own anxiety, and cope appropriately and professionally, so that the focus of the one-to-one remains on the patient.

Students have to determine how to conduct the one-to-one and include a mental status assessment, be aware of and manage their own anxieties, maintain a therapeutic focus on the client, and there seems to be no step by step model of how to do this. This poses challenges for both students and instructors in the mental health setting. How does

one learn to teach something to students when it seems to be difficult to define or describe in its entirety?

A Long and Winding Road: The Instructor's Developmental Journey

The second theme seems to build upon the first. A Long and Winding Road: The Instructor's Developmental Journey, contains the participants descriptions of their experiences of learning to teach the one-to-one in the mental health setting, some of their most memorable experiences of teaching the one-to-one and their reflections of the process, as well as some of the challenges the instructors have faced while teaching this concept and their advice for other instructors that may be teaching similar skills.

Subtheme One, *Define the Destination: Learning to Teach the One-to-One*, includes the instructors' perceptions of teaching the one-to-one and some of the issues they address when doing so. Subtheme Two, *Learning to Make the Connection: Experiences of Teaching the One-to-One*, includes the instructors' most memorable moments and images that for them, surround the one to one. Subtheme Three, *Moving Towards Mastery: Challenges and Advice*, includes the instructors' views on some of the challenges they address while teaching this complex concept, and some advice for others learning to teach the one to one in the mental health setting.

Define the destination: learning to teach the one-to-one. The instructors were very honest and forthright in discussing their struggles with learning to teach the one-to-one in the mental health setting. The instructors were able to highlight some of the issues or barriers they have faced while teaching students this fundamental concept. Three participants mentioned a folkloric approach to teaching, such as teaching as they were

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taught and/or drawing from their own professional experiences working with clients.

John described his approach:

I teach how I've been taught...I don't know that I've ever learned how to teach the one-to-one. I've never had a course in this is how you teach a one-to-one. I've never had a book tell me this is what's in the one-to-one. These are the goals of the one-to-one. So basically what I'm teaching students like I mentioned before, was...how I've been taught to do them myself...there's not a step by step, this is how you teach it.

Karl began by reflecting upon his own experience as a nursing student entering the mental health setting and how that experience impacts how he approaches teaching his students. He explained:

I think that's what's frustrating is, in my own nursing education, we were just told to go talk to the patients...we had no kind of guidance or instruction or model or anything to base this on...it was painful because we'd go in and if the patient didn't want to talk we'd feel like we were bombing and it was very anxiety producing...I guess I never did learn and so I had to figure this out myself when I was nurse...and so partially I guess that's why I felt almost duty bound or honour bound to teach students something because I know it's so frustrating myself just being told to go talk with a patient. And not having the foggiest idea how to do it...one of the things that I was trying to do with students was leave them that sense of...there was something really powerful that nurses can do.

Jane agreed that her own experience as a nursing student has an impact on her approach to teaching the one-to-one. Jane shared the reflection that is helpful for her:

Feeling somewhat apprehensive when I had my first interaction as a student and I think being able to relate to that has been beneficial. I think it's been probably the most important thing is just remembering that anxiety that I felt.

Two participants described learning to teach the one-to-one as a trial and error process. Kathy described the challenges of translating skill to teaching ability:

Trial and error...teaching something that I've done for years but not knowing how to communicate those skills to somebody...getting feedback from others with experience like mine was very helpful in establishing what's the best way for these students to learn what we already know how to do.

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Isabelle agreed that learning to teach the one-to-one is a trial and error process, even with years of experience performing one-to-ones herself. She explained:

Sometimes...you go in and you're pretty confident and it just totally blows up. And it's terrible and get out of my room or whatever and...there's a lot of self-reflection ... Trial and error. And I think also even just the literature...because some of it isn't even actually nursing literature, although some of it is...I read a book by Henry Nowinin called *The Wounded Healer* and it was really about...human beings, what do we long for, what do we need, what makes us feel good, what makes us want to be motivated?...I took that back to my nursing practice...how best can I help this person understand that I want to know about them. And to be genuine.

Learning to make the connection: experiences of teaching the one-to-one.

Participants were asked if a word or phrase came to mind when they were asked to consider their experiences of teaching the one-to-one to nursing students in the mental health setting. These phrases were varied among instructors but each seems to relate the idea of connecting with another person. For example, Karl described:

The word that comes to mind is *touched*. And what I mean by that is it seems to be during one-on-ones that the students get their first real sense of being touched by a close connection with another person...they're moved by the person's suffering or they get a taste of what it must be like to be so despairing you want to kill yourself...they're finally comfortable with sitting with very deep, dark emotions. I would say that, that's certainly when the students seem to be the most *touched*. And it's also when you start to see them grow up a bit? Or mature?

John agreed that when students share with him that they have connected with a client during a one-to-one it can be very rewarding. He explained:

Rewarding...I think the one-to-ones are important in getting the assessments. But they're also an important tool to use as a lesson for the students that the clients and patients **are** human. They're people just like their mom, their dad, their brother, their sisters. They're able to sit down and just **be** with that patient...So it's *rewarding* when they come to me at the end of the semester and say I just had a great time in mental health. I love mental health. I love talking to the individual.

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Kathy also described a similar concept of connection, but between herself and her students. She explained:

Enlightening or revealing. Because I think...that's when I begin to see a little bit more about the student themselves. And what kinds of areas they may struggle in or you know what personality issues, whether they have a strong personality whether they're more a of a shy person...a very revealing experience for me to be able to learn more about my students' strengths and limitations and help them really emphasize those and give them strategies with which to overcome some of the limitations they may experience if they try doing a one-to-one.

In addition to sharing words that they feel capture the essence of teaching the one-to-one, the instructors also shared some of their most meaningful experiences while teaching students how to conduct a one-to-one in the mental health setting. The stories themselves lend a sense of the reflection and process that the instructor participates in along the way. What is interesting to note is that although the instructors shared their most meaningful experiences, the highlight of each experience was the students' learning.

Karl described the following experience of how his student made a deeper connection with a client by asking probing questions within the one-to-one:

I mean it was pretty meaningful...we were working with a woman who is quite psychotic...she has lots of religious delusions and lots of stuff about good and evil and demons and then she started talking about having snakes and serpents in her vagina...But it turned out, that the student instead of focusing on the snakes being a ridiculous delusion she started asking, when the snakes were bad in the vagina and when they weren't in her vagina and different things. Well it turns out that she had a raging UTI. And the student had figured that out as a result of asking this woman when the snakes were bad and when they weren't bad and what did the snakes feel like inside her vagina and that's kind of a solution focused therapy approach...And so the student was very proud that after spending a lot of time she'd been able to actually figure out this UTI...so I think that for the student was pretty rewarding.

Kathy explained how one of her students "cunningly" asked her to come and meet her client, and in doing so provided an opportunity to observe Kathy interact with the client:

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It turned out to be a very useful exercise, I think for both of us...because after that she had no troubles with that client one-to-one. And it made me realize that I am a resource. I'm a very valuable resource with my experience to the students.

John reflected that one of his students had to do an admission, and was nervous “to the point of being scared to interact with the individual.” He explained how the student was able to complete the admission assessment with his support:

When we left that setting she was so proud of herself and what she'd accomplished and so it was just the whole process...and make and chart those observations and follow through on what was required of her. It was just such a night and day thing where she was just terrified and then leaving and being so proud of that interaction. From that point on she was so eager to work with every client that was put in front of her.

Learning about professional boundaries within the one-to-one was mentioned by two instructors. Angela described an experience that helps her reinforce the importance of professional boundaries to her students that will be working with mental health clients:

I had a student who had a young male as a patient...I don't think the student did anything wrong...but the patient felt well, he thought he fell in love with her and felt that she felt the same way...we looked back at her interactions with the patient and the one-to-ones that she had with the patient and you know a few of the things that she said to the patient that I don't think she'll ever say again like when the patient said, oh I'm going to be discharged soon and she said, well, we'll miss you. Which was a very innocent thing but of course he perceived that as, oh she likes me and she wants to see me outside of here...it was a learning experience for her...even though it's a negative thing...she still learned a lot from it about how she should interact.

Angela mentioned that this experience helped her watch for signs that boundaries may be crossed by even simple statements voiced by students who may be unaware of the patient's potential interpretation of the statement. Jane also described a meaningful experience that relates to boundary issues in the mental health setting:

When a student had a patient with a diagnosis of PD and having that student say, you know, the patient is um swearing at me or she'd said something that...I really don't think I deserved...She said well it's firstly the feelings about being shocked...as we go through the scenario we do find that you told her that that was

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inappropriate so good for you. You stated there's a boundary there...breaking down those components so in future work with this patient the student realized that she can set those boundaries and she can follow up on those things...she was very thankful...usually when the student says they're thankful I guess that's the biggest compliment that a teacher can get.

Isabelle also remarked on student progress as being meaningful for her. She described it as one of her favorite parts of teaching mental health:

I don't think it's just been one. I think that that's part of doing that, because this is actually one of my favourite parts of teaching mental health. I love it, because you see such growth in how they interact with their patients. And I totally love it when after that first one that I've sat in on and we go away and the student goes, wow that was great I was so glad you came I thought I did a good job but I learned blah, blah, blah and they're able to really grasp what they needed to do differently. And then for the second one I watch it's completely different. It's like night and day with the student and I just love that. I love seeing them succeed like that. It's awesome.

Moving towards mastery: challenges and advice. It seems that there is a particular kind of dedication or passion about relationships and connecting with other human beings among instructors that teach in this area. As wonderful as that is, it comes with particular challenges, especially when you are trying to teach someone else how to connect to and communicate effectively with a person who is experiencing symptoms of a mental illness. Instructors shared advice, and were honest about the challenges that they have faced during their teaching experience. Three instructors agreed that both the students' anxiety levels and providing feedback to students posed a challenge. Karl explained:

The students' anxiety levels are through the ceiling and if we want to give them complete cardiac failure then the big thing would be to tell them we're watching an interview...that is probably the biggest challenge is you can sit down with a student afterwards and go, well how did it go and they can say, well I bombed or, it went really well but...they don't have the wherewithal to sort of critique their skills yet so I mean it may actually be a really good interview that they did or a one-on-one it was just the patient was challenging so they think they bombed but for that patient they did a great job...I tried to leave students with an idea that at

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the end that they were really skilled at this? And that this was a tough area and they and that they could talk with patients and it wasn't futile.

Kathy agreed that both the students' anxiety levels and providing feedback posed challenges. She describes her experience working with students:

At the start of the semester when the students aren't...comfortable coming into a mental health rotation...because they're afraid of what they might see, experience, hear, that they may say something wrong, those kinds of things and, and try to overcome those fears so that they can actually **do** their job and engage in one to ones with clients. That's often a challenge...it gets very difficult to assess when you're in a classroom situation because it is a safe situation for them to practice things.

Jane also described student anxiety as one of the biggest barriers to learning how to conduct a one-to-one. She explained:

I think that umm the biggest barrier is the students feel that they're umm, they're just scared...they haven't had, perhaps, a lot of contact or interaction with clients with mental health issues and for some reason there's still that stigma...so I think that really it's more the fear of the unknown...having that view that this is a person who is potentially dangerous when oftentimes they're not.

Isabelle agreed that student anxiety levels pose a continual challenge for her as an instructor. She stated, "I think I'm still challenged about how I deal with some of these things. Like, the very nervous student who is almost paralyzed by even just the *thought* of having to talk to a patient."

The instructors went on to mention advice they would share with other instructors who teach or are learning to teach the one-to-one to students. Two instructors' comments focused on skills. Karl explained:

The first thing I'd recommend is to try and get feedback from another colleague about their own one-to-one skills because I think we all assume that just because of virtue of being psych nursing instructors we're all amazingly good at these one-on-ones...and then when we model it to students we're not necessarily modeling the best skills...the second big piece would be to try and give students some coherent model or theory or something...like an algorithm ...when are you going to use different kinds of skills.

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Kathy agreed that the instructor has to be comfortable with his/her own knowledge level of the one-to-one. She described a potential drawback to inadequate knowledge base of the instructor:

Because if you don't know something yourself or you aren't comfortable with the knowledge of that thing you can't accurately give full information to your students...and if the nurse has experience in conducting one-to-ones...they should already be familiar. I think the other thing is not to be afraid to go out on a limb and try something new.

In addition to needing strong skills and knowledge of the one-to-one, a supportive learning environment was also mentioned. Two instructors commented on providing a supportive learning environment. John explained:

Be supportive of the student and listen and look to the cues that they're giving you in regards to **their** needs to be able to interact with...that patient. Is that patient the reason why the one-to-ones aren't working? Or is the student's communication style the reason why that's not working. And if it's the student's communication style well then we need to look at that.

Isabelle agreed that a supportive learning environment is important when teaching the one-to-one. She explained that accompanying the student the first time is beneficial:

Dialogue. Absolutely. And probably to go with them...to set it all up as I'm not going to let you drown out there because it's a huge fear...The whole I'm going to go with you...to actually role model...I really think that going with them the first time is a really beneficial type of thing.

It's Not Like a Dressing Change: Teaching and Evaluation Strategies

It seems that there may not be one particular model or step by step instructions to follow to accomplish a one-to-one interaction with a client, and as one instructor shares, the one-to-one is "not like a dressing change." This theme will further elaborate on the frustrations felt by instructors and students alike regarding the gap in the literature relating to the one-to-one. Despite this challenge, however, instructors have developed

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strategies and resources that they use to both teach and evaluate their students' learning of the one-to-one within the context of mental health nursing. Subtheme One, *It's Not Like a Dressing Change: Frustrating, Painful Teaching of the Abstract & Complex One-to-One*, includes descriptions of the instructors' frustrations of teaching this abstract concept. Subtheme Two, *It's All Relational: Knowledge, Resources and Strategies*, includes descriptions of the resources and strategies the instructors use when teaching the one-to-one. Subtheme Three, *Mission Possible: The Accurate Evaluation of One-to-One Learning*, includes the instructors' perspectives of the evaluation of students' learning surrounding the one-to-one, and some of the challenges unique to this setting.

It's not like a dressing change: frustrating, painful teaching of the abstract & complex one-to-one. Instructors shared some of their frustrations that surround trying to teach something that seems to have no finite directions or steps, or something that may seem to come naturally to themselves after many years of practice. Kathy explained:

It's quite different to teach something than it is to do something...it took a little creative thinking as to how to explain to them the process...It's not like a dressing change where you can say these are the procedures to follow. One-to-ones are very different. Conversations take all different turns and it's very difficult to teach something that you just do innately.

Karl described his experience of teaching the one-to-one as frustrating and confusing. He explained:

Two words I would use are frustrating and confusing. And both for me and the students...my experience is based on one of my values is the most important thing is to give the clients a sense of being heard. So that influences my teaching which influences how I ask students to do one-on-ones...when it gets to one-on-ones, it's all much more value-laden. That's where students get so confused because they hear a different thing from each of the different nurses about what a one-to-one should be...I think a lot of students find it painful...and I think a lot of the patients find it painful.

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John also shared his thoughts about the unique challenges of teaching the one-to-one, and described the concept of the one-to-one as abstract:

It's kind of abstract for them to gain an understanding of...what to do...when they sit down with a client...So when I teach the one-to-one I look for them to gain insight into the bio, psycho, social model...eating well, are they sleeping well...mood...communication style...the biggest thing that I think students need is support, when we're doing a one-to-one. Mental health can be a scary place for students to be when they've never experienced...helping somebody achieve mental health...giving them a second ear and a second opinion and hearing them out...let's try to approach from a different angle...if you're not getting anything **why** are you not getting anything from this client in this one-to-one...I think that if it wasn't so abstract it might not take so long to get to that point.

Isabelle agreed that providing support, discussion opportunities, and prompts assists the students to approach the one-to-one when interacting with clients. She explained:

I also encourage them to listen to the patient because sometimes they'll be talking and they'll be giving you clues about what's important to them and so when you hear that, what kind of question would get you to get more information...what do you think was the most important thing...just said...because patients are complex...sometimes it's not just one idea.

It's all relational: knowledge, resources and strategies. Instructors begin by helping their students to develop a knowledge base about mental health and communication techniques that are helpful in assessing and interacting with this population of individuals. Kathy mentioned that “walking through the terminology around mental illness helps the students understand what they're observing” and Angela shared that videos that demonstrate nurses conducting one-to-ones with clients, “a good one compared to a bad one” are considered helpful by the students. Again, instructors remarked on the uniqueness of the situation and task at hand, and the resulting student anxiety surrounding how to have this conversation with the client. Jane explained, “It's different if they have to give somebody an injection of insulin...they feel a different sense of focus I think, a different sense of nervousness.” Jane stated that there is a lot to

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consider at one time: choices of location, timing, formal vs. informal, get to know the person but also assess the illness, and learn to be with the person “that makes it a bit nerve-racking for the student” however the student needs to be aware that “following a checklist...can break down that communication, break down that relationship.”

In addition to discussing anxieties, instructors also discussed the students’ knowledge base. Isabelle shared her thoughts about some assumptions that the instructors make about each new group of students when teaching the one-to-one. She described how she assists students to draw on their prior experiences:

Well, I think that it’s fairly complex actually, because there’s an assumption that they come with some kind of knowledge base underneath...I pull from a lot of different things...articles to read...I have them reflect on their own personal experience...What has been one of your better memories of going to a doctor’s office and feeling cared for? And what made that experience for you?...so they list off some things and those are things that they then can incorporate into their own practice that they already know about that I don’t need to teach them.

Four instructors spoke at length about role modeling, and its value as a teaching strategy when addressing the complex concept of the one-to-one. The first, Karl, described his use of role plays as being beneficial to the students’ learning:

I try and do role plays with them in their conferences that give them the experience of not being heard versus the experience of being heard...we review the basic communication things around open-ended questions, listening for key words, avoiding changing the topic, avoiding questions out of the blue, basic attending skills.

The second, Kathy, described how she draws on past experience to incorporate into her use of role plays:

If I can recall an experience that I had with a client of my own, where something maybe a little different happened during the one to one and I had to react to that then I share that experience with the students...to make them aware that they have to be kind of prepared for anything that could happen throughout the one-to-one...and explaining to them how that might happen and giving them examples of how they might insert themselves again into the interview to redirect.

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Angela, a third participant in agreement, described how she and other nurses use role modeling to demonstrate skills for the students:

I do pair them up, with a nurse at the beginning and the nurses take them with them to do one-to-ones. So that the students can see how a one-to-one is done...because I think that that makes them more comfortable because they see how they interact.

Finally, Isabelle, agreed with the use of role modeling for students, as well as observation and the occasional interjection with a question or comment of her own, but she added that timing is important to consider also:

The first thing is not leaving it too late in the semester, or in the rotation because they kind of get set into a way of doing things and it's harder to move them out of that...the comments at the end have been that was really helpful because I didn't know what to do, and you gave me some great examples or I really liked how you asked that and I hadn't thought about that...So it gave them an opportunity to practice but then to help them when they got stuck. And for them to be able to reflect back on what they learned.

Mission possible: the accurate evaluation of one-to-one learning. Considering that the instructors have described some of the challenges and frustrations of teaching the one-to-one within the mental health setting, we may now consider the complexities of evaluating the students' learning and application of such an abstract and elusive concept. Again, the candor of the nursing instructors has helped to highlight some strategies and approaches to the accurate evaluation of one-to-one learning, some of which include indirect and direct observation of students performing one-to-ones with their clients. Three instructors shared their experiences of indirectly observing their students, noting that directly observing the one-to-one changes the dynamic of the conversation between the student and the patient. Karl, the first, shared his frustration and his questions surrounding the evaluation of the students' learning the one-to-one. He explained:

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What I ended up doing was they would role play their clients in our conference and then I would try and demonstrate a bad interview and a good interview and that seemed to work...But then I would get no proof as to whether they did it so...I mean I'm ashamed to admit this but I would often resort to hiding behind plants and things like that and trying to be within earshot. And, I would do that for three or four minutes but...either the patient or the student eventually would see me...the only other thing, when the students and I would debrief a one-on-one I would try and get them as much as possible to be very specific around what was the one thing they said that they were most proud of that seemed to help the interview go the deepest.

Kathy, the second participant, agreed that evaluating students is a challenge. She described how she addresses evaluating the students' learning:

I've always kind of been on the fringes and kind of wandered through the unit and I observe from a distance to see if they look like they're struggling than I may, you know, insert myself in the conversation just to redirect, but generally I don't interrupt because that's their time with their client.

A third, Jane, shared that both indirect and direct observation are useful in evaluating the students. She explained:

I will be present when they're doing at least one one-to-one, or in the area. That creates a bit of a difficulty as well...is the focus still on the patient or is it on the student...I guess in that situation too it's an opportunity for role modeling for how we can ask about something or follow up on something.

On the other hand, two instructors agreed that evaluation of the one-to-one occurs in discussing the event with the student afterwards. John described how he evaluates the students' learning of the one-to-one through his discussions with them, "I think evaluation, for me, happens through communication with them, just talking out... the one-to-one that they've just had. Gaining an understanding of how they saw the one-to-one unfold." Angela is in agreement with John, and explained that she evaluates the students' learning:

Basically on what they were telling me...and what was charted and then how was that in comparison to what the nurse had experienced that day...did they go have a one-to-one and say the schizophrenic patient wasn't hallucinating, wasn't

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delusional, was very pleasant and appropriate and then the nurse later on has a one-to-one and the guy's...talking to himself and looking around...evaluated the same as what the staff are seeing or what I'm seeing in the patient if they're up around the unit.

Isabelle agreed that a post-brief is helpful in evaluating the students' learning of the one-to-one, but she added that a written reflection component is also helpful. Isabelle used direct and indirect observation methods to aid in evaluating the students' learning:

I do make them do a written reflection so they are actually identifying the types of questions they've asked. And whether it was effective in a) having the patient or client like provide information or b) if it was effective in actually getting the assessment that they needed...sometimes they'll say that it wasn't and I'll say well what would have made it better and sometimes it's rewording it, sometimes it's a completely different question. Giving them the opportunity to reflect on it *after*, instead of in the moment where they're nervous, seems to make a big difference for when I ask them to go back and do another one-to-one. So that's been helpful.

Chapter Five: Results

Student Perspectives of Learning How to Conduct the One-to-One

During the analysis of the data, three major themes unfolded, each with two-three subthemes (see Appendix J). The first theme, *Defining the One-to-one* includes descriptions of what the one-to-one is, how long it should be, the skills involved, and what nursing students should be aware of within themselves. The second theme, *Students' Learning* includes examples of what the students have learned about how to conduct a one-to-one themselves, their skill development, their most meaningful experiences of learning to conduct a one-to-one, and addressing the challenges of learning the one-to-one. The third theme, *Learning and Evaluation Strategies* includes resources and strategies for building knowledge and skills surrounding conducting the one-to-one, as well as methods of evaluating the students' learning. Table 2 illustrates the three themes and the corresponding subthemes, and detailed descriptions of each are included in the following sections.

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Table 2

Nursing Student Perspectives of Learning the One-to-One

Defining the one-to-one	Outlines students' understanding of the definition and concepts of the one-to-one
“A picnic bench”: what and how long	Describes what the one-to-one is, what potential it holds, how long it should be
From none to many: models and core concepts	Identifies models and core concepts used to guide the one-to-one
Self-Awareness: anxiety, stigma, and personal growth	Describes students' self-reflection and growth when learning the one-to-one
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Students' Learning	Outlines students' experiences of learning to perform the one-to-one
“Not just fluff”: learning to perform a one-to-one	Describes students' perceptions of their progress in learning the one-to-one
“Get one step closer” to the “personal connection”: most meaningful experiences of learning the one-to-one	Identifies students' most meaningful experiences of learning the one-to-one
“Not as scary as you think”: challenges and advice	Identifies challenges of the one-to-one and advice for other students
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Learning and Evaluation Strategies	Identifies students' perceptions of learning and evaluation strategies surrounding the one-to-one
Watching me watching you: role plays and viewed one-to-ones	Describes students' perceived value of role plays and viewed one-to-ones as learning strategies
Facial expressions or verbal feedback: informal vs. formal evaluation	Outlines students' perceptions of informal and formal evaluation techniques when learning the one-to-one

Defining the One-to-One

Participants were asked to describe their understanding of what the one-to-one is before describing how they approached learning how to conduct a one-to-one.

Participants each described portions of what the one-to-one entails, how long it should be, the skills involved in the one-to-one, models or theories used to guide the one-to-one,

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and the self-awareness of the nurse learning to conduct the one-to-one. Each participant added a piece to the puzzle, allowing the following description of the one-to-one to emerge from the data. Subtheme One, *A Picnic Bench: What and How Long*, includes the students' perceptions of what the one-to-one is, and how long it should be. Subtheme Two, *From None to Many: Models and Core Concepts*, includes the students' perceptions of models or theories to guide the one-to-one, and core concepts of the one-to-one. Subtheme Three, *Self-Awareness: Anxieties, Stigma, and Personal Growth*, includes the students' views on developing self-awareness and its importance when conducting the one-to-one.

“A picnic bench”: what and how long. Each of the students participating in the study agreed that the one-to-one is an important concept within mental health nursing education. Four students discussed their understanding of what the one-to-one is. One student, Jane, described her conceptualization of the one-to-one as an image of a picnic bench:

I can picture a picnic bench, as weird as that sounds. Just because sitting down in a comfortable environment and them discussing as light as possible, but also about what they see in the future, and what they've overcome in the past, and then what they are doing right now at the present. Like with all three just kind of there. But in a really comfortable and non-threatening environment.

Three students discussed what they thought the one-to-one should entail. In terms of “what”, Joan thought it should be assessment:

I think with schizophrenia...trying to assess...the hallucinations...that they're seeing. And then presenting reality and depending on the person, being able to present reality might be effective. Or it might not be.

Terri also thought that the one-to-one involved assessment:

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I just had that basic outline that we were given initially...you just had to talk about what they were wanting to talk about and see if you could in a roundabout way get to the assessment piece of it.

On the other hand, Jane thought the one-to-one was about empowerment: “I’m really a big fan of...empowerment...I really like them to think of their own ideas and what can work for them. And for them to feel kind of in control of the situation.”

As well as discussing what a one-to-one should entail, two students commented on how long the one-to-one should be. For example, Jane shared:

About 10 minutes, that’s all you need...also continuous too so I’d go at this part of the day and I would talk to them for ten minutes. I’d come *back* and talk to them another ten minutes so that way I can compare their behavior then to now.

Joan, on the other hand, thought the one-to-one should not be too long:

For example that resident I was talking about with paranoid schizophrenia, if you sat down and you talked to her...for *too* long she would get agitated. But if you went and periodically checked up on her and asked her how she was doing and asked her a couple questions...It’s a lot more effective with her, I found.

From none to many: models and core concepts. Participants agreed that there was no one model or theory that they used to learn how to conduct a one-to-one in the mental health setting, and in fact, the students’ responses were quite varied on the subject. One participant shared that she was not given specific models or theories regarding how to perform a one to one. Robbie shared, “I feel like we haven’t really been *taught* it, theoretically taught it...the way I’ve learned to do it was just straight through clinical, through like watching and learning.”

However, two participants mentioned having more formal instruction on the theoretical basis of how to conduct a one-to-one and they spoke of using the mental status assessment as a basis for the one-to-one with the client. Jane discussed what she was instructed to observe during a one-to-one:

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It's just affect, behaviour and content?... 'cause it's really important to be quite observant in facial expressions...be aware of even the silences...Realizing that their behaviour's appropriate and...they understand the questions that you're talking about and they're responding appropriately.

Bobbie discussed how she approaches the holistic assessment over time, or during multiple one-to-ones with a client:

My first instructor pushed the holistic approach *a lot*. So I started getting into the *big* assessment sheet in our first year that covered every body system, like spirituality, roles, relationships...when I was done the one-to-one, I'd try and see how many of those I hit and then...when I meet with that person next...I'm going to try and find out about these areas...I also like the motivational interviewing...what do you want to accomplish instead of me deciding for them.

Finally, two students shared that there were several models or approaches to the one-to-one discussed within their clinical groups, although each of them could only recall one model that they applied to their client care. Wapo said, "I like the self-care theory" and explained how it helped one of his clients gain independence in her life. Joan shared "the only model I can think of...called the CARE framework," and described how the model addresses awareness, resilience, engagement and provides for client safety.

After describing what they believed to be models or theories surrounding the performance of the one-to-one, students were also asked to describe what they felt were core concepts or core elements of the one-to-one. Again the comments were varied, but all seemed to reflect the idea of being connected to or caring about another person. Three participants discussed openness and caring as core concepts. First, Robbie described "openness...fundamental of one-to-ones. Because who'd want to talk to if you, you know, if you didn't want to talk to them." Secondly, Wapo stated "I think for the one-on-one you truly have to care...I think it's crucial...If you don't care why are you even there." Jane agreed that caring was a core element, "showing that you *care*, that you

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want to listen to them and can just continue to build trust with them. So they can be comfortable about telling you their fears or their feelings or their thoughts about something.”

Two participants discussed that informed consent was a core concept or element of performing the one-to-one. Joan agreed that trust was an important concept but added the component of informed consent. She describes the core concepts as “establishing rapport and trust with your patient so that they’re able to share with you and I find that it’s not something that happens instantly...Also I think making sure you have informed consent.” Bobbie also thinks that consent is important in performing the one-to-one. She states that core concepts include “getting their consent. Making sure they actually want to talk...maintaining respect throughout it. Maintaining safety.”

Finally one participant states that therapeutic communication and proxemics are core concepts of the one-to-one. Nettie described one of her most recent learning experiences:

I think that’s when I actually realized how important therapeutic communication is, is in one-on-one. For example with me, the latest learning experience was I was unaware of my proxemics, my distance...I like to get close to people. I think it’s a culture thing. And you know, other people see that as ‘oh you’re entering my bubble’ and I just have to learn that you know I can’t be side by side with them.

Self-awareness: anxiety, stigma, and personal growth. Learning communication skills and a model for performing the one-to-one in order to properly assess, empower, and connect with the client was deemed important by the participants. However, the participants agreed that being aware of oneself while performing the one-to-one was also important. Although the context of the students’ reflections varied, they shared their thoughts on anxiety, stigma, and personal growth. Three students shared how they were

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scared to approach their clients for conversations at the beginning of their mental health rotations. The first two admit to having stigma against mental illness at the beginning of the rotation. For example, Jordan discussed her experience of learning to perform a one-to-one:

Mostly that I was really afraid of mental health. It scared me, not so much the violent part of it...they might not see me as the good nurse that I'm trying to be...And that I have a stigma against mental illness. It took me awhile to realize that I don't really think of it as highly as I probably should...I might not like what I'm doing now but you know in the be all end all it's well worth it because you do it everywhere.

Wapo described his initial fear at performing a one-to-one, and how the stigma he held affected his approach to the one-to-one:

This is dealing with someone with mental illness...somebody who might not want to be in the place. So I was somewhat afraid...at the start part of having that stigma toward some of the patients was going in and dealing with patients who might be lying to you...but it was hard at the start to understand that's a part of their illness...I started thinking medically. Your heart can get sick. Your lungs can get sick. Your kidneys can get sick and your liver gets sick. And then I think...your brain can get sick. And you know...it started making way more sense to me...You don't think about the brain getting sick and how the brain will act out...So for me that's when something started changing and then it's helped with that stigma thing. Saying yeah, you're right. Your brain is sick. And we need to get you better.

Robbie describes how it was scary in the beginning, but she also feels comfortable in her skill development, and also remarks on being aware of her physical presentation during the one-to-one:

It was scary at first. I was afraid to do it...I feel more comfortable now...It definitely made me aware of things that I don't notice about myself...even the way I *sit* sometimes I, I cross my *legs* and I'm not necessarily directed...I think if anything it's gonna help me develop a greater understanding of one to one interviews and who I am conducting a one-to-one interview... I think that whenever you reflect on past experiences or past educational experiences, I think it can only help you.

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Four students discussed how reflecting on their communication skills, including non-verbal communication and proxemics, have influenced their progress in conducting the one-to-one. Jane discussed one of her initial experiences performing a one-to-one with a client, and how she had to use her communication skills to rephrase her questions and redirect the client:

I was talking with her in the beginning and then I asked her well I want to know some of your thoughts. And she goes, well, that's a dumb question. And right away...I just didn't know what to say. I just was really shocked with it and I just sat there...oh my gosh, my patient just told me that's a dumb question...I felt like really little at that time but as I went on with it...I think it was the same kind of situation...and I was asking well can you elaborate on how you're thinking about that and how you're feeling about that? And she goes, well how are you feeling about it? And I just redirected and said well I want to understand how you're thinking about it so I can better find ways and routines to help you with how you're feeling and how you're thinking and get to know you better. Because I'm here to help you and...I was a little more comfortable with her.

Wapo agreed that communication skills are important, and discussed how for him, tone of voice and eye contact were key factors to consider when performing a one-to-one:

Since I'm a male...there's different techniques...just last week I did an admission at a unit and when I came out of the admission I thought that I almost intimidated my client when I said something in a tone of voice...I saw the way they reacted and that's not at all the way I wanted to come across...I'm always aware of what I'm doing, my eye contact, my tone of voice, especially in there sometimes that you just don't think about it you just speak. And people see it different and because they see my size they *listen* maybe a little bit better than they would for a smaller nurse.

Joan discussed that she learned about the use of silence as a therapeutic communication technique while performing the one-to-one, and explained its importance:

I think maybe not always knowing what to say...it's kind of interesting because you're always afraid well, what if I say the wrong thing. But I've found that it's not really what you say sometimes. Even just being silent or the non-verbals can help. Sometimes when a patient shares something that's really upsetting to them or really hurtful I find it's better to...ask them to share more about it or be silent to let them share what they want to share...that's something that's hard to be comfortable with. Because in our society we're so used to talking, talking, talking

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and then silences are awkward. But they don't necessarily have to be awkward. It just depends on the context.

Nettie described how feedback following a viewed interaction in a role play setting assisted her in becoming more self aware of her body language when performing a one-to-one:

I had no idea that I actually do weird body movements like shakes and tics and twitches... So knowing *that* when I actually see a patient I am trying not to twitch or move and I think I've just gotten more aware of my body language...their feedback was really, really, really helpful in viewed one-to-one...as intimidating as it is to be watched. It is helpful, it really is!

Two students comment on the value of reflection on the part of the student, and the influence that has on learning to perform a one-to-one. Joan explained how guidance from her instructor helped her reflection and described how she then approached performing the one-to-one with her client:

You know reading about insight I got that it's just the person's understanding of their mental illness...but he talked to us about it being the person's understanding of how their mental illness affects their lives...so, that's what we first started talking about, how having schizophrenia affected her life and it was interesting to listen to *how* it did and it was on a personal level with relationships and family...I learned a lot from her with that interaction.

Bobbie stated that discussing the one-to-one afterwards with a peer or her instructor was helpful in providing immediate feedback and suggestions:

I find it really helpful to think about it after. Sometimes for the self-reflection to actually benefit me I almost need to say it out loud...Sometimes when you're just thinking about yourself, you don't get the depth but saying it out loud and discussing it, I find I get a lot more from the reflection.

Students' Learning

After describing their perceptions of what the one-to-one is, models and core concepts of the one-to-one, and self-awareness while conducting the one-to-one, students were asked to discuss their learning surrounding the one-to-one. The second theme,

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Students' Learning, contains students' descriptions of their progress, their most meaningful experiences, and challenges that they faced while learning how to conduct the one-to-one in the mental health setting. Subtheme One, *"Not Just Fluff": Learning to Perform the One-to-One (Skill Development)*, includes the students' perceptions of their progress in learning about this complex concept. Subtheme Two, *"Get One Step Closer" to the "Personal Connection": Most Meaningful Experiences of Performing the One-to-One*, includes the students' most meaningful experiences of performing the one-to-one. Subtheme Three, *"Not as Scary as You Think": Challenges and Advice*, includes the students' views on challenges surrounding learning about this complex concept and advice for future students learning to conduct the one-to-one.

"Not just fluff": learning to perform the one-to-one. Participants shared thoughts about the progress they have made in learning to perform a one-to-one, moving from the unknown to a level of proficiency at asking sensitive or personal questions of clients, rather than just asking superficial "fluff" type questions. As Nettie explains:

In the beginning I really had no clue how to do a one-to-one. Like, I've spoken with patients and it was just a superficial discussion? And now...I can actually talk to people and learn about why they're in the hospital and why they're there and how they're going to better themselves so they can leave. And so I think that's kind of where I'm at with the one-to-ones right now like I can actually talk to them and get something out of it instead of just superficially talking about fluff.

Joan agreed that it took time to become more comfortable talking to clients on more than a superficial level. Joan described:

It's better to kind of focus it on one thing and explore that because...if it jumps around too much then you might not really get to the bottom of why things are happening, if you're asking all these questions and it's on a superficial level...I just found I became more comfortable because I was able to, based on what the client is sharing with me, determine what areas would be good to focus on and what communication techniques are effective.

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Bobbie also thinks that learning to perform the one-to-one is a process, and describes her initial hesitations regarding performing a one-to-one:

I think now it's a lot easier to ask the harder questions, about substance use or suicide. Asking those more *detailed* questions...Because at the beginning you're hesitant, do I want bring up suicide? What if then they start thinking about it more...you have those hesitations as a student...You think well, they're not going to tell me...but now that I have had a patient that overdosed and seeing how she was able to...discuss it with me...they do want to talk about this...So sometimes acknowledging it and discussing it and dealing with it can almost benefit them and...get them to cope with it. So I think that's the student hurdle...you just need to ask the question. And doing it in a confident manner.

“Get one step closer” to the “personal connection”: most meaningful experiences of performing the one-to-one. When asked about their most meaningful experience, the participants responded with stories of personal insights that involved either a developing awareness that small progress is still progress, or the personal connection with their clients. Three participants mentioned that their most meaningful experience was the realization that small progress may be the goal in working with the client. For example, Jane described an experience she had with one of her clients:

Probably with my one sarcastic lady...they were moving to a new facility...And I asked her...what do you think of this facility and how do you think it's going to be for your overall goal. And she goes, “well, you know I think this is a choice in the right direction.”...even just that little bit of optimism in her is a *big* thing. And it was great for her.

Terri agreed that sometimes small progress has to be appreciated when performing the one-to-one. Terri describes an experience working with one of her clients who experienced paranoid delusions:

It was almost like she didn't remember the prior day, this conversation, so it was almost like starting fresh. So I could take a different approach every day...that was probably the best one because she was so difficult...that's going back to the whole mentality of I can fix you. So I didn't feel that I was able to orientate her to reality. But I think I was able to improve her, I was able to socialize with her a little bit more and give her *that* at least. Just being able to try out different

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approaches with her...it was beneficial because some she responded well to and others, she shut down right away.

Jordan also agreed that small progress is sometimes the goal. Jordan shared her realization about this while performing a one-to-one with her client:

It all clicked after I did his one-to-one the other day...The point is not to try and change them every time you talk to them it's just to get one step closer to whatever you're trying to do...you're not going to make big changes in one day...We talked a lot about his beliefs and a lot about just general experiences sort of thing and then all of the sudden...we just found out that he had no insight whatsoever. Didn't know why he was there. Didn't know that he even had a disease and I just thought, this is what we go for.

Other students commented that it was the personal connection with their client that was meaningful for them. Three students shared that was their experience when performing the one-to-one. For example, Wapo shared his experience of his first connection with a client when performing a one-to-one:

The most meaningful one of the one-to-one was my first one...he was willing to talk about his illness. And about how he felt and how he thought people perceived him. And how I might perceive him. And the things he was seeing. So I actually think my first viewed interaction with a real patient was the most meaningful one because it was it helped me break down some of that barrier that I had towards people with mental illness.

Bobbie shared her experience of connecting with her client, and further exploring a comment her client had made about the one-to-one she had just performed. Bobbie explained:

She was really depressed...And she's like some days I can and some days I can't and she's like, you must have got me on a good day at the end of the conversation. And I was like well how do you feel about the conversation, how are you feeling now. 'Cause I didn't want her leaving feeling upset...I focused on how she was feeling...how she coped with it and how she felt she needed to change...I left feeling like I had actually helped...it was pretty rewarding and quite meaningful...she could have just sat in the unit...but never really explored into anything or talked about anything or seen the benefits of talking about it.

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Nettie agreed that for her, the personal connection was the most meaningful experience regarding the one-to-one. Nettie described:

I think the most meaningful thing for me is that personal connection. When your eyes meet and you understand each other. To me that's really meaningful. And if the patient truly, honestly pour their hearts out to me I value that *so* much. And you know at the end of the day, you know you instilled the hope part. And they come back to you and say you know what? I'm so glad you asked me that question because now I'm able to think what really gives my life meaning.

“Not as scary as you think”: challenges and advice. Each of the participants mentioned challenges related to learning how to conduct a one-to-one. Students discussed their thoughts regarding anxieties, communication skills, and being patient and flexible with learning environments. Three students share their thoughts on anxiety surrounding conducting a one-to-one in the mental health setting. Robbie, for example, explained:

I'd probably say that it's *not* as scary as you think it is. That it's not as frightening and prim and proper as you think it is...It's like having a conversation except you're outlining or guiding it to where you want it to go. And I would give them this advice just because I stressed over it before I actually did it.

Jane also had advice for students who are scared to approach conducting the one-to-one:

I think one of the things is the client is just as scared as you are... You're a stranger to them. You're another face that they don't really trust and don't really know and some people can be quite paranoid and such. You have to understand that you're scared but the client can be just as scared as you. And you have no reason to be nervous. They're human just like us and really sitting down and having just a conversation with them makes a big difference, it really does. It can make a huge difference just sitting down with them and *listening* to them can really make a huge difference.

Jordan shared her advice on how to overcome the initial anxiety of approaching a client to conduct a one-to-one:

I would probably say work in pairs, or go together. Just because *I* was so intimidated with it, I think that might have helped me in the beginning...Just not to be afraid so much because it's really not that scary...They're not out to hurt

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you, nobody's going to say that you're dumb when you don't know what you're doing or anything. Because they're just there for help too so that's probably what I'd tell them.

In addition to sharing advice about overcoming anxiety surrounding conducting the one-to-one, students also felt that having strong communication skills helps to overcome barriers when conducting a one-to-one. For example, Nettie described her thoughts on the first year communication skills class and how it relates to learning about the one-to-one:

There's been a lot of moans and groans about first year communication class. *A lot*. And if I can sit in...the first year students' class I'd be telling them, immerse yourself in all these techniques. Immerse yourself in how to talk properly. Because it's what you are going to do, and to be able to talk to people properly is going to help you *a lot*. So don't moan and groan right now. Just take it as it is. Learn as much as you can from it, because it's not going to go away...And in mental health you do a lot of talking, and a lot of therapeutic communication...That's what I would tell them. Just accept it and learn it and learn to love it.

As much as participants agree that it is important to address their anxieties surrounding conducting the one-to-one, and that strong communication skills are also vital, another important concept was the idea of being patient and flexible while learning how to conduct the one-to-one. One student relates this concept to her own attitude.

Terri explained:

Probably getting past the 'I want to fix you' mentality. Because you can't exactly...I wasn't at the acute point? So these people were for the most part stable...You know, you can make them comfortable, you can improve their quality of life by getting rid of the voices or the visions...I think the challenge was getting over that...I'm in nursing to make people, you know, healthy!...Being immersed in it during clinical really helped because...that's what you see every day and you...just learn that way I guess. It's like going to France and not speaking French. You immerse yourself in the culture of mental illness and you learn that way.

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A second student, Wapo, related the concept of being patient and flexible to his experience of working with different clinical instructors throughout his mental health rotation:

The experiences have been good although sometimes they've been different, mixing results when you go from instructor to instructor... In my first rotation I took the advice from my first instructor and did that. And I did that with my *second* instructor and then she gave me the opposite information... so pretty much I've adapted to the instructor to do my one-on-one, according to how they would like it to be done. That being said, knowing when I finish I'll probably do it my own way and use, use both of their ideas.

Learning and Evaluation Strategies

Although it has been worthwhile to explore the students' perspectives on their learning progress, their meaningful experiences, and the challenges they have faced, it is also important to explore how the students have learned and how they have been evaluated during their learning. The third theme, Learning and Evaluation Strategies, includes the students' descriptions of the learning strategies and resources that have assisted in their learning, as well as the evaluation strategies used in assessing their learning of the one-to-one. Subtheme One, *Watching Me Watching You: Role Plays and Viewed One-to-Ones*, includes the students' descriptions of role plays and viewed one-to-ones and the benefits associated with each strategy. Subtheme Two, *Facial Expressions or Verbal Feedback: Informal vs. Formal Evaluation*, includes the students' descriptions of how their learning of the one-to-one was evaluated.

Watching me watching you: Role plays and viewed one-to-ones. The participants shared their thoughts on the learning strategies and resources that assisted them in learning how to perform a one-to-one in the mental health setting. The participants discussed role plays, viewed interactions, and the guidance from the

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instructor as being valuable. Two participants discussed the value of the role plays in their learning. For example, Jane described the opportunity to role play a one-to-one with an instructor displaying characteristics of each of the disorders during orientation. Jane explained, “I think that was really good dealing with mental illnesses separately and seeing how they can impact you. And how you would go about doing such with someone in their manic phase.” Wapo agreed that role playing the one-to-one was valuable to his learning. He described the realistic role plays with his instructor and how the feedback influenced his learning:

When she made us do one-on-one interviews with her imitating patients and she was quite out there when it came to some women, almost imitated patients to reality...it was actually quite helpful and she had us do it within the entire group watching it. So then...she made the rest of the group critique us. So you did not only have her critique, you know her constructive criticism, but you had all your other fellow peers’ constructive criticism at that time. Which, in fact made me feel more comfortable going into the clinical setting.

In addition to role plays with their instructors, two students also commented on viewed interactions and guidance from instructors as helpful in learning how to conduct a one-to-one. For example, Nettie described her experience with her instructor viewing her performance of a one-to-one:

A lot feedback has been really helpful. And I think that’s really the only thing that’s helping me right now...when we do the viewed one-to-one, just that back side of the page where you get to reflect on your communication, build rapport and...you pick out all the stuff that you think you did well and all the stuff you didn’t do so well and even I can pick out...I should have empathized at that part of the conversation...the feedback from teachers really, really help...They know, you guys know your stuff. You’re very observant.

Robbie agreed that feedback given during viewed one-to-ones were beneficial to her learning also, but she went on to describe how her role as observer was helpful to her learning:

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I think watching somebody else do it has been really effective. I've watched my clinical instructor and my peers both conduct one-to-ones and I think that's really beneficial because you really learn from...watching them. You observe what they're doing and their actions and why they're saying what they're saying. And then you translate that into a way you conduct a one-to-one. I think you really become morphed by whatever clinical instructor you have, because *that* sets the tone of what you're going to be for the rest of your life. How you're going to conduct one-to-one interviews for the rest of your life.

Other participants also mentioned that their instructors were a valuable resource for them, and that the instructors' experience and guidance is helpful when student experience is limited. Wapo shared his experience with his first mental health admission, and how his instructor was a resource to his learning while maintaining his confidence in front of his patient:

I've leaned heavily on their advice and their experiences because my experiences of dealing with acute mental illnesses is...I don't have any...For example, last week I was able to do my first admission, my first acute admission into the hospital. And it was much different than any other ones I've done like in a medical setting...she was there right beside me helping me, guiding me. And she knew when I was struggling to get some information out...I didn't have to ask because she would stop...to ask questions...she knew that you needed the help. So before you would stop in the middle of the admission and ask in front of the patient, I need help, she would cut in. That was nice. I appreciated that.

Finally, Joan describes instructors as a resource to student learning in multiple ways:

The biggest resource I would find would be instructors. Whether it's...watching you during the viewed interactions and providing feedback or just even reading through the chart and then commenting on what areas that you could further explore...Just giving suggestions for other things that you could do. And then also...sometimes...you might have something happening that may be a difficult topic to broach, they can give you suggestions for doing that and I find that's really helpful. Because they often have that experience.

Facial expressions or verbal feedback: Informal vs. formal evaluation.

An exploration of students' views of learning how to perform the one-to-one would not be complete without including their thoughts on the evaluation of their learning. Participants were invited to share their thoughts on how to evaluate student

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learning surrounding conducting the one-to-one. Some participants discussed informal methods such as their own experience with the clients' response to their interaction and others discussed experiences that were examples of more formal methods of evaluation. Three participants shared their thoughts about informal evaluation processes. Nettie describes how she uses the client's response to the interaction as a method to evaluate her performance during the one-to-one:

I think you would tell with their facial expression. Most of my clients...they smiled to me and once they opened their mouth you can't stop them from talking, and to me that's opening up. Whereas I've had a patient who totally shut me out, too, and I know their signs because I'll ask them a question and they'll respond one answer and then they'll turn their head, then I know they're not going to open up to me. And I've tried different angles like leaving them for a little bit and come back and asking them and they're the same way or...I'll ask them do you want to go for a walk, do you want to play cards and they still shut me out...if you can get them talking that's when I know they'll open up to me.

Jane also uses the client's response to her one-to-one as a method of evaluation, in addition to self reflection:

I feel like its improving. That I've been able to self evaluate a little bit. Definitely. And reflect on the different types of interviews that I've had and the progress that I've had with my patients...when we think of different statement that they've said and really what they're trying to mean by those statements...it's really important to see how far you've come and the different things that you've done...to boost your confidence...getting a better idea of how you can improve your client's care.

Terri agreed that the client's response to her one-to-one was also used to evaluate her learning how to perform the one-to-one. She described her reflection on the progress she made with one of her patients:

I think it was just how far I got in comparison to the day before...today she's actually talking...giving me a little bit of her background...and this is further than I got yesterday. So I would consider that to be growth...today I'm asking the right questions.

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On the other hand, some students mentioned more formal methods of evaluation as being helpful to their learning. Four participants discussed the viewed interaction, a more formal evaluation approach, as beneficial to their learning, but in varying degrees. This seemed to result from the difference between being evaluated by a peer or the instructor and the resulting feedback, and the influence of an observer during the one-to-one. Terri explained how the viewed one to one was helpful in providing a different perspective when evaluating her progress:

We actually we did do one one-to-one where our instructor evaluated us...And then another one-to-one where we were peer-evaluated as well so that was beneficial...because it's a different perspective I guess you could say...I can see myself doing one thing maybe I'm making the eye contact at the beginning, but then I get involved in what I'm thinking and what I'm trying to get out of the conversation and I'm not making that eye contact or I'm giving off a body language that I wouldn't pick up on but my peer or my instructor would.

Jane agreed that the viewed one-to-one was beneficial for her learning. She described working with the viewed one-to-one worksheet tool:

I find like the one part, the instructor provides feedback. And on the other side you provide feedback on communication techniques you used if they were effective or ways that you could make them more effective. It was just interesting just looking at the ones that I used in the beginning, the ways that I could make them more effective just trying to incorporate that into it. I think that would be maybe the biggest way that I could evaluate that...helping to show that you're learning a bit or gaining experience.

Wapo agreed that the viewed one-to-one was beneficial to his learning how to conduct the one-to-one and evaluate his progress, however he explained that there is a difference between being viewed by a peer and viewed by your instructor:

It was good and it was different when you have your instructor sitting there with you than when you have a student. When you have your instructor sitting there you're, as a student you're almost sometimes worried about how you're saying things...When the student's there you're still somewhat aware but it's different...somebody who's not *grading* you...so then I find myself more relaxed and being able to do the interview.

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Although Wapo felt more nervous about being viewed by his instructor, and perhaps felt that the student viewed interactions were more helpful, Bobbie had a different perspective. Bobbie explained that she felt she received more from the instructor viewed one-to-one as compared to the peer viewed one-to-one:

I feel from peers it's more positive...And I found they'd give more critique *verbally* than what they had written down. So you don't get to go back to it as much but you still got the information. Whereas with the instructor it was even...you did this really good, there was a lot of positive reinforcement but also...suggestions of improvement and changing but there was definitely those differences. I felt I got *more* out of the instructor on how to improve. Whereas the student, you just felt good about it after... because you got all this positive reinforcement.

Chapter Six: Discussion

The purpose of this descriptive qualitative study was to explore mental health nursing instructors' and mental health nursing students' experiences and perceptions of teaching and learning how to conduct a one-to-one as it occurs within the mental health setting. Findings of interest include mutual areas of concern for instructors and students. The lack of literature describing how to conduct a one-to-one or how to teach the concept of the one-to-one makes learning how to conduct a one-to-one challenging for students, and makes teaching how to conduct a one-to-one frustrating for instructors. It seems that nurses have their own constructions or concepts of the one-to-one, and there appears to be a folkloric legacy within mental health nursing education in that instructors teach as they were taught, and their students will conduct one-to-ones in a manner influenced by their clinical instructor. As one instructor, John, describes:

I teach how I've been taught...I don't know that I've ever learned how to teach the one-to-one...So basically what I'm teaching students like I mentioned before, was...how I've been taught to do them myself...there's not a step by step, this is how you teach it.

The students shared their views about the influences of their instructors on the performance of the one-to-one. Robbie, a student, shared:

I think watching somebody else do it has been really effective...You observe what they're doing and their actions and why they're saying what they're saying. And then you translate that into a way you conduct a one-to-one. I think you really become morphed by whatever clinical instructor you have, because *that* sets the tone of what you're going to be for the rest of your life. How you're going to conduct one-to-one interviews for the rest of your life.

A second student, Wapo, added a level of complexity to the discussion when he stated:

The experiences have been good although sometimes they've been different, mixing results when you go from instructor to instructor...In my first rotation I took the advice from my first instructor and did that. And I did that with my *second* instructor and then she gave me the opposite information...so pretty much

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I've adapted to the instructor to do my one-on-one, according to how they would like it to be done. That being said, knowing when I finish I'll probably do it my own way and use, use both of their ideas.

This leads to much debate when students are trying to grasp the concept of the one-to-one and learn the basics of performing this skill with their patients in the clinical setting, and students are often confused as to which way a one-to-one should be performed. Students and instructors remarked on initial student anxieties when approaching a patient to conduct a one-to-one, and that the students benefit from a supportive and flexible learning environment.

Although the term one-to-one was not fully articulated within the literature review, there are some similarities present between findings from this study and studies in the literature. Both the students and instructors within this study have stated that therapeutic communication skills were important to the nurse-client relationship and the performance of the one-to-one. Students shared examples of when their communication skills had been effective, ineffective, and how their skills had developed over time. Students also stated that empathy was important to the quality of the one-to-one, and that without empathy the connection to the client would be negatively influenced or even absent. Findings from the literature review supported these statements. Silverstein (2006) stated that therapeutic interpersonal interactions are quintessential competencies for psychiatric nurses. Empathy has been identified as an essential skill by Perraud, Delaney, Carlson-Sabelli, Johnson, Shepard and Paun (2006), Travelbee (1964), and Bischko (1998). This study indicates that nurses and the one-to-one have value within mental health, for example, Karl states that when teaching the one-to-one, he strives to leave students with the idea that there is something valuable that we can do as nurses.

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Gastmans (1998) states that Peplau has made a clear ethical choice by placing relations at the center of nursing and that the relationship is not only the place where the practice of care takes concrete shape, but it is also the most significant source of knowledge for theory.

Building rapport and trust were mentioned by the students in this study. Several of the students mentioned that trust was a core component to the one-to-one. They described how the development of trust within the nurse-client relationship allowed for deeper and more meaningful one-to-ones with their clients. They also described how they were able to build rapport with their clients, and earn the trust of their clients, in order to enhance the working phase of the therapeutic relationship. These findings are supported by findings within nursing literature. Trust, power, mutuality, self-revelation, congruence and authenticity are themes in the therapeutic relationship identified by Welch (2005). Travelbee (1963) emphasizes the development of rapport with the client as an important skill.

Students in this study also identified the therapeutic relationship and communication skills as important in their clients' recovery, and they each described their learning as a process. Self-reflection was mentioned as an important tool in the development and refinement of therapeutic communication skills by both instructors and students within this study. The therapeutic relationship and communication skills have been outlined as important components of mental health nursing care within the literature to date. The need to understand the client's concerns through the therapeutic relationship has been described by Mac Neela, Scott, Treacy, and Hyde (2007) and they have identified communication skills as a nursing strength arising from nurses' distinctive role

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in health care. However, Burnard and Morrison (2005) identified the need for further training so nurses could move from their self-identified authoritative (prescriptive, informative, and confronting) approaches to facilitative (supportive, cathartic, and catalytic) approaches to the client.

The experience of the first encounter with a mental health patient can greatly influence student nurses' perceptions of the one-to-one and of mental health nursing. Students within this study described how a positive first one-to-one with their patient enhanced their confidence and competence when conducting subsequent one-to-ones. These findings were supported by statements within the literature review. Granskar, Edberg and Fridlund (2001) described two core categories of nursing students' experiences with patients with mental disorders; they are nursing student qualities (either focused on own needs or focused on patients' needs) and patient behavior (either rejecting nursing students or willing to engage in relationships with students) and the authors listed the resulting feelings of the nursing students.

Students within this study described how their perceptions of their contributions to client care were enhanced by positive encouragement from the staff on the units. This finding is supported by information within the literature review. Psychiatric nurses rated the contributions of nursing students significantly higher than did nurses working on perinatal units, according to Matsumura, Clark Callister, Palmer, Harmer Cox and Larsen (2004), and they go on to list five factors that influence staff nurse perceptions: student preparation, student qualities, level of students, the influence of the clinical instructor, and ways in which having students promotes professional growth in staff nurses.

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Students within this study described a reduction or elimination of the stigma they held for mental health clients throughout their clinical experience. Students described feeling more confident about their communication skills by the end of their mental health clinical experience, and also described how their initial anxieties decreased throughout the semester with more interactions with mental health clients. These statements were also corroborated by findings from the literature. Madianos, Priami, Alevisopoulos, Koukia, and Rogakou (2005) state that lecturing and field experience are effective in changing stereotypes of persons with mental illness in undergraduate nursing students. Emrich, Cervantez Thompson and Moore (2003) state that student attitudes are more positive at the completion of an experience, and that attitudes are influenced by exposure to factual information, talking with clients with mental illness, treatment options available, and use of fear-reducing strategies.

Although there were similarities among the findings from this study and the literature, there were also some contrasts. Findings from this study indicate that nurses continue to conduct one-to-ones with their patients on the inpatient psychiatric units in Lethbridge, Alberta, and nursing students continue to be taught to conduct one-to-ones within their mental health nursing rotations. This was not supported by the literature review, where it is mentioned that there is a lack of time to interact meaningfully with clients in the inpatient setting and Shattell (2007) suggests that 'one-to-ones' are disappearing. Could Shattell's statement be influenced by the lack of literature surrounding the one-to-one, or perhaps by the apparent inability to clearly articulate how to perform a competent one-to-one?

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The findings of this study stress that the therapeutic relationship, and more specifically the one-to-one, are vital to the patients' recovery. However, O'Brien (2001) states that mental health nursing has a number of possible future directions, not all of them compatible with the same concept of therapeutic relationship.

Implications for Nursing Education

Students state that they are challenged by the lack of direction and education regarding theories and models of how to perform the one-to-one. One solution to this challenge is to role play the one-to-one in a safe setting with the students. Students feel role playing is very valuable, not only watching instructors role play to observe how to interact with a patient, but being able to role play themselves in a safe environment adds richness to the learning experience. The findings of this study contain students' descriptions of the experiences they had learning to conduct the one-to-one within the mental health setting. Students describe that role playing with their instructor has been a valuable learning tool in trying therapeutic communication skills in a safe environment and that receiving feedback immediately is helpful to the development of their skills. Students also describe how they viewed one-to-one as a useful learning tool, as feedback from an observer often illuminates areas for improvement that the student had not yet considered, such as non-verbal body language. Further development and use of similar teaching strategies would be of benefit to student development.

Students within this study explained the importance of self-reflection during their mental health rotation, particularly when it came to skill development when conducting the one-to-one. Students described how they coped with initial anxieties with support and guidance from their instructors, how feedback was essential to developing

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therapeutic communication skills (both verbal and non-verbal), and how reflection helped them to overcome any stigma they may have held toward mental health clients.

Reflective exercises need to be available for students in order to develop and enhance skills and self-awareness when performing the one-to-one. Students described how reflection was vital to the learning process surrounding the one-to-one, and that their instructors' guidance was an important aspect of the reflective process.

Instructors must be able to clearly articulate a variety of approaches to conducting the one-to-one, as it seems that there is no cookie cutter approach to conducting the one-to-one. Within this study this was viewed as a challenge. As Kathy described, the one-to-one is not like a dressing change, as there is difficulty articulating something that you do innately, and confusion surrounding teaching something that can be different every time we conduct the one-to-one. It is imperative that instructors have strong one-to-one skills themselves, as Karl described, in order to teach strong skills to the students.

Instructors must be open and flexible to new teaching strategies, and work together within nursing education programs to provide consistency when teaching major concepts such as the one-to-one. As students become confused when there are multiple approaches or perhaps no clear approach provided when teaching the one-to-one, instructor consistency would be beneficial to student learning. Melrose (2002) states that there is a serious lack of guidance for instructors in mental health and proposes a clinical teaching guide to improve mental health nursing education and provide consistency among nurse educators' approaches to instruction.

Students must feel supported by their instructors in order to gain both competence and confidence in their skills conducting the one-to-one. Instructor support helps to

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reduce student anxiety in an unfamiliar clinical setting, and also in approaching unfamiliar patients against whom the student may hold stigma, often influenced by the media. Instructors must maintain high standards for competency of performance in the clinical setting, but must appear approachable to students. Students within this study shared that their instructor was perhaps their greatest resource in learning how to conduct the one-to-one, and that the instructor's approach was extremely influential to their learning.

Limitations

This study had several limitations, the first of which being timeframe and budget. There was no external funding for this study, so the researcher maintained a strict budget, and the setting was restricted to the local post-secondary community which may limit broader cultural or political influences on the data. Secondly, the purposive and convenient sample for this study might limit the transferability of findings from the study to the larger population of mental health nursing instructors and students, even though it is not the goal of naturalistic inquiry to generalize findings. Third, there was the potential for bias during the study as the researcher has had a previous professional relationship with many of the proposed participants of the study. However, the researcher kept a journal to document any potential bias and was able to let the themes emerge from the data with minimal risk of misperception. Fourth, the researcher is a novice to the research process, so the potential for human error may be greater (related to interview skills or data analysis, for example). Close contact with the members of the thesis committee helped to clarify questions about the research process.

Recommendations for Further Research

The one-to-one continues to be a vague or elusive concept. There is much need for further research into the concept of the one-to-one to provide clear articulation of its concepts, its value, and guidelines on how to perform a one-to-one correctly. The development of a model would greatly enhance student learning, and perhaps in the process, ease instructor frustration surrounding the teaching of this abstract concept. There are a number of questions surrounding the research of the mental health one-to-one and the nurse-client relationship. Lego (1999) lists several questions for further research: What does/should take place in the one-to-one relationship? Can this be measured? Are certain patients susceptible to change? Should all psychiatric nurses practice this modality? What variables affect its success? How does the one-to-one relationship fit into the current delivery of health care services? These questions arose within this study also. It was difficult for participants to articulate the answers to the above questions in their entirety, although we can weave together the participants' responses as a whole to achieve a clearer picture of the one-to-one.

Chambers (1998) suggests that a pluralistic approach is necessary in order to fully understand the nature of psychiatric/mental health nursing, and discusses phenomenological and hermeneutic approaches to further research. As such, the use of a naturalistic design within the current study was an appropriate choice, and may be useful in future studies. It may also be useful to conduct other studies in a broader geographic location, to enhance the cultural and political influences on the data.

Conclusion

In this study I explored mental health nursing instructors' and mental health nursing students' experiences and perceptions of teaching and learning how to conduct a one-to-one as it occurs within the mental health setting. Chapters One and Six serve as introduction and conclusion to the study. In Chapter Two, I explored the literature surrounding the phenomenon of the one-to-one, and factors that may influence the teaching and learning of the one-to-one in the mental health setting. In Chapter Three, I outlined the method of the study. Chapters Four and Five present the results of the study, for instructors and students respectively.

This study reinforced the need for further research into the one-to-one to define its use, the skills involved, and the steps involved in the performance of the one-to-one. A model is needed to guide teaching and learning of the one-to-one in the clinical setting in order to reduce student anxieties and instructor frustrations surrounding this concept. A more consistent approach is needed when presenting the concept of the one-to-one in the mental health nursing education setting.

Dissemination of Research

This thesis constitutes one method of knowledge transfer of the research findings. I also intend to present the findings of this study at scholarly conferences and submit Chapters Two, Four, and Five as separate papers for publication in scholarly, peer-reviewed journals. I intend to continue to encourage progress in the teaching and learning of this fundamental concept within mental health nursing education.

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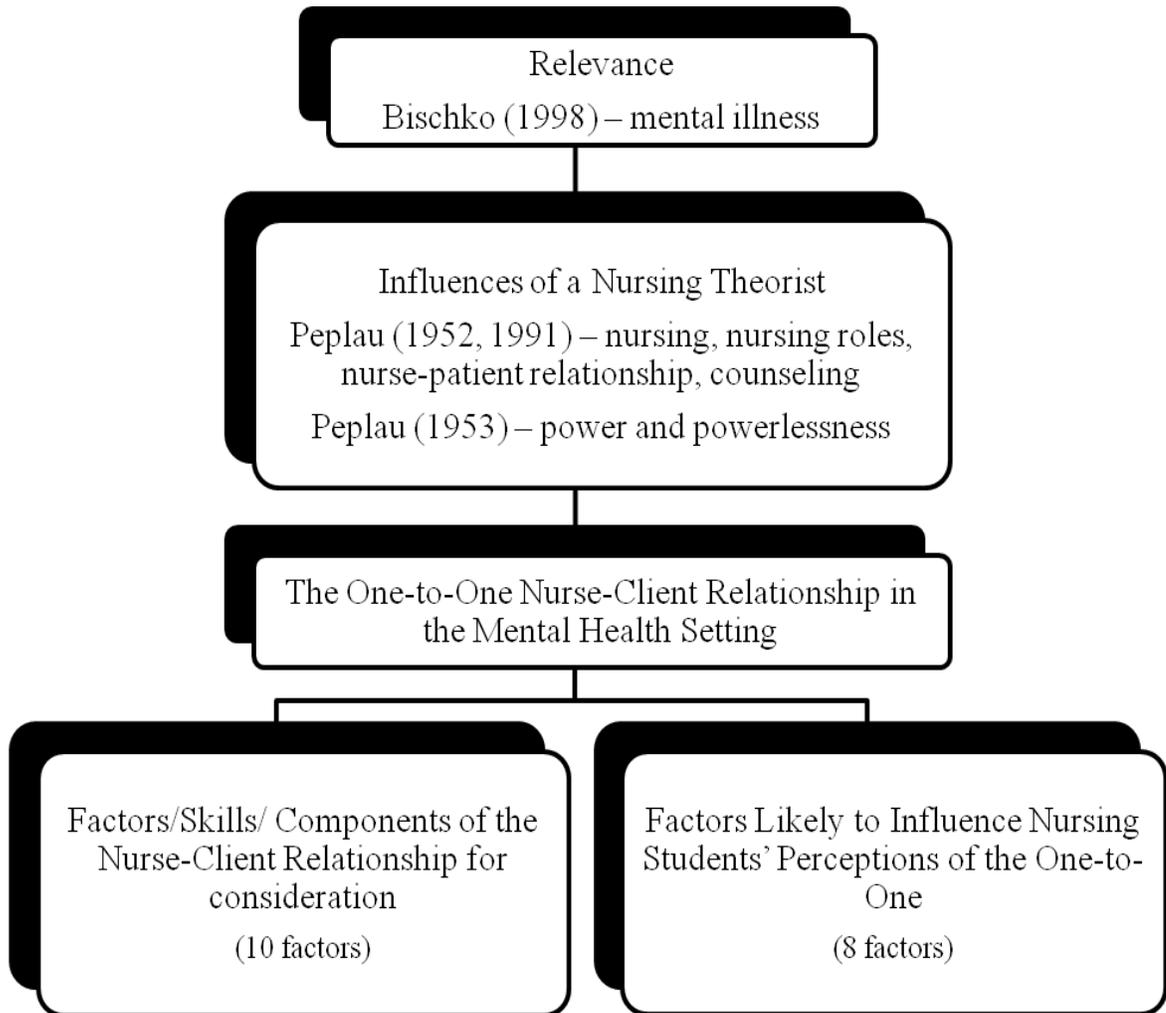
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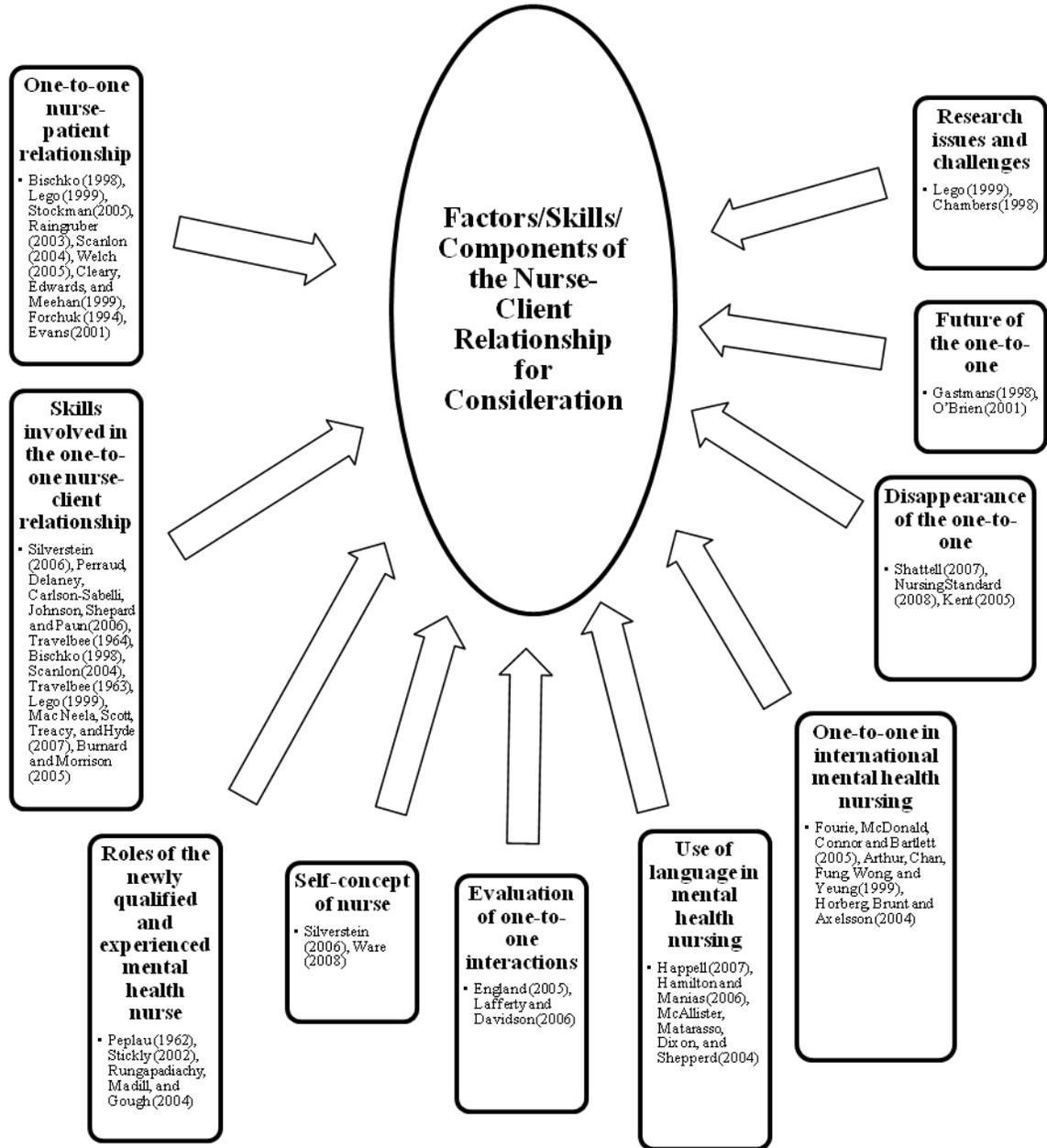
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Appendix A

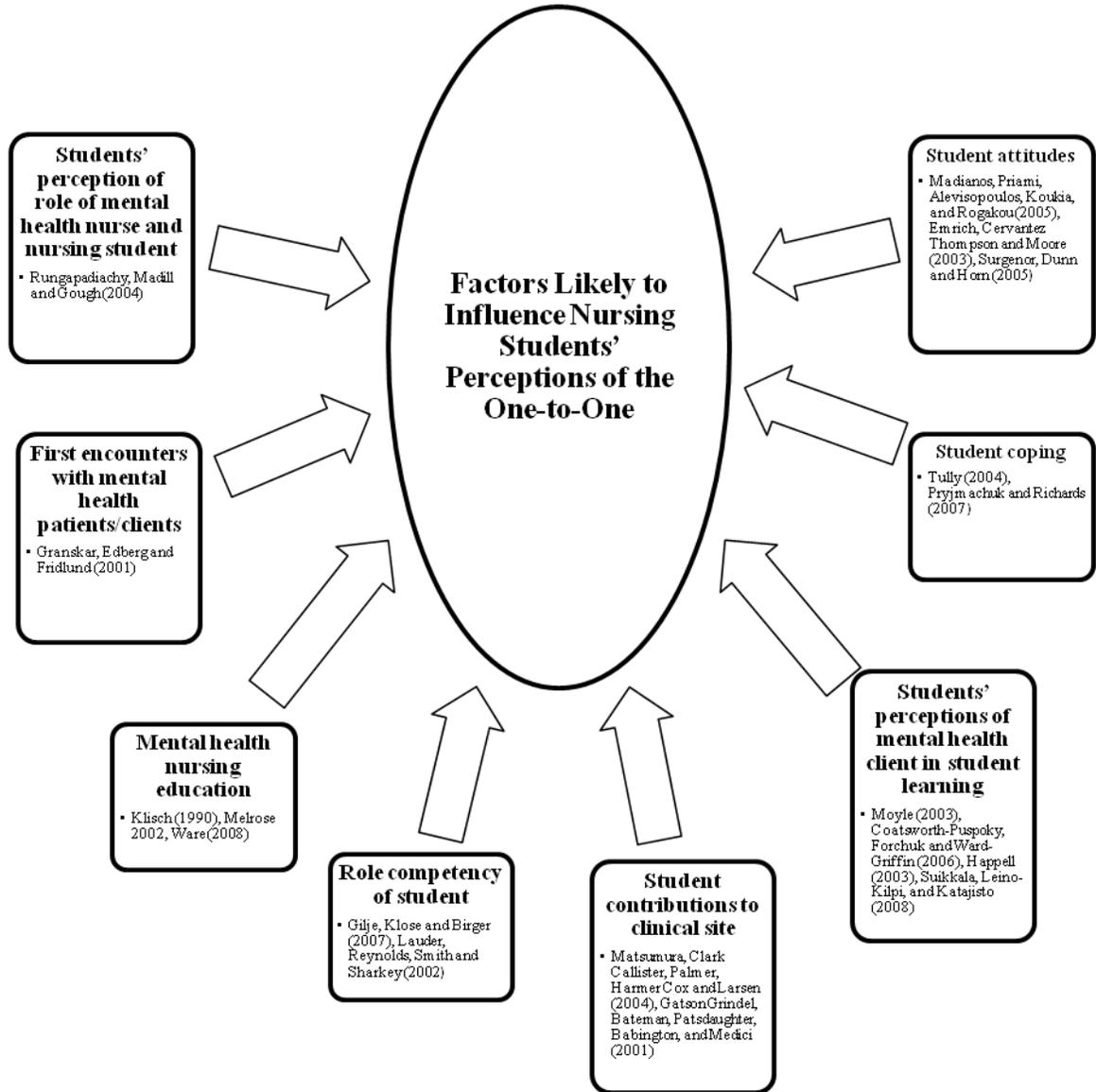
Overview: A Review of the Literature



Factors/Skills/Components of the Nurse-Client Relationship for Consideration



Factors Likely to Influence Nursing Students' Perceptions of the One-to-One



Appendix B

Poster Invitation

**Nursing Students
and Nursing
Instructors
You are needed
to explore the
mental health nursing
one-to-one!**

If you are interested
in sharing your experiences
about conducting a mental health one-to-one interview,

please contact:

Karen Leskosek

karen.leskosek@uleth.ca

403-795-1123

Appendix C

Letter of Invitation to Instructors

Karen Leskosek, RN, BN
Faculty of Health Sciences
University of Lethbridge
4401 University Drive
Lethbridge, Alberta T1K 3M4
Phone: (403)795-1123
Email: karen.leskosek@uleth.ca

July 1, 2009

Dear NESAs Mental Health Clinical Nursing Instructor,

I would like to extend an invitation to participate in a research study entitled, "Exploring the One-to-One Interview within the Context of Mental Health Nursing Education." This study will be conducted as part of a Master of Science in Nursing thesis.

The purpose of this study is to gain an understanding of the experiences and perceptions of mental health clinical nursing instructors surrounding teaching nursing students how to conduct the one-to-one interview in a mental health setting. I feel that this study has the potential to contribute to the existing knowledge of mental health clinical instruction and has significance for nursing education programs.

I am seeking participants who are Registered Nurses and have a minimum credential of a BN or BScN, and who are mental health clinical instructors within the NESAs Program at the University of Lethbridge. If you choose to participate, your participation is completely voluntary and you may withdraw from the study at any time without consequence. If you choose to withdraw, any data collected from you will be destroyed in the appropriate manner. Participation in this study involves a face-to-face interview, lasting approximately one to two hours, at a time and location convenient for you. If you consent, I would like to ask you questions about your experiences and perceptions of teaching students how to conduct a one-to-one interview, and this will allow you to share stories of these experiences and perceptions. You may share as much as you wish. With your permission, this interview will be audio-taped. There is no perceived harm or risk associated with the study. Anonymity and confidentiality will be maintained.

You will receive a small gift for your participation in the study. You may also find a personal benefit in sharing your experiences.

If you have any questions about this study, or you are interested in participating, please contact me at the number listed above. Please leave a message with your contact information in my confidential voicemail. Thank you for your consideration.

Sincerely,

Karen Leskosek

Appendix D

Letter of Invitation to Students

Karen Leskosek, RN, BN
Faculty of Health Sciences
University of Lethbridge
4401 University Drive
Lethbridge, Alberta T1K 3M4
Phone: (403)795-1123
Email: karen.leskosek@uleth.ca

October 29, 2009

Dear NESAs student,

I would like to extend an invitation to participate in a research study entitled, "Exploring the One-to-One Interview within the Context of Mental Health Nursing Education." This study will be conducted as part of a Master of Science in Nursing thesis.

The purpose of this study is to gain an understanding of the experiences and perceptions of mental health clinical nursing students surrounding learning how to conduct the one-to-one interview in a mental health setting. I feel that this study has the potential to contribute to the existing knowledge of mental health clinical instruction and has significance for nursing education programs.

I am seeking participants who are current NESAs students and have either commenced or completed their mental health clinical rotation at the University of Lethbridge. If you choose to participate, your participation is completely voluntary and you may withdraw from the study at any time without consequence. If you choose to withdraw, any data collected from you will be destroyed in the appropriate manner. Participation in this study involves a face-to-face interview, lasting approximately one to two hours, at a time and location convenient for you. If you consent, I would like to ask you questions about your experiences and perceptions of learning how to conduct a one-to-one interview, and this will allow you to share stories of these experiences and perceptions. You may share as much as you wish. With your permission, this interview will be audio-taped. There is no perceived harm or risk associated with the study. Anonymity and confidentiality will be maintained.

You will receive a small gift for your participation in the study. You may also find a personal benefit in sharing your experiences.

If you have any questions about this study, or you are interested in participating, please contact me at the number listed above. Please leave a message with your contact information in my confidential voicemail. Thank you for your consideration.

Sincerely,

Karen Leskosek

Appendix E

Participant Informed Consent Release (Instructor)



4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Phone 403.329.2699
Fax 403.329.2668

health.sciences@uleth.ca
www.uleth.ca

August 1, 2009

Dear Nursing Instructor,

You are being invited to participate in a research study exploring the mental health one-to-one interview. In particular, my interest lies in the phenomenon of teaching and learning how to conduct a one-to-one in the mental health setting. This study, *Exploring the One-to-One Interview Within the Context of Mental Health Nursing Education: A Descriptive Qualitative Study*, is the main component of my thesis work in completing my Master's of Science (Nursing) within the Faculty of Health Sciences at the University of Lethbridge. Within this study I will be interviewing both nursing instructors and nursing students.

This research will require approximately 1-2 hours of your time. During this time, you will be interviewed by me about your perceptions/experiences of teaching mental health nursing students how to conduct a one-to-one within the context of mental health nursing education.

The interview will be conducted at a place and time you feel are appropriate, and will be tape/digitally recorded (audio only) with your permission. You may also be invited to share your thoughts on a summary of the results from your interview during an email contact within a few weeks of your interview. Your participation in this study is voluntary, and you may withdraw from the study at any time without any consequences. If you choose to withdraw from the study, all information and data provided by you will be destroyed in the appropriate manner. You will be given a small gift for your participation in this study.

There are no anticipated risks or discomforts anticipated with this research. However, I can give you the names and numbers of counsellors available at the University of Lethbridge Counselling Services office to support you with any distress you may experience as a result of participation in this study.

You may also find the interview to be enjoyable and rewarding, as many instructors do not have the opportunity to share their views on this unique experience. By participating in this research, you also have the opportunity to share information that may help direct future nursing education and research.

EXPLORING THE ONE-TO-ONE

Several steps will be taken to ensure your anonymity and confidentiality. While the interviews will be recorded, the interview transcription will not contain any mention of your name or other identifying information. Pseudonyms will be used in written transcripts. However, there is a small risk that readers of the final study may identify you by the experiences that you describe. Any identifying information will be removed to minimize this risk. The researcher may hire a transcriptionist, and if so he/she will sign an oath of confidentiality. The typed interviews will be kept in a locked cabinet to which only the researcher and supervisor have access. All information will be destroyed after 5 years time.

The results from this study will be presented in writing in journals read by mental health nurses, mental health nursing instructors, and nursing students, to help them better understand the experience of teaching and learning how to conduct a one-to-one interview within the mental health setting. The results may also be presented orally to groups of mental health nurses, nursing instructors, or nursing students. If you would like to receive a summary of the results from this study, you may contact the researcher at the telephone number listed below.

If you require any information about this study, or would like to speak to the researcher, please call me, Karen Leskosek at 403-795-1123 at the University of Lethbridge. You may also contact my thesis supervisor, Dr. Brad Hagen at 403-329-2299. If you have any other questions regarding your rights as a participant in this research, you may also contact the Office of Research Services at the University of Lethbridge at 403-329-2747.

Yours sincerely,

Karen Leskosek, RN, BN, Master's Student
Academic Assistant/Nursing Instructor
Faculty of Health Sciences
University of Lethbridge
403-795-1123
karen.leskosek@uleth.ca

I have read the above information regarding this research study on the experience of teaching and learning how to conduct a one-to-one, and I consent to participate in the study.

_____ (Printed Name)

_____ (Signature)

_____ (Date)

Appendix F

Participant Informed Consent Release (Student)



4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Phone 403.329.2699
Fax 403.329.2668

health.sciences@uleth.ca
www.uleth.ca

November 1, 2009

Dear Nursing Student,

You are being invited to participate in a research study exploring the mental health one-to-one interview. In particular, my interest lies in the phenomenon of teaching and learning how to conduct a one-to-one in the mental health setting. This study, *Exploring the One-to-One Interview Within the Context of Mental Health Nursing Education: A Descriptive Qualitative Study*, is the main component of my thesis work in completing my Master's of Science (Nursing) within the Faculty of Health Sciences at the University of Lethbridge. Within this study I will be interviewing both nursing instructors and nursing students.

This research will require approximately 1-2 hours of your time. During this time, you will be interviewed by me about your perceptions/experiences of learning how to conduct a one-to-one within the context of mental health nursing education.

The interview will be conducted at a place and time you feel are appropriate, and will be tape/digitally recorded (audio only) with your permission. You may also be invited to share your thoughts on a summary of the results from your interview during an email contact within a few weeks of your interview. Your participation in this study is voluntary, and you may withdraw from the study at any time without any consequences. If you choose to withdraw from the study, all information and data provided by you will be destroyed in the appropriate manner. You will be given a small gift for your participation in this study.

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You may also find the interview to be enjoyable and rewarding, as many students do not have the opportunity to share their views on this unique experience. By participating in this research, you also have the opportunity to share information that may help direct future nursing education and research.

EXPLORING THE ONE-TO-ONE

Several steps will be taken to ensure your anonymity and confidentiality. While the interviews will be recorded, the interview transcription will not contain any mention of your name or other identifying information. Pseudonyms will be used in written transcripts. However, there is a small risk that readers of the final study may identify you by the experiences that you describe. Any identifying information will be removed to minimize this risk. The researcher may hire a transcriptionist, and if so he/she will sign an oath of confidentiality. The typed interviews will be kept in a locked cabinet to which only the researcher and supervisor have access. All information will be destroyed after 5 years time.

The results from this study will be presented in writing in journals read by mental health nurses, mental health nursing instructors, and nursing students, to help them better understand the experience of teaching and learning how to conduct a one-to-one interview within the mental health setting. The results may also be presented orally to groups of mental health nurses, nursing instructors, or nursing students. If you would like to receive a summary of the results from this study, you may contact the researcher at the telephone number listed below.

If you require any information about this study, or would like to speak to the researcher, please call me, Karen Leskosek at 403-795-1123 at the University of Lethbridge. You may also contact my thesis supervisor, Dr. Brad Hagen at 403-329-2299. If you have any other questions regarding your rights as a participant in this research, you may also contact the Office of Research Services at the University of Lethbridge at 403-329-2747.

Yours sincerely,

Karen Leskosek, RN, BN, Master's Student
Academic Assistant/Nursing Instructor
Faculty of Health Sciences
University of Lethbridge
403-795-1123
aren.leskosek@uleth.ca

I have read the above information regarding this research study on the experience of teaching and learning how to conduct a one-to-one, and I consent to participate in the study.

_____ (Printed Name)

_____ (Signature)

_____ (Date)

Appendix G

Interview Guide for Nursing Instructors

1. What have been your experiences/perceptions of teaching mental health nursing students how to conduct a one-to-one?
2. What do you think are the core elements of conducting a one-to-one?
3. What teaching resources do you use?
4. What have been your most effective strategies in teaching the one-to-one?
5. What have been your challenges/barriers in teaching the one-to-one and how did you approach these challenges?
6. Is there a model or format that you use when teaching the one-to-one? Is there a model or format that you encourage students to follow when performing a one-to-one?
7. How do you evaluate the student's learning in relation to conducting a one-to-one?
8. What was your most meaningful experience involving teaching how to conduct a one-to-one? Why?
9. Tell me how you learned to teach students how to conduct a one-to-one.
10. How has your experience as a nurse influenced your instruction of the one-to-one?
11. What advice would you have for other nursing instructors who are teaching students how to conduct a one-to-one?
12. Could you take a minute to think of a word, phrase, or picture that describes your experience of teaching how to conduct a one-to-one? Why does this resonate with you?
13. How might you approach teaching how to conduct the one-to-one following your participation in this study? Will anything be different for you?

Appendix H

Interview Guide for Nursing Students

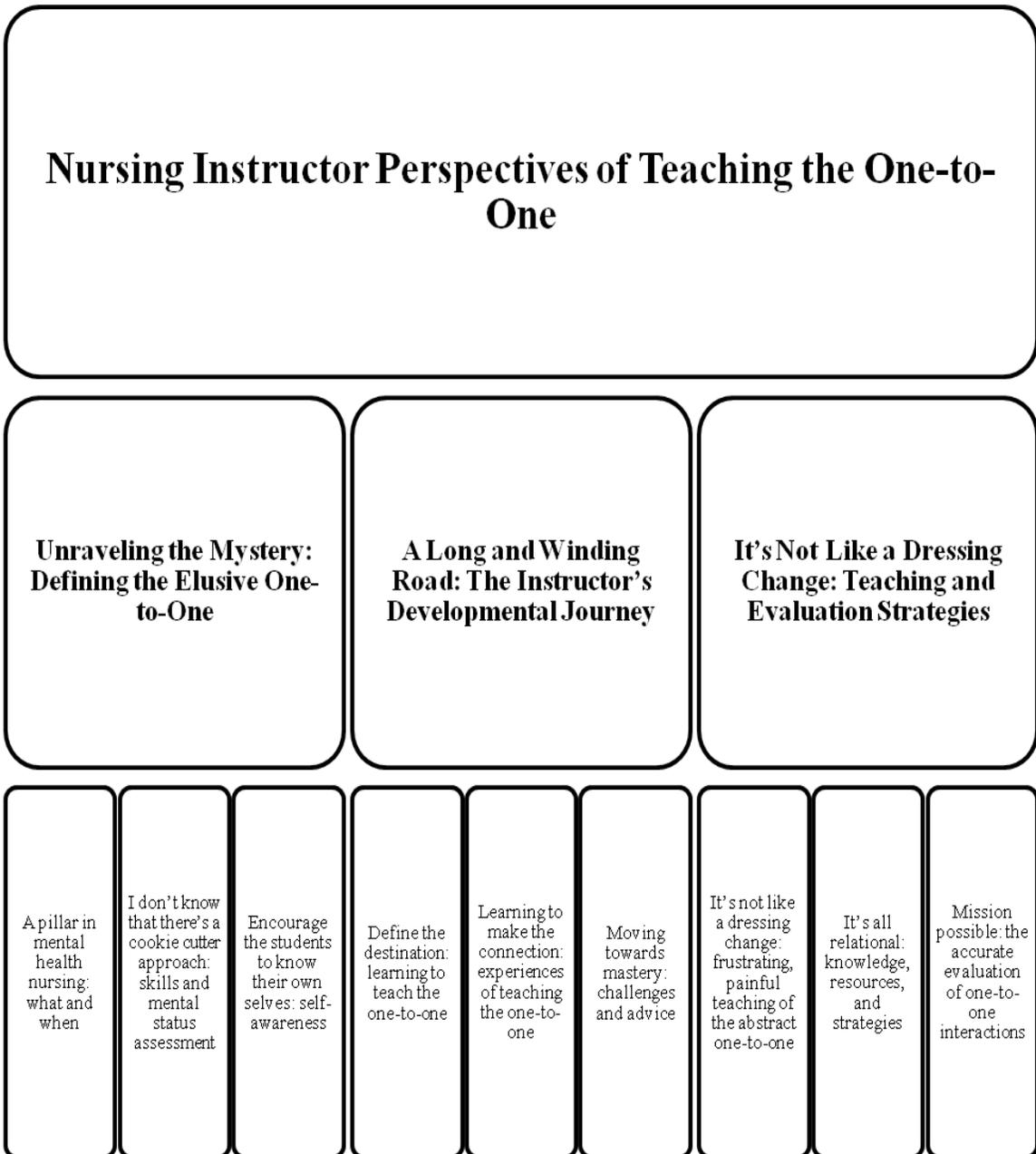
1. What have been your experiences/perceptions of learning how to conduct a one-to-one?
2. How do you prepare to conduct a one-to-one?
3. Is there a model or format that you follow when conducting a one-to-one? Please describe.
4. What do you think are the core elements of conducting a one-to-one?
5. What learning resources do you use? How have these been helpful?
6. What has been the most effective strategy for you in learning how to conduct a one-to-one? Why?
7. What have been your challenges/barriers in learning how to conduct a one-to-one and how did you approach these challenges?
8. How do you evaluate your learning in relation to conducting a one-to-one?
9. What was your most meaningful experience involving learning how to conduct a one-to-one? Why?
10. What initial feelings did you have about learning to conduct a one-to-one? (How) did these feelings change during your clinical experience?
11. What advice would you have for other nursing students who are learning how to conduct a one-to-one? Why would you give this advice?
12. What will you take away from this experience of learning to conduct a one-to-one and how and where might you apply it?
13. How does self-reflection influence your learning of the one-to-one?

EXPLORING THE ONE-TO-ONE

14. What has been the most helpful and least helpful thing in relation to your learning how to conduct a one-to-one?
15. Could you take a minute to think of a word or phrase that describes your experience of learning how to conduct a one-to-one? Why does this image/phrase resonate with you?
16. How might you approach conducting a one-to-one following your participation in this study? Will anything be different for you?
17. Is there anything else that you think is important about learning how to conduct a one-to-one, that I have not yet asked? Please explain.

Appendix I

Thematic Framework: Nursing Instructor Perspectives



Appendix J

Thematic Framework: Nursing Student Perspectives

