

What's Therapeutic About the Therapeutic Milieu?

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Abstract:

While the milieu of an inpatient facility is considered a treatment modality, extant literature focuses on the staff's role in creating the milieu rather than the patient's perception of it. Not since Goffman's *Asylums* (1961) has there been an in-depth examination of the phenomenal world of the hospitalized psychiatric patient. In this study, eight inpatients (ages 23 to 58) on the acute psychiatric unit of a metropolitan general hospital participated in phenomenological interviews about their experience of the environment. The essential meaning of the hospital was refuge from self-destructiveness. Prominent aspects of patients' experience within the place of refuge were three interrelated themes (like me/not like me, possibilities/no possibilities, and connection/disconnection). Universally, patients perceived peer-administered "therapy" as the most beneficial aspect of their hospitalization. They expressed longing for a deeper connection with staff and more intensive insight-oriented therapies. Although their needs for safety, structure, and medication were met, patients were not gaining greater understanding of their dysfunctional patterns of behavior. Renewed emphasis must be placed on the nurse-patient relationship and the therapeutic alliance.

Article:

Not since Goffman's *Asylums* (1961) has there been an in-depth examination of the phenomenal world of the hospitalized psychiatric patient. The milieu of an inpatient facility is considered a treatment modality (Peplau, 1989), and nurses are charged with creation and maintenance of this "therapeutic milieu" (American Nurses Association, 1994). Although milieu therapy was originally implemented in long-term care settings, now its concepts are applied in short-term inpatient and community settings as well (Boyd & Nihart, 1998). Its premise is that all aspects of the environment that the patient experiences should contribute to his or her care and recovery. However, extant literature focuses on the staff's role in creating the therapeutic milieu rather than the patient's perception of it. There has been little empirical examination of patients' experience. Despite Peplau's (1989, p. 76) assertion that milieu continues to be an "important subject for discussion and further investigation," there has been scant attention in recent publications. Notes Echternacht (2001, p. 43), "in the past five years, research and professional articles about the therapeutic milieu and milieu therapy concepts have been almost nonexistent."

LITERATURE REVIEW

Seminal reports by Sills (1975) and Peplau (1982, 1989) have outlined the history and precepts of the therapeutic milieu, and many textbooks present detailed explanations of nursing interventions in milieu therapy (e.g., Parios, 1984). Some investigators (Tuck & Keels, 1992)

recommend updating traditional milieu therapy because of significant changes in societal context and severe economic pressures affecting today's acute psychiatric settings. According to Peplau (1989), the milieu has both structured and unstructured components, the latter including the diverse interactions between patients, staff, and visitors that take place throughout hospitalization. Published materials tend to devote greater attention to the structured components of the milieu, such as staff-led community meetings, therapy groups, and psychoeducational classes. It is not known, however, whether patients derive more benefit from these structured components or from spontaneously occurring interpersonal interactions.

As long ago as 1980, researchers noted significant differences between patients' and nurses' perceptions of ward environments (Miller & Lee, 1980). Yet patients are seldom asked to provide first-person accounts of their lived experience while in our care on inpatient units. According to Peplau, "understanding the meaning of the experience to the patient is required in order for nursing to function as an educative, therapeutic, maturing force" (1952/1991, p. 41). Qualitative research, therefore, informs the practice of psychiatric nurses who use Peplau's theory. However, in an overview of Peplau's legacy, Haber (2000) expresses bewilderment at the dearth of qualitative studies.

Studies in other countries (Great Britain, South Africa, Canada) shed light on elements of the inpatient environment and nurse behavior that are salient to psychiatric patients (Jackson & Stevenson, 2000; Muller & Poggenpoel, 1996; Wallace, Robertson, Millar, & Frisch, 1999). In the South African study, researchers focused exclusively on patients' perceptions of their interactions with psychiatric nurses (Muller & Poggenpoel, 1996). They discovered themes of stereotyping, custodialism, rule enforcement, lack of intimacy, and lack of empathy as well as themes of caring and friendliness. Both clients and families were interviewed in the Canadian study (Wallace et al., 1999); participants revealed significant dissatisfactions with inpatient mental health care, including unmet needs, lack of involvement in treatment planning, breaches of confidentiality, inactivity, and bleakness of the physical environment. Motivated by the results of this study, hospital personnel modified the environment and the regimen of care. In the British study, professionals as well as service users participated in focus groups about nursing interventions. Among the findings were client expectations for nurses to be accessible to them, anticipate their needs, and relate to them as both friend and professional (Jackson & Stevenson, 2000). Because of important differences in philosophies of care, educational preparation of psychiatric nurses, and structural aspects of the mental health systems in these countries, it is risky to conclude that these studies are directly relevant to experiences of inpatients in the United States.

A recent qualitative study conducted by Shattell (2002) provided a glimpse of what hospitalization meant to patients on diverse units in three metropolitan general hospitals in the U.S. Patients participated in phenomenological interviews about their experience of the environment. Unexpectedly, the resultant thematic structure was different for medical patients than for psychiatric patients. For medical patients, the hospital was a confining, dangerous environment that was discordant with their sense of identity and produced feelings of disconnection and intense desire for discharge. In contrast, psychiatric patients experienced greater freedom, affirmation of identity, and possibilities—even though they were confined within a locked unit. This unexpected and intriguing finding suggested a need for conducting

additional interviews with psychiatric patients. The purpose of the present study, then, was to further explore the psychiatric patient's experience of the contemporary inpatient milieu.

METHODOLOGY

The study was conducted according to the tenets of existential phenomenology. More specifically, we used a descriptive phenomenological approach within the tradition of Husserl (1913/1931) and Merleau-Ponty (1962), as further elucidated by Pollio, Henley, and Thompson (1997) and Thomas and Pollio (2002). This approach involves a 1:1 dialogue about the participant's life-world in which the interviewer's chief responsibility is to elicit a complete and careful description of that world. Validity of a phenomenological study is judged by the reader, who considers the question, "Is there convincing evidence for believing that the thematic description affords insight into the experiential world of the participants?" (Pollio et al., 1997, p. 53).

The setting for the study was the acute psychiatric unit of a metropolitan general hospital in the southeast. The unit accommodates 20 adult inpa-

Table 1. Demographic Characteristics of Participants

Gender	Age	Education	Reason for Hospitalization
Male	48	High school	Suicide attempt, bipolar disorder
Female	34	Some college	Suicidal thoughts, bipolar disorder
Male	58	Less than high school	Substance abuse
Male	39	High school	Substance abuse
Female	23	High school	Depression, suicidal, personality disorder
Female	31	High school	OCD, ADD, bipolar disorder, borderline
Male	53	Some college	PTSD, depression
Male	47	Some college	Substance abuse, depression, panic disorder

tients and is staffed by a multidisciplinary team, including 12 registered nurses, 13 mental health associates, 2 intake staff, 1 nurse manager, 1 nurse clinician, and 1 licensed clinical social worker. Typically, when the patient census ranges between 1 and 14, the unit is staffed by 1 RN and 2 MHAs (1 MHA on night shift); a census of 15 or more is staffed by 2 RNs and 2 MHAs. Length of hospital stay averages 3 to 5 days. According to an informational pamphlet given to patients upon admission, the unit has "a strong emphasis on the quality of the milieu environment." In the procedure manual for the unit, stated goals include "providing safe and confidential treatment in a supportive and nonjudgmental environment" and "providing therapeutic and educational opportunities to facilitate individual growth and independence."

Four phenomenological interviews had been conducted on this unit for the study by Shattell (2002). Purposeful sampling was used to recruit four additional inpatients that met inclusion criteria (at least 21 years of age, not acutely distressed at the time of the interview, and willing to talk to researchers about their experience). Data were collected over a 5-month period during 2000. By the eighth interview, redundancy of thematic material was evident and data collection was terminated. Characteristics of the eight participants are presented in Table 1. Before initiating data collection, approval of the university and hospital Institutional Review Boards had been received. Each interviewer was trained in phenomenological interviewing and participated in a bracketing interview to sensitize her to presuppositions. Bracketing interviews were transcribed and subsequently read aloud and thematized in an interdisciplinary research group

that meets weekly. The interviewers were experienced master's-prepared mental health nurses currently enrolled in a doctoral program; they were not previously acquainted with any of the participants nor involved in their care. Written informed consent was obtained from all participants. The duration of each interview was approximately one hour. Interviews were audiotaped, transcribed verbatim, and analyzed according to the rigorous procedure developed by Pollio et al. (1997). This procedure includes (1) reading the transcripts for meaning units, (2) analyzing the transcripts for a sense of the whole, (3) aggregating meaning units into themes, (4) developing a thematic structure, and (5) sharing the proposed thematic structure with the research group (a step which is analogous to an external audit). Although some phenomenologists transform the language of participants into language of the researcher's discipline, we adhere to Husserl's (1913/1931) advice to characterize phenomena in the language derived from common speech. We describe meanings in the simple and powerful language of participants whenever possible.

FINDINGS

The essential meaning of the hospital to psychiatric patients was a refuge from self-destructiveness. Three interrelated themes (like me/not like me, possibilities/no possibilities, and connection/ disconnection) were the figural or dominant aspects of patients' experience within the place of refuge. As each theme is discussed in the following paragraphs, it will be illustrated with participants' words, extracted from the transcripts. All words within quotation marks are verbatim excerpts from the interview data.

REFUGE FROM SELF-DESTRUCTIVENESS

In contrast to the chaotic outside world, the hospital was portrayed as a "safe house," "neutral territory" and "a cooling place." Hospitalization provided a calming respite or "brief interlude" from the daily struggle against self-destructive impulses. Metaphorically, patients described admission as being "received" by a caring surrogate family. The choice of the word "received" suggests the embodied feeling of being swaddled in someone's arms in a warm receiving blanket. As one participant expressed it, "I can basically trust my life... into someone else's hands." Another participant compared his secure feeling on the inpatient unit with the security of an earlier time in his life when he was married: "I can remember times just being with my wife and silent night, just cuddling. Secure feeling, you know... you can close your eyes... and not have any worries... It's security, like Linus" [cartoon character known for his attachment to his security blanket].

While in the hospital, patients could "cool... head and mind," "just become limp," and "be subdued by the environment." One participant described a cocoon-like experience: "The first 2 or 3 days I just laid in here [patient's room]. Couldn't sleep, depressed...Just laid, kept the drapes shut and the lights off and just stayed by myself for 2 days." All participants described the hospital environment as protective against, in the words of one man, "my own vices." In addition to "a break from self," participants also described the experience as a break from the "stress factors of life" and from other people who could "cause trouble" for them, such as a "drug-dealing girlfriend": "You know the papers that I signed when I came in, say I have the right to refuse visitors. If I didn't want to see certain people, and the fact that we're in a locked up unit, makes me feel comforted; I don't have to worry about anybody that don't like me or anything. Or come down here and try to cause trouble for me. I just feel very safe here."

Unlike the medical patients in a previous study who saw the hospital environment as confining (Shattell, 2002), psychiatric patients experienced it as freeing. Paradoxically, they reported feeling unconstrained within the confinement of the locked psychiatric unit. For example, a man who called the hospital his “fortress” spoke of gaining a “sense of freedom, freedom from an evil stress factor that is within myself.” The fortress provided the boundaries that he was unable to establish in the outside world. He went on to say, rather wistfully, “I wish I could get these boundaries outside of the hospital.”

In the world of the psychiatric patient, there was a specific inner sanctuary, a world within a world that provided even greater freedom because staff did not intrude there. This inner world was the unit’s smoking room. The smoking room, although quite drab and small (with only four chairs), was described as “the best place on this floor” and “very therapeutic”: “People will sit in there and talk and get some things off your mind that you don’t feel comfortable doing in a big group, you know, like in group therapy.” In group therapy there were “guidelines” for participation and staff prohibitions against “drift[ing] on and on and on,” but there were no rules for the interactions in the smoking room. A participant termed it the “one room [where] everybody can sit down... and discuss whatever’s on their mind without a staff member being there. You can express anger and you can yell and scream or cuss or whatever you want to do in that room. And ...what happens in the smoke room stays in the smoke room.” Even nonsmoking participants spoke positively of the smoking room.

One participant related his fear of losing the smoking room because he sensed the staff would “love to get rid of [it].” He foresaw dire consequences of this: “Honest to God, I believe if they took that away, I think it would, oh Lord, I don’t know whether you could stand it or not ...Because ...sometimes we can help each other...with no teacher or person around.” This man had broken his arm in the smoking room after water leaked through the ceiling, causing him to slide on the wet floor. Yet he told the interviewer, “I don’t want you blaming it on the smoking room, because it could have happened in any room...they came back in and patched the ceiling [the] next day.”

Within the inner sanctuary of the smoking room, participants also described viewing the outside world, daydreaming about it, and vicariously participating in the ongoing stream of life by looking out the “huge window” of the smoking room: “The paint in there is kind of gloomy looking, but it has a good view of the river...it is so beautiful and so soothing... I like to go in there at night and watch the lights and stuff, and during the day you can sit there and watch people going by on their boats and pulling their little kids on the skis or little inner- tubes and things, and that’s a lot of fun.” Kaysen (1993) refers to this as a “parallel universe,” invisible to the outside world. People on the outside cannot look in; however once in, the outside world is clearly visible. In the words of Kaysen, “every window on Alcatraz has a view of San Francisco” (p. 6).

LIKE ME/NOT LIKE ME

In the psychiatric unit, identity was affirmed amidst kindred souls. Participants described the environment as like “home” for them, “a close-knit adopted family” in which “I feel like being like myself. I’m not criticized for being odd or I’m not put down [for doing] something someone else hasn’t.” There was a solidarity amongst the patients, often referred to as “bonding,” that

most did not experience in the outside world: “You don’t see it outside...Where I work you can’t get five people together to plan a Christmas party...here, we’re just one group. All for one, one for all.” Patients described important roles they filled within their “adopted family,” such as the comedian or the greeter of new admissions. Like siblings, the patients looked after each other and worried about each other. They engaged in banter and comic antics: “We’re all nuts. We call each other nuts, you know.” Like surrogate parents, the staff met patients’ needs for food, comfort, and structure. Participants commented approvingly on well-stocked refrigerators and snack cabinets. Pride was evident in one patient’s description of the hospital’s cleanliness: “the hospital is always clean, and ...there’s one thing about us drunks, we try to keep it that way.”

The like me/not like me theme was also evident in the comparisons participants made between themselves and others in the environment. Looking toward others for similarities and differences shaped participants’ judgments about themselves. These judgments often had a positive effect either by normalizing events, thoughts, or feelings (e.g., like me, other people have attempted suicide) or by lessening the severity of the illness experience: “Other people can tell you their stories and yours in some cases seems insignificant compared with what happened to them.” One man with a long history of chemical dependency (CD) felt superior to the other CD patients because he used clean needles and did not burglarize people to support his addiction.

POSSIBILITIES/NO POSSIBILITIES

Hospitalization opened possibilities of a future. Participants described feeling more levelheaded, “straightened out,” back in “balance” again. Medication provided a sense of new life for some patients, and an orientation towards the future was evident in statements such as these: “I’ve come to the conclusion you can’t live in the future if you live in the past”; “I haven’t had a goal in years, you know. Since I’ve been up here and gotten this new medicine I feel...more goal-oriented, and the groups have helped me ...with that, to take a look at myself and think about what I’m doing with my life.”

Despite formulation of goals and determination to follow up with aftercare, patients feared being released from the safe hospital environment: “You can be up here and be joyous, and 5 minutes after you’re out the door, you go right back into your anxiety and fears.” While retaining a fragile hope for the future, participants voiced foreboding and dread of discharge. Continued existence was in doubt: “If I go back to using [drugs], I don’t think I’ll get out of it again.” Some patients were unable to envision future possibilities. With fatalistic premonition of impending death, one chronically suicidal patient said, “So many years ago ... I had what could have been small problems, but now I’ve come to seeing [them] to be a matter of. ..life or death, [and] it’s an inescapable feeling that I feel nowMy sickness has progressed to an extreme height....it makes you feel like there’s no hope.... It’s like the only thing left for me is the box [coffin].”

CONNECTION/DISCONNECTION

The connection/disconnection theme refers to participants’ experiences within the milieu of connecting—or failing to connect—with other people (nurses, doctors, other hospital staff, other patients). Socialization with others was a valued aspect of hospitalization: “People come in here and you can sit and talk with them...We really care about each other and that’s a strange environment for me, because I’ve always been a loner”; “At home I usually sleep till at least

9:00, you know. But over here I want to get up. I'm looking forward to it since the people, the patients are very friendly, and the staff's very friendly. And I love interacting with all of them."

Interactions with the professional staff tended to be superficial, however. Rather than playing "little games" with staff or attending "classes," participants yearned for greater closeness: "I think a person should receive a lot of one on one ...When I came to this hospital, I was expecting to receive one on one care, group times and activity times that people put their heart into; I keep hoping against hope that something will be said or done for me to make a change; I don't feel like I'm receiving the care that a person should receive from a hospital. I feel like I'm hanging out in this nice little hotel room and attending a couple of meetings a day." Participants disliked idle time and wanted more than medications and occupational therapy:

"I'm aware that this is a psychiatric ward and the dispensing of medication is probably the primary help for therapy. The doctors come by to see you once a day for a few minutes and then the rest of the time they have you scheduled for little things like occupational therapy, where you go paint or draw or do something like that...I'm left to my own vices like I was on the outside."

"I don't believe that the psychiatric field is what it used to be or what it could be. I think that it could be much more...personal ...more seriously delving to find out what troubles people—and find solutions, rather than just put a pill on it or a tab on it or something, saying 'You're going to be okay now. Just hang in there.' I haven't really gotten any therapy...They're just letting you stay in the shadows...rather than the old style of psychiatric treatment I've seen where the issues were forced out of you in group therapy.... I think that we are failing and these type wards are failing."

Good staff/bad staff was a subtheme of connection/disconnection. Making connections with staff appeared to be contingent upon personal qualities that staff members exhibited: "The personalities differ considerably between the staff and there are quite a few that we can't relate to at all, and others that we grow so fond of that we don't want to leave the hospital." Good staff, who elicited the fondness described by this participant, displayed an attitude of willingness to give (attention, time, information, services) and to be flexible about unit rules. Participants used descriptors such as warm, gentle, kind, friendly, supportive, and willing to laugh. Rather than viewing close monitoring by staff as intrusive or aversive, participants appreciated it: the good staff were "on top of things" and "keep a close eye on you."

Bad staff were perceived as uncaring, withholding, too strict, and/or too "professional" to be easily approachable. Moreover, some staff used threats (e.g., commitment or loss of privileges) and displayed condescending, "smart-alecky" behavior. Particularly resented were staff who treated patients "like children," scolding them for developing close relationships with other patients. Inexperienced staff, who seemed to be lacking knowledge or "doing it from a book," were also disparaged. For example, one patient described a class on stress led by "this poor little girl [who] didn't have any stress in her life... she didn't know what it meant or how to deal with it."

Most patients failed to differentiate nurses from other staff but tended instead to refer to "staff" in the aggregate. In instances where the discipline of nursing was specified, patients tended to speak in vague generalities ("the nursing staff are very nice") or mention nurses in conjunction with receipt of medication or information about medication. One patient was distressed that a nurse was unable to answer her question about a medicine: "She was an RN and she didn't know." In only one instance did a patient mention a nurse offering to make herself available for

dialogue: “Hey, if you need to talk, [if] you’ve got something special on your chest you’ve got to get out right now, let’s talk.” Perhaps the closed nurses’ station window was perceived as a barrier. According to one patient, “95% of the time they’ll keep their nurses’ station window closed unless they’re giving out medicine.” It is notable that not one participant used a nurse’s name when relating inpatient experiences, although names of doctors were frequently mentioned. One participant even spoke at length about “Jim,” a man on the hospital’s housekeeping staff, who spent time each day “shooting the breeze” while cleaning his room. The patient obviously appreciated this time of simple companionship.

DISCUSSION

Findings of this study provide insight into the unstructured aspects of the inpatient milieu that researchers have traditionally neglected (Peplau, 1989). Universally, patients perceived their peer-administered “therapy” in the smoking room as the most beneficial aspect of their hospitalization. They vividly portrayed the inner sanctuary of the tiny smoking room where they shared meaningful intimacies with one another away from the watchful eyes of the staff. Although staff often discourage such fraternization, our study participants report that something valuable is gained from it. Support for the value of this peer interaction is provided by a first-person account of hospitalization by Maxson (1974, pp. 121-122): “It was the other patients who worked to help bring me out of myself.. I recall many ‘group therapy’ sessions after dinner, or midnight ‘graham crackers and milk therapy’ in the kitchen. It was therapy not only because we laughed and were able to reduce feelings of isolation, but because we often dealt with someone’s particular problem...It is not only people with degrees and diplomas who are able to ...give therapy.” Additional support is provided by a recent study of patient satisfaction with services in a Kentucky psychiatric hospital (Howard et al., 2001). Satisfaction with opportunities to talk with other patients was greater than satisfaction with any other aspect of the hospital experience that the researchers measured, i.e., greater than satisfaction with aspects such as availability of staff to discuss problems, physical aspects of the setting such as cleanliness, and involvement in treatment planning.

A significant benefit of hospitalization, based on narratives of our study participants, is that within the locked unit patients find refuge. The theme of hospital as a refuge is consistent with first-person accounts of psychiatric hospitalization in both empirical (e.g., Jackson & Stevenson, 2000) and lay literature (e.g., Kaysen, 1993; Sexton, 1981). Poet Anne Sexton contrasted the “succoring shelter” of the hospital with “the awful subway of the world, the awful shop of trousers and skirts” (1981, pp. 593-594). The hospital frees individuals from the demands of work, school, or anything “except eating or taking your medication” (Kaysen, 1993, p. 94). It is clear that patients come to the hospital seeking asylum. It is interesting to consider that the archaic word “asylum,” which we no longer use to describe psychiatric inpatient facilities, actually means “an inviolable refuge, as formerly for criminals and debtors” or “any secure retreat” (Webster’s Encyclopedic Unabridged Dictionary, 1989). The word is derived from the Greek: a-sylon (not susceptible to the right of seizure). Not only are inpatients secure from external threat, but also protected from “seizure” by their own self-destructive thoughts and impulses—at least temporarily. Corroborating the findings of Jones, Ward, Wellman, and Lowe (2000), participants in the present study viewed close observation by staff—even checks as often as every 15 minutes—as reassuring rather than intrusive.

Merleau-Ponty (1962, p. 136) said that people's intentions are connected by an arc that brings about "unity of the senses, of intelligence, of sensibility, and motility." In illness, he observes, this intentional arc "goes limp" (p. 136), a metaphor for impotence that is similar to descriptions by these study participants. Powerless to combat the disunity they are experiencing in the outside world, admission mercifully permits them to regress, to "cool head and mind." Hospital staff extend them a lifeline and open up the possibility of a future. Safe within the locked unit, daydreaming at the window of the smoking room, they can engage in the "vicarious consumption of free places" that was described by Goffman (1961, p. 237).

Perhaps the most poignant finding of this study is the longing expressed by patients for a deeper connection with staff and more intensive insight-oriented therapies. Although their needs for safety, structure, and medication have been met, and hospitalization once again has postponed their dying, they are not being helped to live. They are not gaining greater understanding of their dysfunctional patterns of behavior. In the words of one individual, "I want to be better, but I just don't know how. I've never figured out why I do the things that I do." With the advent of managed care, inpatient treatment has been drastically altered, focusing mainly on stabilization and rapid return to the community. Many units no longer have adequate numbers of nurses to maintain a therapeutic milieu and deliver individual interventions. As noted by Echternacht (2001, p. 42), managed care "minimizes the importance of interpersonal aspects of care in the clinical ward community." Yet it is the interpersonal aspects of care, so beautifully delineated in classic works by Peplau (1952) and Travelbee (1971), that patients are telling us they need. Echoing this need, a participant in the study by Howard et al. (2001, p.19) told the researchers: "I was expecting more therapy...counseling; keeping more busy [sic], keeping my mind from thinking because that's my biggest problem right now. I think and I hurt—I hurt and I die."

CONCLUSION

According to Polkinghorne (1989, p. 58), one consequence of phenomenological research is greater appreciation of what it is like for our participants to experience something, "a particularly significant consequence for those in the helping professions." Although nurses may feel gratified that psychiatric patients experience the hospital as a refuge from their turbulent existence in the outside world, this study suggests that not enough is being done to prepare patients for their return to that world. If we consider Gunderson's (1978) five functions of the therapeutic milieu (containment, support, structure, involvement, and validation), we might conclude that containment and structure are achieved, and to some extent support and involvement, especially involvement with other patients. But validation, which Gunderson says is the affirmation of individuality through 1:1 interactions with staff, does not appear to be achieved. Patients are lamenting the lack of such interactions.

Are these research findings generalizable? In phenomenology, generalizability is not a matter of statistics or experimental procedures but rather a matter of clinical judgment (Thomas & Pollio, 2002). Although participants in this study were recruited from one inpatient setting, and thus cannot be presumed to represent the universe of patients hospitalized in general hospital acute psychiatric units, Ray (1994, p. 117) has proposed a useful criterion for evaluating a phenomenological study. She advises clinicians to consider "Does this have any relevance or validity in the context of my practice?"

Potentially, there are a number of implications for nurses charged with maintenance of the “therapeutic milieu.” If patients must gather in smoking rooms to achieve the valued peer intimacy described by our study participants, it behooves nurses to find alternative ways to facilitate this intimacy. The deleterious effects of both smoking and second-hand smoke are well known. Given patients’ clearly expressed desires for less time in games and classes and more time in dialogue with professional staff, daily schedules could be configured differently. Nurses should avail themselves of opportunities for brief on-the-spot counseling as described by Peplau (1982) and Echternacht (2001). Barriers to interaction, such as a closed door or window of the nurses’ station, should be minimized. Patients in studies other than our own have reported reluctance to disturb nurses who appeared to be “busy”; for example, they had to knock on an office door to get nurses’ attention in the facility that Jackson and Stevenson (2000) studied. In our view, it is a basic patient right to have a primary nurse who is known by name. It is disturbing that no participant in this study referred to a nurse by name, suggesting that nurses on this unit do not commonly identify themselves by name to the patients or devote sufficient time to establishing relationships with them. Patients have a right to expect something more than peer therapy while hospitalized. Let us heed the call of Krauss (2000) for renewed emphasis on the nurse-patient relationship and the therapeutic alliance.

At this point, a caveat is in order. Although no participant in the present study made mention of a beneficial interaction with a nurse, readers should not conclude that such interactions never take place. When using phenomenological methodology, interviewers do not pose questions based on their own interests (i.e., “Did you have any meaningful talks with a nurse?”) but rather listen carefully to interviewees as they report figural (predominant) aspects of their experience that stand out to them. Thus, all we can conclude with certainty is that therapeutic conversations with nurses were not figural to the participants in the present study. Findings of the study beg the question: How do the nurses on this unit perceive the milieu and their role in it? As a counterpart to this examination of patients’ perceptions, a companion study of the perceptions of nurses on the same inpatient psychiatric unit is currently under way. Results of studies such as these will contribute to filling the knowledge gaps regarding the therapeutic milieu.

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