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# Promoting Personal Recovery Within Psychiatric Inpatient Care—Nurses' Experiences

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## ABSTRACT

To meet the aim of synthesising research on nurses' experiences of promoting personal recovery within psychiatric inpatient care, meta ethnography according to Noblit and Hare has been chosen as the method, which is a qualitative review of scientific literature that results in a synthesis. The focus is on interpretation and is expressed to be able to reduce a story, but at the same time keep what is unique using metaphors. Nine articles formed the basis of the synthesis. The analysis resulted in two levels of synthesis. The first level involved the translation of metaphors into one another, which proceeded in two directions, described as two principal headings. The second level produced five overarching metaphors. The first principal heading is that 'erected walls in psychiatric inpatient care impedes personal recovery.' It encompasses the overarching metaphors 'cultivating in exhausted soil' and 'nurses are gatekeeping watchdogs'. The second principal heading is 'torn-down walls in psychiatric inpatient care enable personal recovery'. It encompasses the overarching metaphors 'disarming and de-escalating', 'facing suffering together reveals treasures' and 'elevating the competent partner promotes recovery'. Conclusively, if the nurse is to be able to promote personal recovery in psychiatric inpatient care, bridges of cooperation and consensus need to be built to other professions in care. Otherwise, the obstacles to promoting personal recovery will be far too hard to overcome.

## 1 | Introduction

Recovery-oriented care is garnering increasing international interest. William Anthony is often described as one of the early theoretical pioneers in the recovery movement. Together with Ashcraft (Anthony and Ashcraft 2010), he outlines how recovery-oriented psychiatric care was considered unthinkable for much of the 20th century. With reference to Braslow (1995, 1997) and Grob (1994a, 1994b, 1996), as well as Micale and Porter (1994), a bleak perspective is depicted concerning persons with severe mental ill-health in North America and Europe. In addition to the idea that recovery was considered unthinkable, it is described that persons with mental ill-health were dehumanised and devalued by both professionals and society. In contrast, recovery is highlighted as a perspective originating from persons who themselves suffered from severe mental ill-health. Here, a shift is described from a problem-focused view of ill-health to a striving to empower the person to regain control and grow as a human being. Nursing guidelines also highlight a more empowering approach to providing care. International council of nurses (ICN) express, in the ICN code of ethics for nurses (ICN 2021), in article 1:2, that nurses are expected to promote an environment characterised by respect for human rights. In article 1:10, person-centred care is emphasised, as well as care being evidence informed. Further on, in article 3:5, it also states that nurses are to challenge unethical practices in a spirit of collaboration with other disciplines. In the Office of the United Nations High Commissioner for Human Rights, OHCHR, universal declaration of human rights, article one, it

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states that 'all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood' (OHCHR 1996).

So, how far have we come? Is psychiatric inpatient care still plagued with a problem-focused paradigm that can be perceived as devaluating and dehumanising, or can we use wordings such as brotherhood, dignity, empowerment and personal growth? More research is needed on personal recovery as a transformative force within the field of psychiatry, and this review attempts to synthesise research on nurses' experiences of promoting personal recovery among persons receiving psychiatric inpatient care.

### 1.1 | Clinical Recovery or Personal Recovery

The term 'recovery' can have various meanings depending on the context. Barber (2012), writing from a medical perspective, proposes three distinct approaches to understanding recovery. The first is clinical recovery, defined as the remission or cure of the illness. The second approach is illness management, which involves controlling symptoms through medication or adherence to a prescribed programme. Both of these perspectives will be considered as medical or clinical approaches in this review. The third approach Barber suggests is personal recovery, which emphasises living one's best life despite the presence of symptoms.

Macpherson et al. (2016) reference Torgalsbøen (2005) and Austin et al. (2013) to describe that clinical recovery primarily pertains to clinical assessments of illness symptoms related to schizophrenia conditions, where recovery entails the absence of these symptoms, or the person being cured. To examine the empirical relationship between clinical recovery and personal recovery, they conducted a quantitative study involving patients diagnosed with psychosis. The study initially involved 403 patients, and assessments were conducted by both staff and patients at the outset, as well as in a follow-up after 1 year. Three factors emerged in evaluating recovery: patient-rated personal recovery, patient-rated clinical recovery and staff-rated clinical recovery. Despite neither the patients' nor the staff's assessments of clinical recovery showing improvement, the patients' ratings of personal recovery indicated improvement. Further, the authors interpret this as evidence that clinical and personal recovery are not synonymous. The authors also suggested, based on what emerged from the assessments, that evaluations should ideally be based on factors such as hope, social functioning impairments and patient-reported unmet needs.

Topor, Bülow, and Denhov (2019) provide a critical retrospective analysis of the psychiatry reform in Sweden of 1995 and the subsequent two decades. In this article, the primary standpoint is that of social work. Nonetheless, it undeniably raises numerous inquiries regarding the functionality and organisation of care and support for persons with mental health issues. What was envisioned as a reform aimed at enabling persons who had previously been relegated to concrete-framed institutions to become integrated into society encounters both praise and criticism. The recovery-oriented efforts taking place within municipalities in the realm of social work are, to some extent, juxtaposed with a medical perspective within the psychiatric healthcare system. It is highlighted that some of the successes achieved by the psychiatry reform have paradoxically generated an increased interest in medical solutions to people's problems, even in cases where such approaches lack empirical support.

### 1.2 | Personal Recovery

To differentiate recovery from the clinical perspective, this work employs the term 'personal recovery' or simply 'recovery,' where the emphasis is on the persons recovery from a holistic perspective. There is no internationally unified definition of personal recovery, but one frequently referenced definition originates from a subdivision of the U.S. Department of Health and Human Services, namely, the Substance Abuse and Mental Health Services Administration (SAMHSA), and their document titled 'SAMHSA's Working Definition of Recovery' (2012). In this document, recovery is defined as 'a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential' (p. 3). Four areas are highlighted as support for an individual in recovery: (1) health, which involves overcoming or managing one's illness or symptoms, or being able to make well-informed decisions that support physical and emotional well-being, (2) a safe and stable home to live in, (3) meaningful daily activities and independence, income and resources to participate in society and (4) a social network that can provide support, hope, friendship and love.

SAMHSA (2012) proceeds to outline various guiding principles of recovery. In brief, hope is posited as a prerequisite and catalyst for recovery, and the person should exercise control over their journey and establish their own objectives. This journey is deeply personal and can traverse various paths, including setbacks. Recovery is advocated as holistic, encompassing all aspects of the person's life. Various services and support initiatives can, in some instances, facilitate recovery and must be coordinated, culturally tailored and personalised. The person requires a supportive network to transition from previous unhealthy roles and find a sense of belonging, empowerment and community participation. Recovery is strengthened by addressing trauma. Healthcare institutions and support services must be cognizant and knowledgeable about these traumas to promote safety and trust. Recovery involves both responsibilities and strengths for the person, family and society. Ultimately, the person bears responsibility for their journey towards recovery and should be supported in advocating for themselves, both individually and collectively, and treated with respect.

Leamy et al. (2011) present a conceptual framework through the synthesis of published descriptions and existing models of personal recovery. A key finding that has gained considerable international influence is the set of recovery processes found, represented by the acronym CHIME. 'Connectedness', the first element, involves support from various relationships, including support groups and being part of the community. 'Hope' focuses on optimism about the future and includes the belief in the possibility of recovery, motivation for change, valuing success, maintaining a positive mindset, having



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aspirations and relationships that inspire hope. The third element addresses various dimensions of 'identity,' including rebuilding or redefining a positive sense of self and overcoming stigma. 'Meaning in life' involves finding meaning of mental ill-health, spirituality, quality of life, having a meaningful life, setting social goals and rebuilding one's life. Finally, 'empowerment' focuses on personal responsibility, gaining control over one's life and emphasising strengths.

Various attempts have been made to implement personal recovery in healthcare in a practical way. One such attempt, that has gained influence in several continents, is the Tidal model. It is presented by Barker and Buchanan-Barker (2005) as a person-centred approach in which healthcare professionals collaborate with the person in the pursuit of recovery and reclaiming one's life, i.e., a therapeutic alliance. They place significant emphasis on the importance of the person's narrative in their model. They express that the narrative encompasses everything that is meaningful to the person, and that the person is their story, their experience. Disease is said not to define a person; it is the story that does. Drawing inspiration from chaos theory, they view a small, seemingly insignificant change as capable of bringing about the needed transformation. They condense the approach into several commitments. This includes valuing the person's narrative, which encompasses both the reasons for their difficulties and their hopes for a solution, and respecting the language, the unique way in which the person expresses their life story. It is encouraged to develop a genuine curiosity to better understand the storyteller and become an apprentice to the person who is an expert on their life story, acknowledging personal wisdom that the person has gathered. Further on, be transparent about what is being done and why. For teamwork with the person to be successful, trust must be built, and the other person must be included. The persons' narrative contains many examples of what has worked or what might work on the path to recovery. Make good use of this toolbox. Also, build steps into the future by jointly assessing what needs to be done *now*. The first step is the most important, as it demonstrates the power of change as a step towards recovery. Offer time as a gift, where content is more important than considering how much time is available. Finally, in the Tidal model, change is viewed as something that is ongoing. The role of the staff is to develop awareness of how change is occurring and how it can be used to steer the person away from danger and difficulties towards reclamation and recovery.

### 1.3 | Psychiatric Inpatient Care

In most developed countries, laws allow for the involuntary internment and treatment of persons with severe mental ill-health. Psychiatry is the only medical discipline where institutions utilise locked doors, primarily for safety. This may be necessary to prevent persons from harming themselves or others when their judgement is impaired by mental ill-health or related conditions (McSherry 2019). Knowledge about the extent of the use of locked doors in psychiatric wards is limited, but research indicates significant variation across countries, hospitals and departments (Kowalinski et al. 2017). It is also possible to be sentenced to forensic psychiatric care after committing a crime during a psychiatric illness.

This review examines articles from Australia, New Zealand, the Netherlands and Sweden. In these countries, psychiatric inpatient care primarily focuses on voluntary treatment. However, when a person is deemed severely mentally ill, and care is considered absolutely necessary, compulsory care, treatment and seclusion are permissible under strict legal safeguards designed to protect the person (Australian Institute for Health and Welfare 2024; Ministerie van Volkgezhondheid, Welzijn en Sport n.d.; Ministry of Health 2021; Nationell samverkan för psykisk hälsa & Sveriges kommuner och landsting n.d.). According to the World Health Organisation (2021), the mental health workforce generally consists of psychiatrists, other medical doctors, nurses, psychologists, social workers, occupational therapists and other formally trained mental health workers. The availability of these professions varies between countries.

Regarding nurses' experiences of delivering care in acute mental health settings, Wyder et al. (2017) expresses in a review that it is evident that nurses face a complex role that requires balancing conflicting perspectives. The study identifies five key areas of this complex nursing role. First is the clinical aspect, which involves conducting assessments, managing crises, administering medication, alleviating symptoms and planning for discharge. Secondly, providing practical and emotional support. Thirdly, educating and advocating for patients and their families. Fourthly, balancing the conflicting demands of enforcing legal measures, such as confinement and involuntary medication, with delivering holistic care. Finally, ensuring the safety of the entire ward amidst competing needs, where fostering connectedness plays a crucial role. Andersson, Fathollahi, and Gustin (2020) adds to the complexity by examining nurses' experiences of informal coercion and the ethical dilemmas it poses. Nurses were striving to connect with the person while also attempting to involve other professionals to avoid the sole responsibility of making decisions. In addition to this, the nurse needed to adapt to the care environment, which involved not only the limitations of the physical setting and following the ward's routines but also balancing professional power. There were also considerations of different laws. If the person was admitted under compulsory care, it made it easier for the nurse to employ informal coercion.

Wyder et al. (2017) identifies three areas as hindering recovery-oriented support. Firstly, operational barriers, including a high workload, administrative tasks and an unsupportive organisational structure, which manifest through various administrative practices that collectively limit the time available for person-centred care. Additionally, unclear roles, insufficient support for person-centred tasks, pressure for rapid discharges and a lack of resources such as therapy, activities and available beds further exacerbate these challenges. Under such conditions, discharge planning is often improvised and reactive. Secondly, the acuity of persons receiving care is perceived to have increased due to a reduction in available beds, coupled with more frequent readmissions. This, combined with shorter inpatient stays, has resulted in fewer opportunities for activities, therapy and meaningful engagement between nurses and persons in their care. The rise in drug-related mental health issues is also perceived to have contributed to increased incidents of violence. Thirdly, restrictive cultures, such as an overemphasis on risk management or a risk-averse culture that fosters blame, are highlighted. A dominant medical focus further limits nurses' autonomy in providing care



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and promoting recovery. Collectively, these three factors contribute to nurses feeling overburdened (Wyder et al. 2017).

In a mixed-methods study, Thompson, Senek, and Ryan (2024) investigated mental health nurses' (MHNs) perceptions of the quality of care during their most recent shift on an inpatient mental health ward, the reasons for compromised care and the potential impact on patient outcomes. With 1126 survey responses, around one-third reported understaffing defined as less than planned number of MHNs, and about one-third reported that care was compromised. The top three reasons for compromised care were reported as lack of nurses, higher patient acuity and non-nursing duties taking too much time. The qualitative analysis concerning reasons for compromised care gave three main themes with several subthemes. The primary theme, understaffing, impacts nearly every aspect of care. Subthemes include safety and risk-related issues, a lack of permanent staff and continuity of care as well as an inadequate skill mix among staff. The second theme pertains to professional code expectations and moral distress, encompassing the pressure to uphold high standards of care. Subthemes include high workloads, sickness and burnout, a lack of breaks or unpaid overtime and poor-quality care resulting from self-neglect and exhaustion. The final theme pertains to poor management, with subthemes focusing on poor escalation and response to concerns, lack of support or supervision and a culture of blame and bullying. The outcomes for patients associated with compromised care are reflected in subthemes such as aggression or assault towards staff and other patients, compromised safety, missed basic care or legally required leave, minimal one-to-one care and poor recovery progress.

McCluskey and Vries (2021), in a qualitative study, explored the perspectives and experiences of 16 Irish nurses, mainly psychiatric nurses, working in acute care, focusing, among other things, on the interventions they implemented for people hearing voices. This study was conducted against the backdrop of changing mental health policies in Ireland, which emphasise person-centred care, recovery and increased responsibilities for psychiatric nurses, alongside the growing international prominence of psychosocial interventions. Four themes emerged. As a basis for any intervention, the first theme highlights that a foundation of a therapeutic relationship is an important precondition. Organisational limitations and low staffing levels were identified as major obstacles to achieving this. The second theme expresses the frustration psychiatric nurses feel towards the medical paradigm and its emphasis on the administration of medication as a core nursing intervention. The third theme points to the lack of training and knowledge about interventions among psychiatric nurses. Finally, the fourth theme describes interventions as ad hoc and unstructured, primarily focusing on distractions from the voices. The impact of these interventions is described as temporary, with unclear long-term effects. They conclude that the disempowerment of psychiatric nurses is not promising for the future improvement of mental health services in Ireland.

Wyder et al. (2017) identifies three factors that facilitate the provision of recovery-oriented support. The first are ward-level factors, which include having qualified staff, effective teamwork, professional conduct and access to clinical supervision. The second factor is nursing practices centred on person-centred care, which involve building therapeutic relationships and offering recovery-oriented support. These practices encompass the use of de-escalation techniques and the administration of PRN medication. Thirdly, nurse characteristics, encompassing the ability to make therapeutic use of themselves across three domains: their approach to people, which includes distinguishing the illness from the person and effectively involving them in their own care; nurses' approach to work, characterised by being prepared for unexpected challenges and viewing their role as meaningful; and lastly, their ability to engage in self-care, manage their emotional well-being to sustain person-centred care and critically self-reflect on their practice (Wyder et al. 2017).

## 2 | Rationale

Psychiatric inpatient care has undergone significant transformations over the past century. The manner in which persons with mental health issues are treated has been subjected to substantial criticism, particularly from the patients themselves. When a problem-focused, clinical perspective has been predominant, it has resulted in a lack of consideration for the person as a whole. In response to this, a perspective emphasising personal recovery has emerged, that promote connectedness, hope, renewed identity, meaning in life and empowerment. Efforts to implement this approach in healthcare have been made around the world, as exemplified by models such as the Tidal Model. Part of the nurse's responsibility in psychiatric inpatient care is promoting person-centred care and an environment characterised by respect for human rights, and to challenge unethical practices in a spirit of collaboration with other disciplines. Further on, that care should be evidence informed. These responsibilities provide the nurse with valuable insight into both perspectives' paradigms but may also pose challenges in balancing the recovery-oriented perspective with the clinical, medical paradigm. Previous research confirms that nurses' experiences of delivering care in acute mental health settings are complex, with competing paradigms to navigate, often within an unsupportive organisational environment. Psychiatric reforms and legislation aimed at safeguarding patient rights have been made around the world. Despite this, it seems that a clinical, problem-focused approach, lacking a genuine holistic perspective, still prevails in psychiatric inpatient care. Although older reviews with related points exist, to our knowledge, no synthesis has been made on nurses' experiences of promoting personal recovery in psychiatric inpatient care.

## 3 | Aims

The aim was to synthesise research on nurses' experiences of promoting personal recovery among persons receiving psychiatric inpatient care.

## 4 | Methods

### 4.1 | Design

To align with the research aim, a constructivist, qualitative approach has been selected, as it, in accordance with Polit and Beck (2021), seeks to achieve an understanding of human



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experience. The current study is grounded in Meta ethnography, as described by Noblit and Hare (1988). Polit and Beck categorise this method as a form of meta synthesis, essentially a type of literature review. Noblit and Hare articulate how they recognised the necessity of this method after employing an aggregative approach that failed to yield useful results. The emphasis is placed on interpretation rather than analysis, with the ability to condense a narrative while retaining its uniqueness through the utilisation of key metaphors that conveys the essence of the message. These metaphors are systematically compared and interpreted in relation to metaphors from other narratives, in a process called translation, all while considering the original source material. The compilation of these interpretations constitutes the meta ethnographic synthesis. Noblit and Hare (1988) delineate seven phases, emphasising that these phases overlap and involve a back-and-forth movement.

#### 4.1.1 | Phase 1—Selecting an Area to Explore

The first phase highlighted by Noblit and Hare (1988) in their method is to choose a qualitatively intellectually intriguing area worth exploring, with a focus on contemporary phenomena in real life. The area is preferably described as somewhat open, as it is likely to evolve and change over the course of the journey.

The primary author works as a nurse on a closed psychiatric ward, where there are sometimes perceived to be conflicting interests between, for example, medical, administrative and organisational goals versus nursing goals for the patient. In this context, there arouses a curiosity about other nurses' experiences of promoting personal recovery among persons receiving psychiatric inpatient care. Finding that no reviews have been conducted on the subject provided the basis for proceeding.

#### 4.1.2 | Phase 2—Selection

In phase two, as described by Noblit and Hare (1988), decisions are made regarding which narratives are relevant to the original interest. The decision was made to seek literature through systematic literature searches to gather as rich a body of available research on the chosen topic as possible. The databases Cinahl and PsychInfo were chosen for this purpose. Before conducting structured literature searches in databases, some preliminary review of previous research was carried out to identify suitable terms and synonyms for searching in the English language. Criteria for the systematic searches were established prior to conducting the searches. The inclusion criteria consisted of articles that aligned with the study's purpose, including the ability to discern nurses as a professional group in the results, were qualitative (or a portion of the study that was qualitative and aligned with the study's purpose), and focused on adults (aged 18 and above). Exclusion criteria involved literature reviews, a sole focus on clinical recovery, children (under 18 years) and dementia. Limitations were placed on peer-reviewed and English-language literature. No specific year limitation was imposed as it could potentially reduce the richness of the selected phenomenon for study. In the structured searches, truncation (*) was occasionally used to include various inflections of words. The distinguishing factor between the searches lies in the differences in subject terms used across the databases; otherwise, the searches are identical. A table containing the search results is available in Appendix 1. Even though the search terms in Appendix 1 are presented in blocks, separate searches were conducted for individual keywords and blocks to ensure that relevant hits were identified individually, which was confirmed. The search process is described in a PRISMA flow diagram in Appendix 2. The articles were subjected to quality assessment using templates from the Critical Appraisal Skills Programme (CASP) (2018a). A total of nine articles were found, and they were assessed using the CASP qualitative checklist (2018a), and a mixed-methods study (Nardella et al. 2021) was also assessed with the CASP cohort study checklist (Critical Appraisal Skills Programme 2018b). Please refer to Appendix 3 for an overview of the assessment results. Only the qualitative components have been used in this work, and these parts are of satisfactory quality.

#### 4.1.3 | Phase 3—Reading and Extraction of Metaphors or Concepts

In phase three, as described by Noblit and Hare (1988), the narratives are read repeatedly, and interpretive metaphors or concepts are noted in relation to the chosen area of exploration. The material that forms the basis for metaphors or concepts in this phase primarily consists of the results section of the included articles.

For this synthesis, the result sections of the articles were carefully examined, and relevant text was highlighted based on its alignment with the aim of the current review, while carefully considering the inclusion and exclusion criteria.

#### 4.1.4 | Phase 4—Assess How the Studies Are Related to Each Other

In phase four, Noblit and Hare (1988) describe the assessment of how the studies are related to each other. They suggest creating a list of important metaphors, phrases, ideas and concepts in each narrative and placing them side by side. This allows for a preliminary understanding of how the different studies relate to each other. They outline three possible ways for studies to relate to each other, assuming that there are fundamental points of contact. During phase four, the analysis examines whether the texts are reciprocal or mutually exclusive. At times, texts may initially appear falsely comparable; therefore, a more in-depth reading is required to confirm their reciprocity. When this assessment has been made and the texts are in reciprocity, they can under certain conditions relate to each other as an in line of argument. The criteria for this are described in phase six.

In practical terms, text highlighted in the previous phase was carefully summarised for better overview on a separate sheet of paper for each article in relation to context. These texts



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could be sorted into different groups, allowing the construction of a metaphor from each set, and served as a basis for translation at a later stage. Throughout the process, the original articles were continually referenced in their entirety to ensure that nothing was misrepresented. Based on this, the assessment was made that the studies relate to each other in a similar manner. In this review, the use of the word 'recovery' exemplifies the dilemma of reciprocity. Some articles initially appeared to meet the inclusion and exclusion criteria for personal recovery but, upon closer reading, were excluded as they focused solely on clinical recovery. The selection process is described in phase two.

#### 4.1.5 | Phase 5—Translation

Noblit and Hare (1988) describe that in phase five, translation takes place, which is the first level of synthesis, and requires more engagement than treating the narratives as entirely alike. The unique and holistic aspects are preserved, but comparison becomes possible. Central concepts and metaphors are retained in relation to key concepts and metaphors within each narrative but are compared with their counterparts and how they interact in the other narrative.

In previous phases, summarised text was made, sorted in different piles and was the basis for constructing a metaphor from each pile (please see Table 1). Now these piles of texts, represented by a metaphor, can be compared to relevant piles, or metaphors from the other articles. This process is called translation and is the first level of synthesis. There was a back-and-forth motion between this phase and the next phase where synthesis level two was made, which were deemed to improve the quality of the metaphors.

#### 4.1.6 | Phase 6—Further Synthesis

In phase six, Noblit and Hare (1988) describe that even though translation in step five is a level of metaethnographic synthesis, these translations can be further synthesised if there are many included studies and translations. This is where the whole can transform into something more than what each part contributes. Comparisons are made between translations, concepts or metaphors to see if any of them encompass the other narratives. A new translation between competing interpretations can then be made for a second level of synthesis. This step corresponds to the phase mentioned in phase four about how the articles relate to each other, in line of argument.

To do this, a reflective process started, where previously developed metaphors sorted in piles were compared to each other to see if any single metaphor could encompass others. A retrospective review of previously made summarisations and the included articles was continuously conducted to support this process. This was a back-and-forth process between previous stages that were deemed to improve the quality of previously made metaphors. This second level of synthesis yielded five overarching metaphors. Long before this level of synthesis, it was evident that the metaphors unfolded in two separate directions, resulting in two principal headings.

#### 4.1.7 | Phase 7—Presentation

In phase seven, Noblit and Hare (1988) discuss how the synthesis should be communicated. They emphasise the importance of considering the audience for whom the content is presented and adapting it to the cultural expressions, presentation style and language that suit the listeners, which may include more forms of expression than just written words. This artistic freedom inspired the making of principal headings in this synthesis (please see phase 6) to facilitate the communication of the result in a figure.

### 4.2 | Ethical Considerations

The European Code of Conduct for Research Integrity (All European Academies, [ALLEA] 2023) outlines four principles of good research practice. Diligence was applied to both the execution and presentation of the various components in relation to the chosen method and scientific paradigm, emphasising transparency and honesty in reporting how the method and analysis were conducted. The selected articles for review in this literature review have all received ethical approval in accordance with the requirements of the Helsinki Declaration (World Medical Association, [WMA] 2022). Furthermore, ALLEA (2023) emphasises that authors should disclose any potential conflicts of interest.

## 5 | Results

The analysis resulted in two levels of synthesis. The first level involved the translation of metaphors into one another, which proceeded in two directions, described as two principal headings. The second level produced five overarching metaphors (Figure 1). Individual study metaphors are presented in Table 1.

### 5.1 | Erected Walls in Psychiatric Inpatient Care Impedes Personal Recovery

The first principal heading is that 'erected walls in psychiatric inpatient care impedes personal recovery.' It encompasses the overarching metaphors 'cultivating in exhausted soil' and 'nurses are gatekeeping watchdogs'.

#### 5.1.1 | Cultivating in Exhausted Soil

Five studies (Cleary et al. 2013; Hristodoulidis, Munro, and Brooks 2022; Kingston and Greenwood 2020; Solomon, Sutton, and McKenna 2021; Wesseldijk-Elferink, Hendriks, and van den Heuvel 2021) highlight challenging working conditions as obstacles to promoting personal recovery. Two studies explicitly state that lack of continuity in care is an obstacle, even though this can be inferred in several other studies. Insufficient continuity in care, with different patients on various days, undermines the therapeutic relationship. Also, constant interruptions for fragmented tasks, patient supervision and administrative duties consume time and hinder recovery-oriented care (Hristodoulidis, Munro, and Brooks 2022). Cleary et al. (2013) similarly point



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**TABLE 1** | Individual study metaphors as related to five overarching metaphors.

| | Principal heading | Erected walls in psychiatric inpatient care impedes personal recovery | | Torn-down walls in psychiatric inpatient care enable personal recovery | | |
|---|---|---|---|---|---|---|
| | Overarching metaphor | Cultivating in exhausted soil | Nurses are gatekeeping watchdogs | Disarming and de-escalating | Facing suffering together reveals treasures | Elevating the competent partner promotes recovery |
| **Study** | | | | | | |
| Cleary, M., Horsfall, J., O'Hara, A. M. and Hunt, G. E. (2013) | | Cultivating in exhausted soil | | | Building firm foundation together | Elevating the competent partner promotes recovery |
| Cook, N. R., Phillips, B. N. and Sadler, D. (2005) | | | | | Being in the mud together elevates both | Partnership is facilitating |
| Hristodoulidis, D., Munro, I. and Brooks, C. (2022) | | Nurses are scatterbrained | Nurses are watchdogs on a leash | A cooling agent that prevents ignition | | |
| Kingston, M. A. and Greenwood, S. (2020) | | Nurses are choked by weeds | | | Life in the mud can be explored together | |
| Lim, E., Wynaden, D. and Heslop, K. (2019) | | | | Disarming and de-escalating | | |
| Nardella, N., Hooper, S., Lau, R. and Hutchinson, A. (2021) | | | Nurses can be hard soil | | | Encouraging participation as partner promotes recovery |
| Sellin, L., Kumlin, T., Wallsten, T. and Wiklund Gustin, L. (2019) | | | | Dampening the fuse | Facing suffering together reveals treasures | |

(Continues)



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**TABLE 1** | (Continued)

| Principal heading | Erected walls in psychiatric inpatient care impedes personal recovery | | Torn-down walls in psychiatric inpatient care enable personal recovery | | |
|---|---|---|---|---|---|
| Overarching metaphor | Cultivating in exhausted soil | Nurses are gatekeeping watchdogs | Disarming and de-escalating | Facing suffering together reveals treasures | Elevating the competent partner promotes recovery |
| Solomon, B., Sutton, D. and McKenna, B. (2021) | Stretching the field too thin | | Taking cover together | Finding shelter together in the mud | Bonding promotes partnership towards recovery |
| Wesseldijk-Elferink, I. J. M., Hendriks, A. W. and van den Heuvel, S. C. G. H. (2021) | Nurses must outpace time weeds | Nurses are gatekeeping watchdogs | | True alliances go beyond labels | |

out shattered tasks that result in a lack of continuity. While the context with Hristodoulidis, Munro, and Brooks (2022) is that nurses under these circumstances are scatterbrained, Cleary et al. (2013) share the notion of the futility for nurses to cultivate personal recovery in exhausted soil.

All five of these studies discuss in different ways that high workload is an obstacle to promoting personal recovery. As previous mentioned, Hristodoulidis, Munro, and Brooks (2022) discusses time-consuming tasks that hinder recovery-oriented care, by making nurses scatterbrained. With Kingston and Greenwood (2020), however, the underlying metaphor is that nurses are choked by weeds. They point out that high workload, rules, expectations and processes that do not benefit patients are barriers to having time for therapeutic relationships. Furthermore, that nurses struggle to stay afloat within time constraints and testing care environments, to open up space for therapeutic relationships. This struggle is also highlighted by Solomon, Sutton, and McKenna (2021), who express that novel work methods, high expectations and complex patient care needs, combined with limited resources, generate frustration and fatigue among nurses, thereby impeding the focus on recovery-oriented care. The analogy is that these circumstances are stretching the field too thin for nurses to promote personal recovery.

In relation to high workload, three studies focus on understaffing. Cleary et al. (2013) with the metaphor that nurses are cultivating in exhausted soil identify that understaffing, crowded wards and rapid patient turnover hinder recovery-oriented care. Wesseldijk-Elferink, Hendriks, and van den Heuvel (2021) delineate the sense of obligation that nurses must outpace time weeds and conclude that sparse economic resources, frequent use of temporary replacements and lack of commitment by the patient's family often lead to limited time for a personal approach, even though nurses with the appropriate training recognise the need to overcome these challenges. Kingston and Greenwood (2020) point out that frequent crisis in the form of staff shortages, high patient acuity and patient needs make therapeutic relationships difficult. The context shares the notion that nurses are choked by weeds.

Other structural obstacles that are mentioned are hierarchical team culture, challenging hospital systems, and lack of education in recovery-oriented care that diminish the capacity to promote the same (Solomon, Sutton, and McKenna 2021). Cleary et al. (2013) reveal a symptom-centred medical approach and illegal drugs as hindrances to promoting personal recovery. With Solomon, Sutton, and McKenna (2021), the analogy is that the field is stretched too thin, while Cleary et al. (2013) point to the futility of cultivating in exhausted soil. The same two studies also discuss issues related to discharge as insufficient follow-up and collaboration with community care providers that hinder recovery-oriented care (Cleary et al. 2013), or negative factors like pressure to discharge patients quickly or delayed discharge due to a shortage of suitable housing that diminish the sense of hope and perception of choice (Solomon, Sutton, and McKenna 2021).

### 5.1.2 | Nurses Are Gatekeeping Watchdogs

Three studies (Hristodoulidis, Munro, and Brooks 2022; Nardella et al. 2021; Wesseldijk-Elferink, Hendriks, and van



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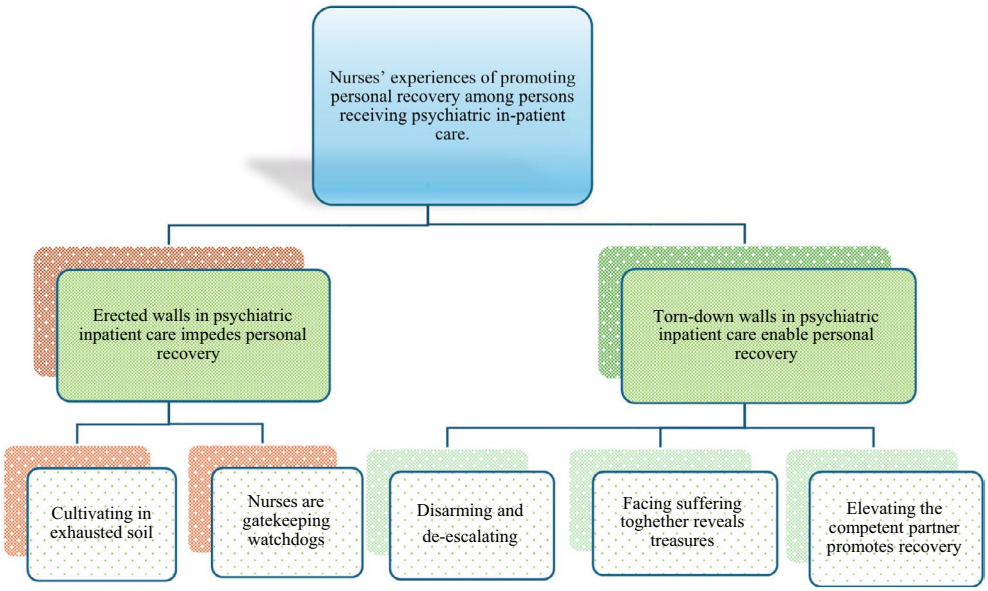


**FIGURE 1** | Showing the aim and results with two levels of synthesis.

den Heuvel 2021) discuss that lack of competence in personal recovery is an obstacle. Hristodoulidis, Munro, and Brooks (2022) state that nurses who solely perceive recovery from a medical, symptom-relief perspective, will not provide support for personal recovery. The context shares the notion that nurses are watchdogs on a leash. Nardella et al. (2021) point out that reduced functioning during the acute phase of illness or short hospitalisation periods may lead to patients being perceived as capable of taking only small, cautious steps towards recovery while on the ward. They give the impression that nurses can be hard soil. Similarly, Wesseldijk-Elferink, Hendriks, and van den Heuvel (2021) describe that the patient's reduced functioning results in prioritising other things over involvement in decision-making. Furthermore, the nurses assume the role of surrogate decision-makers when the patient is assessed to lack sufficient functioning. Also, when nurses perceive that the patient makes choices that promote health, the scope for involvement increases. However, when the patient makes adverse decisions, nurses are more inclined to take over, even though a dialogue could be initiated if the patient presents good reasons for it. In short, nurses are gatekeeping watchdogs.

Closely connected to competence in personal recovery is the role the nurse will take. Two studies (Hristodoulidis, Munro, and Brooks 2022; Wesseldijk-Elferink, Hendriks, and van den Heuvel 2021) highlight a custodial role as impediment for recovery. Wesseldijk-Elferink, Hendriks, and van den Heuvel (2021), with the context giving the impression that nurses are gatekeeping watchdogs, describes that the patient's reduced functioning makes the nurse prioritise safety, medication and structure on the ward. When Hristodoulidis, Munro, and Brooks (2022) describe the matter, it is as if nurses are watchdogs on a leash. They state that the nurses' role is primarily perceived as custodial rather than therapeutic. Frequently, the utilisation of coercive measures is regarded as the sole way forward, thereby impeding personal recovery. The time-consuming custodial role of the nurse transfers the therapeutic work to other staff members. Another role pointed out by Hristodoulidis, Munro, and Brooks (2022) that hinders personal recovery, which can also be inferred in some of the other studies, is that the constant availability of the nurse as a doctor's assistant disrupts the development of a therapeutic patient relationship, thereby impeding personal recovery.

## 5.2 | Torn-Down Walls in Psychiatric Inpatient Care Enable Personal Recovery

The second principal heading is 'torn-down walls in psychiatric inpatient care enable personal recovery'. It encompasses the overarching metaphors 'disarming and de-escalating', 'facing suffering together reveals treasures' and 'elevating the competent partner promotes recovery'.

### 5.2.1 | Disarming and De-Escalating

Four studies (Lim, Wynaden, and Heslop 2019; Hristodoulidis, Munro, and Brooks 2022; Sellin et al. 2019; Solomon, Sutton, and McKenna 2021) describe personal recovery as being able to mitigate aggression and coercive measures.

Lim, Wynaden, and Heslop (2019) highlight the power of promoting personal recovery as being able to disarm and de-escalate. They express that recovery-oriented care made nurses more sensitive towards patients' triggers. Despite communication difficulties and lowered stress thresholds, they take the time to assist them to feel safe. Even though nurses are pressured to maintain safety within the ward, recovery-oriented care assists nurses in getting to know the patient and individualising support to reduce the risk of aggression. Despite underlying traumas that can intensify the risk of aggression during psychiatric inpatient admissions, recovery-oriented care has the potential to mitigate this risk and allow the patient to feel supported. With recovery-oriented care, nurses are enabled to focus on patients' strengths and support, encouraging the patient to use these resources to reduce the



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risk for aggression, rather than solely relying on risk assessment. Sellin et al. (2019) similarly state that recovery-oriented care shifts the focus from surveillance, routines and problems to making nurses more open and empathetic, allowing the patient to express and be present in their experience. They give the notion that promoting personal recovery dampens the fuse. Solomon, Sutton, and McKenna (2021) paint a picture that nurses and persons receiving care are taking cover together. They convey that walking alongside the patient at eye level creates a sense of both physical and emotional safety as a foundation for recovery-oriented care, despite an uneasy healthcare environment.

A slightly different, structural angle is promoted by Hristodoulidis, Munro, and Brooks (2022), where they express that with increased nursing ratios and teamwork, opportunities arise to build patient relationships with a focus on personal recovery, potentially reducing the need for coercive measures. The analogy here is that promoting personal recovery is a cooling agent that prevents ignition. Another way of preventing aggression is highlighted by Lim, Wynaden, and Heslop (2019), where recovery-oriented care is stated to view aggression as a learning opportunity, thereby enhancing the potential for future self-regulation and lessen the risk of aggression. Again, promoting personal recovery is disarming and de-escalating a potential hazardous situation.

#### 5.2.2 | Facing Suffering Together Reveals Treasures

Six articles (Cleary et al. 2013; Cook, Phillips, and Sadler 2005; Kingston and Greenwood 2020; Sellin et al. 2019; Solomon, Sutton, and McKenna 2021; Wesseldijk-Elferink, Hendriks, and van den Heuvel 2021) describe positive experiences of promoting personal recovery. Two of them also express that it does something with the nurse. Cook, Phillips, and Sadler (2005) convey an atmosphere of that being in the mud together elevates both the nurse and the person receiving care. They state that when nurses acknowledge and share common human life conditions with the patient, the ability to act genuinely and empathetically is enhanced. Sellin et al. (2019) describe that in mutual dialogue, nurses allow themselves to become vulnerable in order to confront the profound suffering but find reward in aligning with their values. This also enables the nurse to see the other person as a human being with resources. They paint a beautiful picture of that facing suffering together reveals treasures.

All six of these articles highlight reciprocity as important foundation for personal recovery. Besides Sellin et al. (2019) mentioned above, Cook, Phillips, and Sadler (2005), in the ambience of that being in the mud together elevates both, express that the deepened relationship fosters a holistic perspective with qualities such as hope, respect, empathy, openness, energy and accessibility. Solomon, Sutton, and McKenna (2021), with the metaphor of finding shelter together in the mud, point out that with mutual and trusting relationships as foundation, space opens for inner healing, the creation of meaning and the process of grieving to occur. Wesseldijk-Elferink, Hendriks, and van den Heuvel (2021) highlight that gaining trust, being honest and investing in communicative reciprocity and inter-human contact by getting acquainted with the person behind the illness increase the therapeutic alliance. They metaphorically state that true alliances go beyond labels. Kingston and Greenwood (2020) share that life in the mud can be explored together and convey that therapeutic relationships provide an opportunity to approach the patient's lifeworld and collaboratively explore their issues, balancing a natural flow and structured support. Cleary et al. (2013) state that a holistic approach, along with a therapeutic relationship, emphasises the patient's strengths and hope for the future and enhances the potential for recovery, portraying a picture of building firm foundation together.

Three of the articles convey a levelling in the relationship as one key ingredient. Cook, Phillips, and Sadler (2005) hint that being in the mud together elevates both, and Sellin et al. (2019) breathe that facing suffering together reveals treasures. Both are mentioned above. Solomon, Sutton, and McKenna (2021) express that walking alongside the patient at eye level and creating a feeling of safety, using hopeful language regarding new possibilities, can instill a sense of hope, implying a metaphor of finding shelter together in the mud.

#### 5.2.3 | Elevating the Competent Partner Promotes Recovery

Three studies (Cook, Phillips, and Sadler 2005; Nardella et al. 2021; Solomon, Sutton, and McKenna 2021) underscore participation as an important part of promoting personal recovery. Cook, Phillips, and Sadler (2005) express that levelling and participation cultivate a facilitating approach within nursing care. In short, partnership is facilitating. Nardella et al. (2021) states that participation in the care plan provides an opportunity for discussions concerning recovery, self-care and social support, but also that daily goals and encouragement to participate in activities are important starting points for recovery. The metaphor conveyed here is that encouraging participation as partner promotes personal recovery. Solomon, Sutton, and McKenna (2021) share a notion that bonding promotes partnership towards recovery by underscoring that you can cultivate mutual and trusting relationships over time through humour, play and a shared culture to gain a deeper understanding of the patient.

Two studies (Cleary et al. 2013; Solomon, Sutton, and McKenna 2021) highlight the importance on focusing on strengths. Cleary et al. (2013), in the atmosphere that elevating the competent partner promotes recovery, state that nurses can support the patient's recovery by emphasising abilities and potential in the planning process, as well as facilitating higher functioning through everyday psychiatric care. Solomon, Sutton, and McKenna (2021) express that an ambience of bonding is crucial in promoting partnership towards recovery, the importance not solely concentrating on deficits but also recognising the patients' positive strengths. They then become active partners in their own recovery.

## 6 | Discussion

### 6.1 | Results and Discussion

The purpose of the study was to synthesise research on nurses' experiences of promoting personal recovery among persons receiving psychiatric inpatient care. Nine articles were included



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as the basis for the synthesis, collectively involving between 116 and 138 nurses. The variation in numbers was due to one study incorporating a follow-up with partially different participants. Four of the studies were conducted in Australia, three in New Zealand, one in the Netherlands and finally, one was conducted in Sweden.

In the analysed articles, recovery-oriented care is portrayed positively and deemed worthwhile. The description of recovery in the articles often aligns with SAMHSA's (2012) definition of recovery, as outlined in the background section. It is evident in several included studies (Lim, Wynaden, and Heslop 2019; Nardella et al. 2021; Hristodoulidis, Munro, and Brooks 2022; Cleary et al. 2013; and Wesseldijk-Elferink, Hendriks, and van den Heuvel 2021) that recovery-oriented care is perceived to varying degrees. This perception is influenced by how much the care is shaped by the clinical perspective on recovery versus personal recovery.

A pronounced clinical perspective on recovery in inpatient care is described in this synthesis as a barrier within the principal heading 'erected walls in psychiatric inpatient care impedes personal recovery' and can be discerned in the overarching metaphors 'cultivating in exhausted soil' and 'nurses are gatekeeping watchdogs' which pertains to the more cultural aspect within the profession. Similar findings of conflicting views among staff regarding recovery were reported in a review by Waldemar et al. (2016). However, Wyder et al. (2017) found that nurses perceive effective clinical nursing as essential for recovery. Nonetheless, when care becomes too task-focused at the expense of building person-centred relationships, it may be regarded as counterproductive. The high workload for nurses combined with shattered tasks and the task of ensuring safety was highlighted as a complicating factor stemming from cultural and structural barriers in line with these metaphors. Waldemar et al. (2016) highlight that even though there were expressions of a focus on recovery-oriented care, it was largely empty rhetoric and not implemented in the hospital's structures and daily work. This was despite the staff's efforts to promote recovery-oriented principles. The cultural reality for nurses is vividly portrayed by Rio et al. (2020) in a study regarding the impact of workplace culture on nurses' responsibility to involve patients in care planning, in the context of recovery-oriented care. It is expressed that a culture prioritising shorter lengths of stay and, consequently, administrative tasks, resulted in less recovery-oriented care. Furthermore, a focus on crises and risk management also resulted in fewer opportunities for patients to be involved in care planning. Nurses' contributions in rounds with multidisciplinary teams were considered minimal, with medical staff primarily turning to allies whose opinions carried more weight. This also led to nurses feeling lower in rank, resulting in less focus on the care plan. Leadership did not demand any responsibility for the care plan or its quality. The nurse's therapeutic engagement with the patient was considered a solid foundation for discussing various possibilities and jointly deciding on the way forward. However, the nurse's multiple responsibilities, including responding to safety concerns, managing coercive situations and attempting to build a therapeutic relationship around the care plan, created tensions between therapy and coercion.

These reviews consistently support the finding that nurses are forced to cultivate in exhausted soil. Cultural settings position the nurse as a gatekeeping watchdog. The necessary conditions for nurses to effectively support personal recovery are insufficient. It appears that competing interests and rigid structures in psychiatric inpatient care are challenging to change. Perhaps that is why Barker and Buchanan-Barker (2005) in the Tidal Model go so far as to almost reject a focus on evidence-based care unless there is an ethical focus of an empowered person at the center. In their presentation, the comparison is made that a person receiving psychiatric care is objectified and placed under slave-like conditions. A similar comparison is also found in a meta-synthesis of 15 studies by Lindgren et al. (2019) on patients' experiences of psychiatric inpatient care. Here, the experience is described as being in a prison. Patients felt physically and socially restricted by rules, without rights, controlled and powerless. Additionally, they experienced a sense of abandonment without support from family and staff. It is indeed a thought-provoking reflection. Reassessing how psychiatric inpatient care promotes ethical care with a holistic perspective in relation to resource allocation and the medical perspective's focus on problems is a crucial and challenging task. A holistic approach to care and an increased emphasis on patients' experiences and autonomy can be guiding principles for improving healthcare. However, it likely requires both structural and cultural changes within the healthcare system to create a more conducive environment for both patients and staff.

This brings us to the second and more hopeful part of this synthesis. The second principal heading that has emerged in this study is that 'torn-down walls in psychiatric inpatient care enable personal recovery'. The first overarching metaphor 'disarming and de-escalating' concerns the safety of the ward and how nurses find that recovery-focused care can reduce the risk of aggression and enhance security. A systematic review on patients' experiences of psychiatric inpatient care (Staniszewska et al. 2019) describes similar findings. It is expressed that good relationships between staff and patients reduced the use of coercive measures. Furthermore, the experience of feeling safe on the ward was a priority for patients, which they could feel if they perceived the staff as reliable, supportive and caring. The overarching metaphor 'facing suffering together reveals treasures' underscores the significance of the therapeutic relationship, which is an integral part of personal recovery. In the literature review by Staniszewska et al. (2019) on patients' experiences of psychiatric inpatient care, it is emphasised that the importance of a high-quality relationship with the staff was one of the most consistent findings in the reviewed studies. Here, crucial conditions for building such a relationship are described, including being treated with respect, experiencing stability, feeling empathy from the staff and having high-quality communication with reliable and helpful personnel. The therapeutic relationship is also a cornerstone in the Tidal Model as described by Barker and Buchanan-Barker (2005). The nurse is to have daily, private conversations with the person where they explore change together. In this model, the nurse does not lead the process but is seen as a co-traveller in a mutual relationship, which is described as meaning caregiving together or a therapeutic relationship.



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The last overarching metaphor 'elevating the competent partner promotes recovery' relates to the invitation for participation in an unpretentious manner. There are related findings in McAllister et al.'s (2019) literature review on therapeutic engagement between nurses and patients in psychiatric inpatient care, exploring how this has been defined in various studies. Nurses assumed an enabling role, starting from the perspective that patients themselves knew the way to regain well-being and achieve a new understanding of themselves. In this way, patients achieved increased empowerment. To facilitate this, nurses were open, honest and empathetic in their feedback. Creating a secure environment where patients felt protected and validated was essential for them to venture into finding new ways of being. Another principle related to this type of engagement, touching on the undertone of this work, is 'choosing the right approach.' This highlights the nurse's use of both planned and formal, as well as spontaneous, informal encounters, even though there was a risk that the meeting could also have elements of being non-therapeutic. The nurse adjusted their approach to the patient based on individual needs and behaviour.

This second part of the synthesis shows that nurses view promotion of personal recovery in psychiatric inpatient care possible to some degree. Although quality relationships take time to build, they bring dignity to psychiatric inpatient care. In the introduction to this work, several concerns were raised. Nurses have an ethical code (ICN 2021) that promotes person-centred care and fosters an environment characterised by respect for human rights. These principles, among others, emphasise that we are all equal in dignity and rights and should act towards one another in a spirit of brotherhood (UNOHCHR 1996). It appears that the concept of personal recovery achieves this. However, it could be argued that, in the experiences of nurses and persons receiving psychiatric inpatient care, clinical recovery, important as it is, does not in its more rigid and limited form. The obstacles nurses face in promoting personal recovery appear to resonate with the experiences of persons receiving psychiatric inpatient care as prison-like conditions, where an overly strong medical focus reduces the person to a medical condition to be cured or alleviated. In a modern society that strives to promote human rights, a person cannot be reduced to a diagnosis. A holistic approach is required, and healthcare as an organisation must reassess its practices to better support personal recovery. Nurses need to continue advocating for persons under their care, so that, together with other healthcare professionals, they can find ways to collaborate and support the patient's own path to recovery.

### 6.2 | Method Discussion

The metaethnographic synthesis chosen follows the seven steps outlined by Noblit and Hare (1988). According to Polit and Beck (2021), metasynthesis is not a mere aggregation of literature but, in reference to Schreiber, Crooks, and Stern (1997), it involves bringing together and deconstructing findings, examining them, identifying crucial components and then constructing a new cohesive whole. The ability to interpret and condense meaning while preserving uniqueness and subsequently building a new comprehensive narrative has been a fundamental characteristic and aspect influencing the choice of method, and it is deemed to be well-suited for this synthesis. The word interpretation raises certain questions, but the hope is that the presentation and execution of the synthesis are done in a trustworthy manner. A strength in the conducted synthesis is the effort to report and be meticulous and consistent in the various steps of the method. This includes studies where multiple parties are involved. The experiences of nurses have been clearly discernible, in line with this reviews' aim. Despite significant efforts to find synonyms for search terms by reading relevant literature before literature searches, there is a possibility that additional keywords could have yielded more results.

To enhance dependability, the method and approach have been presented at each step, facilitating the possibility of replicating the study in a similar manner. Additionally, the data collection through searches has been detailed, including keywords, the number of hits and inclusion and exclusion criteria. Perhaps the reporting of statistics regarding reasons for excluding articles could have been presented in greater detail. Concerning confirmability, the literature review conducted is done with an ambition for precision, manifested by repeatedly returning to the original material in the context of the original articles to ensure that meaning is not lost or distorted. However, it could be perceived as weakness that the draft of the synthesis has been carried out mainly by the primary author, although the critical input and discussions between all the authors has been an invaluable contribution to further the analytical perspective. In the background of the conducted synthesis, there is a description of various aspects related to the purpose underlying the synthesis. While not exhaustive, the hope is that the reader, with the help of this, can gain an understanding of the complexity and context of the chosen topic for investigation, thus enhancing transferability.

## 7 | Conclusion

This synthesis offers greater insights into nurses' experiences in promoting personal recovery within psychiatric inpatient care. Although no previous reviews on the specific topic could be found, related research proclaim the same message. Nurses striving to advance personal recovery face considerable challenges, including a competing medical and clinical culture, insufficient resources and an unsupportive organisational environment. Despite these obstacles, personal recovery can be promoted to some extent, though occasionally at the expense of the nurse's own well-being. However, the benefits are substantial, including reduced aggression on the ward, the promotion of human rights in a spirit of brotherhood and the treatment of persons with dignity. Collaborative bridges need to be built with other healthcare professionals to genuinely promote personal recovery in psychiatric inpatient care. Otherwise, obstacles for nurses to promote personal recovery may become too insurmountable.

## 8 | Relevance for Clinical Practice

The synthesis highlights two different paradigms in psychiatric inpatient care that compete for resources and attention. We need an ethical reflection on the type of care we want and how



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persons should be treated. There is a need for more collaboration between professions and different units within the healthcare organisation to create space for promoting personal recovery.

### Author Contributions

**Patrick Hallberg:** conceptualisation, collection of data, formal analysis and writing – original draft. **Ulla Hällgren Graneheim:** reviewing critically and editing. **Maivor Olsson-Tall:** conceptualisation, formal analysis, writing – original draft and supervising the manuscript. All authors read and approved the final manuscript for publication.

### Conflicts of Interest

The authors declare no conflicts of interest.

### Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Asterisk (*) indicates references included in the results section.

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**Appendix 1**

**Searches**

Search one:

| PsychInfo 230 224 | Search words/subject terms | Hits | Read titles | Read abstracts | Read articles | Chosen articles |
|---|---|---|---|---|---|---|
| S1 | (DE "Mental Disorders") OR (DE "Psychiatric Patients") OR (DE "Psychiatry") | 199 864 | | | | |
| S2 | Psychiatr* OR "mental illness" OR "mental health" OR "mental disorder" OR "mental ill-health" | 1 354 639 | | | | |
| S3 | S1 OR S2 | 1 371 759 | | | | |
| S4 | Nurse* | 88 362 | | | | |
| S5 | (DE "Psychiatric Nurses") | 3 939 | | | | |
| S6 | S4 OR S5 | 88 362 | | | | |
| S7 | (DE "Psychiatric Hospitals") OR (DE "Psychiatric Units") | 10 961 | | | | |
| S8 | Inpatient OR hospital OR ward OR unit | 669 405 | | | | |
| S9 | S7 OR S8 | 669 405 | | | | |
| S10 | (DE "Recovery (Disorders)") | 15 512 | | | | |
| S11 | Recovery | 88 134 | | | | |
| S12 | S10 OR S11 | 88 134 | | | | |
| S13 | (DE "Attitudes") OR (DE "Life Experiences") | 61 845 | | | | |
| S14 | Perception* OR attitude* OR opinion* OR experience* OR view* OR reflection* | 2 047 076 | | | | |
| S15 | S13 OR S14 | 2 047 076 | | | | |
| S16 | S3 AND S6 AND S9 AND S12 AND S15 | 310 | | | | |
| Limitations: peer review, english | | 278 | 278 | 56 | 17 | 5 |

Search two:

| Cinahl 230 302 | Search words/subject terms | Hits | Read titles | Read abstracts | Read articles | Chosen articles |
|---|---|---|---|---|---|---|
| S1 | (MH "Psychiatry") OR (MH "Forensic Psychiatry") OR (MH "Psychiatric Units") OR (MH "Psychiatric Patients") | 28 877 | | | | |
| S2 | Psychiatr* OR "mental illness" OR "mental health" OR "mental disorder" OR "mental ill-health" | 284 640 | | | | |
| S3 | (MH "Mental Disorders") OR (MH "Mental Disorders, Chronic") OR (MH "Organic Mental Disorders, Substance-Induces") OR (MH "Organic Mental Disorders, Psychotic") OR (MH "Organic Mental Disorders") OR (MH "Behavioural and Mental Disorders") | 68 941 | | | | |
| S4 | S1 OR S2 OR S3 | 303 133 | | | | |
| S5 | Nurse* | 579 553 | | | | |
| S6 | (MH "Psychiatric Nursing") | 19 229 | | | | |
| S7 | S5 OR S6 | 588 039 | | | | |
| S8 | (MH "Inpatients") OR (MH "Psychiatric Patients") OR (MH "Patients") | 109 310 | | | | |



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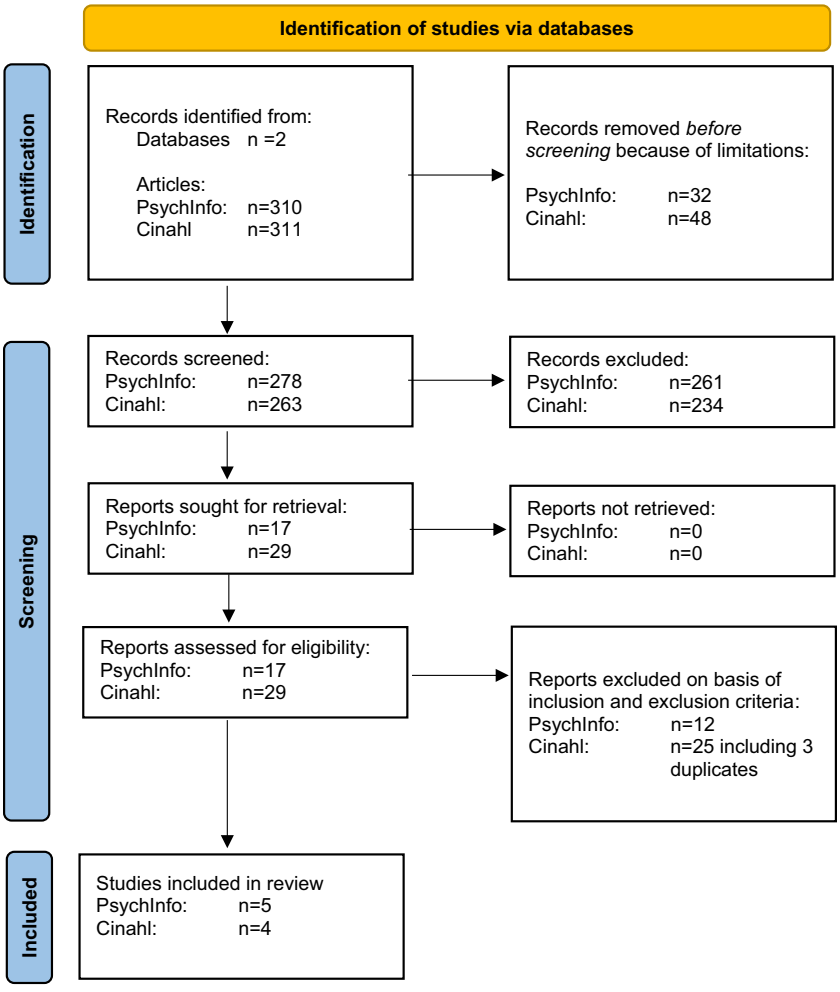
| Cinahl 230 302 | Search words/subject terms | Hits | Read titles | Read abstracts | Read articles | Chosen articles |
|---|---|---|---|---|---|---|
| S9 | Inpatient OR hospital OR ward OR unit | 807 971 | | | | |
| S10 | S8 OR S9 | 825 543 | | | | |
| S11 | (MH "Recovery") | 38 675 | | | | |
| S12 | Recovery | 122 584 | | | | |
| S13 | S11 OR S12 | 122 584 | | | | |
| S14 | (MH "Job Experience") OR (MH "Work Experiences") | 24 025 | | | | |
| S15 | Perception* OR attitude* OR opinion* OR experience* OR view* OR reflection* | 1 103 976 | | | | |
| S16 | (MH "Nurse Attitudes") OR (MH "Attitude of health Personnel") | 89 230 | | | | |
| S17 | S15 OR S16 | 1 103 976 | | | | |
| S18 | S4 AND S7 AND S10 AND S13 AND 14 AND S17 | 311 | | | | |
| Limitations: peer review, english | | 263 | 263 | 94 | 29 | 4 |

## Appendix 2

### PRISMA Flow Diagram

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## Appendix 3

### Quality Assessment

CASP qualitative checklist (2018a).

| | Question | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Article** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| Lim, Wynaden, and Heslop (2019) | Y | Y | Y | Y | Y | Y | Y | N | Y | Y |
| Nardella et al. (2021) | Y | Y | Y | N | Y | Y | Y | Y | Y | Y |
| Sellin et al. (2019) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Hristodoulidis, Munro, and Brooks (2022) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Cleary et al. (2013) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Wesseldijk-Elferink, Hendriks, and van den Heuvel (2021) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Solomon, Sutton, and McKenna (2021) | Y | Y | Y | Y | Y | C/T | Y | Y | Y | Y |
| Cook, Phillips, and Sadler (2005) | Y | Y | Y | Y | Y | C/T | Y | Y | Y | Y |
| Kingston and Greenwood (2020) | Y | Y | Y | Y | Y | C/T | Y | Y | Y | Y |

*Note:* 1: Was there a clear statement of the claims of the research? 2: Is a qualitative methodology appropriate? 3: Was the research design appropriate to address the aims of the research? 4: Was the recruitment strategy appropriate to the aims of the research? 5: Was the data collected in a way that addressed the research issue? 6: Has the relationship between researcher and participants been adequately considered? 7: Have ethical issues been taken into consideration? 8: Was the data analysis sufficiently rigorous? 9: Is there a clear statement of findings? 10: How valuable is the research?
Abbreviations: C/T, can't tell; N, No; Y, Yes.

CASP Cohort Study (2018b).

| | Question | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Artikel** | **1** | **2** | **3** | **4** | **5A** | **5B** | **6A** | **6B** | **7** | **8** | **9** | **10** | **11** | **12** |
| Nardella et al. (2021) | Y | N | N | Y | Y | N | N | Y | Y | Y | Y | N | Y | Y |

*Note:* For questions that cannot be answered with a simple Yes/No, a Yes response signifies an acceptable level with a thorough explanation of potential sources of error.. 1: Did the study address a clearly focused issue? 2: Was the cohort recruited in an acceptable way? 3: Was the exposure accurately measured to minimise bias? 4: Was the outcome accurately measured to minimise bias? 5A: Have the authors identified all important confounding factors? 5B: Have they taken account of the confounding factors in the design and/or analysis? 6A: Was the follow up of subjects complete enough? 6B: Was the follow up of subjects long enough? 7: What are the results of this study? 8: How precise are the results? 9: Do you believe the results? 10: Can the results be applied to the local population? 11: Do the results of this study fit with other available evidence? 12: What are the implications of this study for practice?
Abbreviations: C/T, can't tell; N, No; Y, Yes.

## Appendix 4

### Overview of Analysed Literature

| Title, author, year, country | Problem statement and aim | Approach and methodology | Selection and study group | Main result |
|---|---|---|---|---|
| Changing practice using recovery-focused care in acute mental health settings to reduce aggression: a qualitative study, Lim, E., Wynaden, D. and Heslop, K., 2019, Australia | Aggression among patients is common in psychiatric emergency care. The aim of this study was to gain an enhanced understanding of nurses' knowledge regarding components of recovery-oriented care and how it can be employed to reduce aggression in psychiatric emergency care | Empirical, qualitative study. The interviews were semi-structured and analysed using qualitative content analysis following Charmaz's approach | 27 nurses with a minimum of 12 months' experience in psychiatric emergency care<br>Quality assessment<br>Acceptable level. Please refer to Appendix 3 | The analysis resulted in five categories: (1) Identifying the cause of behaviour before responding, (2) being sensitive to patients' triggers for aggression, (3) focusing on patients' strengths and support, not risks, (4) being attentive to patients' needs, (5) reassessing aggression as a learning opportunity |

(Continues)



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**Appendix 4** | (Continued)

| Title, author, year, country | Problem statement and aim | Approach and methodology | Selection and study group | Main result |
|---|---|---|---|---|
| Developing acute care-based mental health nurses' knowledge and skills in providing recovery-oriented care: a mixed methods study, Nardella, N., Hooper, S., Lau, R., and Hutchinson, A., 2021, Australia | A private hospital aims to implement recovery-focused principles in nursing through an educational intervention and collaboration with patients to develop resources for promoting active patient participation. The purpose was to evaluate these interventions concerning nurses' knowledge of and ability to provide recovery-oriented care when working with patients in an emergency healthcare environment | Empirical, mixed methods. The qualitative component has been utilised for the current review. The interviews were semi-structured and analysed using qualitative content analysis following Braun and Clarke's approach | 13 nurses from two psychiatric inpatient units<br>Quality assessment<br>Acceptable level. Please refer to Appendix 3 | Three themes emerged from the qualitative analysis of interviews: (1) Nurses' understanding of personal recovery-oriented practice, (2) how to implement personal recovery-oriented care in practice, (3) barriers to patient participation in recovery-oriented activities in emergency healthcare |
| Experiences of a recovery-oriented caring approach to suicidal behaviour: a single-case study, Sellin, L., Kumlin, T., Wallsten, T. and Wiklund Gustin, L., 2019, Sweden | The aim was to explore and evaluate how a novel recovery-oriented nursing approach was experienced by a suicidal patient in the context of close relatives and nurses | Empirical, qualitative interview study. The analysis employed qualitative content analysis according to Ödman | One patient, one close relative, and three nurses in psychiatric inpatient care<br>Quality assessment<br>Acceptable level. Please refer to Appendix 3 | Recovery-focused care empowers the patient to articulate, carry experiences of hopelessness, seek support rather than viewing suicide as the only possible way out. Furthermore, it has the potential to assist patients, relatives and nurses in developing a shared language, considering the patient's life situation and struggles, and using this as a source for the patient's individual care planning |
| Exploration of personal recovery-oriented care on an acute mental health unit, Hristodoulidis, D., Munro, I. and Brooks, C., 2022, Australia | The purpose was to explore psychiatric nurses' lived experience of their practice, understanding and knowledge of personal recovery-oriented care in psychiatric emergency care units | Empirical, qualitative study. The interviews were semi-structured and analysed using thematic content analysis according to van Manen | Seven nurses working in a psychiatric inpatient unit.<br>Quality assessment<br>Acceptable level. Please refer to Appendix 3 | Participants experienced that personal recovery was challenging in psychiatric inpatient care. Barriers included the severity of patients' illness, lack of time to engage with patients and the loss of a therapeutic role for psychiatric nurses in emergency care units |
| Mental health nurses' views of recovery within an acute setting, Cleary, M., Horsfall, J., O'Hara, A. M., & Hunt, G. E., 2013, Australia | The aim was to inquire psychiatric nurses in closed acute care about their understanding of recovery and how they incorporate a recovery paradigm into their daily nursing practice. | Empirical, qualitative interview study analysed through thematic content analysis | 21 nurses working in psychiatric inpatient care<br>Quality assessment<br>Acceptable level. Please refer to Appendix 3 | Three themes emerged: (1) Perceptions of recovery, (2) Congruent humanistic approaches, (3) Practical realities |
| Shared decision-making in a semi-secluded chronic psychiatric ward: the reflective lifeworld experiences of patients with schizophrenia or schizoaffective disorders and nursing staff, Wesseldijk-Elferink, I. J. M., Hendriks, A. W., & van den Heuvel, S. C. G. H., 2021, The Netherlands | The purpose was to describe the experiences of patients with schizophrenia or schizoaffective disorder regarding shared decision-making in partially locked psychiatric inpatient care, and psychiatric nurses' attitudes towards shared decision-making | Empirical, qualitative interview study analysed using content analysis according to Dahlberg et al. | 7 patients and 6 psychiatric nurses in a psychiatric inpatient unit<br>Quality assessment<br>Acceptable level. Please refer to Appendix 3 | Despite psychiatric nurses' scepticism towards the use of shared decision-making, and patients often feeling overlooked, the therapeutic alliance increased when there was an investment in interpersonal contact |

(Continues)



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**Appendix 4** | (Continued)

| Title, author, year, country | Problem statement and aim | Approach and methodology | Selection and study group | Main result |
|---|---|---|---|---|
| The experience and meaning of recovery-oriented practice for nurses working in acute mental health services, Solomon, B., Sutton, D., and McKenna, B., 2021, New Zealand | The aim was to explore the experience and meaning of recovery-oriented practice among 10 nurses working in psychiatric inpatient care | Empirical, qualitative in-depth interviews analysed using qualitative content analysis according to van Manen | 10 nurses in a psychiatric inpatient unit<br>Quality assessment<br>Acceptable level. Please refer to Appendix 3 | Although the experience and meaning of recovery-oriented care varied among nurses, there were common themes in their statements, such as emphasising nurses' role in creating diverse therapeutic environments to promote safety, relational commitment and healing for patients. Nurses also encountered challenges for recovery-oriented care, such as hierarchical culture within the team and the system |
| The tidal model as experienced by patients and nurses in a regional forensic unit, Cook, N. R., Phillips, B. N., and Sadler, D., 2005, New Zealand | The purpose was to explore the experience of using the Tidal Model by eliciting perspectives from the two groups directly affected by the model: registered nurses and the special patients | Empirical, qualitative interview analysed using qualitative content analysis according to van Manen | Four patients and four nurses in a forensic psychiatric unit<br>Quality assessment<br>Acceptable level. Please refer to Appendix 3 | Five themes emerged, indicating (1) a sense of hope, (2) power balancing, (3) connectedness in relationships, (4) more effective collaboration and (5) a human face |
| Therapeutic relationships: making space to practice in chaotic institutional environments, Kingston, M. A. and Greenwood, S., 2020, New Zealand | Increasing bureaucracy, partially driven by risk assessment, hinders psychiatric nurses' ability to engage therapeutically with patients, potentially impeding their recovery. The aim was to explore nurses' experiences of therapeutic relationships in their current workplace | Empirical, qualitative semi-structured interviews analysed using qualitative content analysis according to van Manen. | 8 psychiatric nurses working in psychiatric inpatient care<br>Quality assessment<br>Acceptable level. Please refer to Appendix 3 | Four themes emerged: (1) crisis, crisis, crisis, (2) fragmented structures and excessive regulations, (3) creating space for practice and (4) joining the patient's world and exploring together |



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