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Anna Treloar
School of Nursing and Midwifery,
University of Newcastle, Callaghan
NSW 2308, Australia
Tel: +61-2-4921-7873
Fax: +61-2-4921-6301
E-mail: anna.treloar@newcastle.edu.au

Developing Criteria for the Selection of Contemporary Stimulus Material in Mental Health Nursing Education: Engaging Students and Meeting Curriculum Goals – Part 1: Critical Analysis of Simulation and Stimulus Material in Mental Health Nursing Education

Anna Treloar, Margaret McMillan, Teresa Stone, Miran Kim

School of Nursing and Midwifery, University of Newcastle, Australia

Purpose: By focussing on curricula reliant on blended (online and face-to-face) learning, to test the value of mental health stimulus material created/used by Australians in an Australian context to achieve learning outcomes through assessment tasks for students from a range of cultural backgrounds. Can we find stimulus material that facilitators can use with diverse cultures?

Methods: Case studies centred on two groups of students – Australian (Part 1) and international (Part 2).

Results: An analysis of simulation and stimulus material in mental health nursing education (Part 1) and the development of i) a set of principles for choosing 'authentic' stimulus material ii) a set of recommendations for choices of assessment tasks that ensure application of the principles irrespective of the culture and context in which graduates choose to work (Part 2).

Conclusion: While there are many types of stimulus material available today, authentic stories from clinical practice may also have a useful role in mental health nursing curricula.

Keywords: Psychiatric/mental health nursing; Education

INTRODUCTION

"PBL (Problem Based Learning) is an educational approach that has the potential to foster the construction of meaning and deeper learning: it is a 'hallmark' of curriculum design for the health professions" (Park, Conway & McMillan, 2016) and has a philosophical and methodological basis. Models of PBL have developed significantly so that there is now greater focus on many different types of stimulus materials linked to stronger preparation for practice and offered with structured debriefing (Conway & McMillan, 2010). The success of PBL is dependent on the quality, authenticity and applicability of the teaching materials used and Part 2 of this paper will focus on the development of a set of principles for choosing 'authentic' stimulus material for the mental health nursing context.

We will first describe the context of care before considering the educational context. Graduate employment rates are high for health professionals in Australia, and in 2015 aged care received the greatest numbers of nurses and midwives, and hospital (excluding outpatients) was

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their principal work setting (AIHW, 2016b). Even when the nurse is not in a mental health setting, integrated care requires mental health nursing skills. Integrated health services delivery is defined by the World Health Organization Regional Office for Europe as

an approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course (WHO, 2016).

Mental health conditions were the second most common chronic illness in Australia (after cardiovascular disease) in the years 2014-2015 (Australian Institute of Health and Welfare, 2016a). Nurses themselves may also have mental health problems (Joyce et al., 2012).

This paper will look at the importance of equipping students with the mental health skills required for practice by using authentic clinical anecdotes from actual clinical settings.

One of the greatest challenges for those responsible for curriculum implementation is how to access, manage and be assured of quality in clinical placements, experience, clinical teaching and the learners' responses to settings and clientele (Park et al., 2016). How students are assessed on their learning then becomes crucial. There may be a need in implementing a new curriculum "to challenge existing long held ideals, practices, and sacred cows within the health and higher education sectors" (Waters, Rochester & McMillan, 2012). This includes a distinguishing feature of PBL, ie critical examination of the stimulus material used in teaching, simulation and assessment.

Nursing clinical placements have become harder to establish and organise, and simulation, while not a substitute for clinical placement, may be a useful adjunct. There are many types of simulation in current use and simulation may be supported by online learning. Universities are an integral part of the society surrounding them and must play a critical role in the development of that society (McIntyre, 2014). As reliance on digital technology increases throughout society, tertiary education too must adapt and change.

Simulation

Simulation is defined as the artificial representation of a phenomenon or activity that allows participants to experience a realistic situation without real-world risks (Larew et al., 2006). A concept analysis of simulation provided this definition:

"A dynamic process involving the creation of a hypothetical opportunity that incorporates an authentic representation of reality, facilitates active student engagement and integrates the complexities of practical and theoretical learning with opportunity for repetition, feedback, evaluation

and reflection" (Bland, Topping & Wood, 2011).

The Australian Nursing and Midwifery Accreditation Council (ANMAC) proposes to adopt the simulation definition given by Gaba (2004) - "Simulation is a technique, not a technology, to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner". It may include actors, roleplays, software, manikins, task trainers, virtual reality, gaming and case studies with the aim of active learning, creative thinking and higher level problem solving. Simulation allows repeated practice of skills, exposure to unpredictable practice situations, formative and summative assessment, and opportunities to reflect on practice (ANMAC, 2018). Feedback is essential and students can also reflect on their interactions.

Types of simulation material available

There are a number of types of simulation materials available including web-based simulation, standardised patients, three dimensional (3D) simulation games, involving blended learning as well as patented approaches such as MaskEd™.

High fidelity web-based simulation can be used to teach undergraduates to recognise the deteriorating patient (Cooper et al., 2012) and a simulated "live" setting in a laboratory can allow mental health nursing students to increase their ability to recognise physical deterioration in a patient (Chadwick & Withnell, 2016). High fidelity simulation has been used to teach students how to undertake an alcohol withdrawal assessment following possible deliberate self harm in the ED setting (Kunst, Mitchell & Johnston, 2017).

Standardised patients (actors) are used to teach nurses communication in various clinical settings, including mental health (Martin & Chanda, 2016); discharge and transition of care are identified as areas of particular relevance (MacLean, Kelly, Geddes & Della, 2017).

Three dimensional (3D) simulation games can be used to teach clinical reasoning in nurse education, with authentic patient-related experiences and learning clinical reasoning having a positive relationship, and reflection having a strong relationship with the application of nursing knowledge; usability and exploration are also important (Koivisto, Haavisto, Niemi, Katajisto & Multisilta 2016). Multimedia resources have been developed for interprofessional education in the quality use of medicines, modules based on actual clinical situations and incident reports (Levett-Jones, Gilligan, Lapkin & Hoffman, 2012).

Web-based simulation can allow students to immerse themselves in a character role-play but more usually offer a mix of vid-

eo, audio, quiz, graphics, text and memo in a multimedia format. It can be personalised, individualised or made culturally relevant, it can be repeated so is cost-effective and it is accessible provided there is good internet access (Cant & Cooper, 2014).

Some blended learning programs which incorporate simulation such as video-assisted online resources were found in an integrative review by Coyne et al. (2018) to increase students' knowledge and skills but needed to be realistic and culturally appropriate. CaseWorld™, an online case based simulated learning environment incorporating actual cases with the input of expert clinicians, and the addition of video and audio with input from students as well, provides situational learning, authentic assessment, critical thinking, case-based learning and evidence-based practice. It does not aim to show perfect care but rather to show authenticity in clinical situations and to allow room for debate (Gilham et al., 2015).

An unusual type of simulation called MaskEd™ involves an educator wearing a full latex face mask to play a character with a history in an unscripted and spontaneous interaction with students. The acronym KRS stands for knowledgeable, realistic and spontaneous, and allows the educator to combine the art and science of nursing in a safe environment as well as in debriefing later (Frost & Reid-Searl, 2017).

Mental health consumer consultants worked with academics to produce mp3 files containing content characteristic of voice-hearing experiences for the education of undergraduate nursing student (Orr, Kellehear, Armari, Pearson & Holmes, 2013).

A technique called scenariation provides interactive individualised learning pathways which allows students to make decisions based on clinical presentations and then see the results of their decisions and this is seen as ideal for capturing the complex nature of the real-life workplace. Australian slang was included to assist international students to become familiar with the language they would hear in the Australian setting and a patient with specific cultural needs was included in the scenariation (Smith, Gillham, McCutcheon & Ziaian, 2011).

Moulage or the use of special effects makeup to simulate wounds or illnesses is another technique, but there is no clear evidence that it enhances student engagement (Stokes-Parish, Duvivier & Jolly, 2018).

Even compassion can be taught through a self-directed online module (Hofmeyer et al., 2018).

Fidelity vs authenticity

Interpretation of authenticity is highly individual (Bland, Topping & Tobbell, 2014). Knowledge should be translated through

action and in an authentic setting; however, authenticity does not follow fidelity automatically, and authenticity can be achieved with low fidelity (Bland et al. 2011). Fidelity seeks to reproduce object reality as closely as possible whereas authenticity “may be considered as a subjective interpretation/response to a constructed situation in which the student interacts with context, other students, facilitators and technology with varying degrees of fidelity” (Bland, Topping & Tobbell, 2014). Distinguishing between authenticity and fidelity is critical; high fidelity helps replicate a life like clinical situation. There are conceptual tensions between authenticity and fidelity but MaskEd™ may provide both, with the mask achieving some fidelity and the skill of the educator inside the mask providing authenticity (Bland, Topping & Tobbell, 2014).

Engaging students through use of simulation

Perceived value, perceived authenticity, and perceived choice are important factors in how students view simulation (Khaled, Gulikers, Biemans & Mulder, 2015) and whatever stimuli are used, the facilitator needs to be effective in motivating and engaging students.

Students found thinking on their feet and working with a ‘real’ patient during simulated case studies were the most valuable aspects (Mills et al., 2014). For a student to become “caught up in” a simulation and suspend disbelief, there needs to be fidelity, a fiction contract, psychological safety, emotional buy-in and assigned meaning; these will be influenced by attitudes, previous learning experiences, feeling of presence, personality differences and imagination (Muckler, 2017).

However, transfer of knowledge from simulation to clinical practice cannot be assumed, with students reporting a disconnect between the laboratory and the hospital setting (Nash & Harvey, 2017). Nursing as a practice discipline requires situated cognition and action, and students enjoyed developing critical thinking, integrating theory and practice and reflecting in a debriefing afterwards for a simulation involving an acute surgical patient, although once again in this study, transfer of learning to clinical practice was not demonstrated (Nevin, Neill & Mulkerins, 2014). Repeating psychomotor and communication skills in various simulated environments increased student confidence and lowered anxiety levels, and student satisfaction increased as the simulated environment became closer to an authentic clinical situation (Terzioglu et al., 2016). For new graduates, simulation helped with relating theory to practice, with problem solving and with critical thinking, as well as seeing the “big picture” of patient care and actively seeking critique of their performance (Thomas & Mraz, 2017).

An Australian study found that mental health simulation can give students an opportunity to link theory to practice and to identify areas of deficiency and also allay their own anxiety about “saying the wrong thing” in a real clinical setting. The simulation was viewed as more useful than videos because it took place in real time, could be altered to fit with current issues and was highly interactive and engaging. “Buy in” was achieved because of realism and the immersive nature of simulation and this achieved “an authentic learning opportunity” (Alexander et al. 2018) which is important because interactions in mental health nursing are unscripted.

For it to be genuine and for you to be empathetic, you need to have a conversation not a checklist because there are no tickboxes in it (FS3 in Alexander et al. 2018).

Similar results were reported in a New Zealand study. Even the most sophisticated manikins cannot be programmed so as to provide authentic simulation of genuine mental health interactions. To be effective the actors who play the clients need to have self-awareness and avoid adding their personal experiences to the agreed roleplay. An effective simulation using an actor helps students to read situations including affect and body language, difficult skills to acquire using only lectures and textbooks (Bartlett & Butson, 2014).

To help students “get past the plastic” when using manikins in a clinical scenario, audio-visual vignettes using trained actors to depict patients from a variety of different cultural and socio-economic backgrounds were used. There was scope for the actors to use some of their own personal experiences in the vignettes to enhance authenticity and manikins and actors wore the same clothes for each role (Power et al., 2016). Many health professional programs now feature on-line learning but challenges around student engagement remain.

Engaging students online through effective teaching

Students in online courses value perceived connection with staff and this may be achieved through a variety of techniques; doing the work and being actively engaged in the course; various methods of content delivery; and course organisation. A flexible approach and feedback including affirmations were also important (Post, Mastel-Smith & Lake, 2017; Price, Whitlatch, Mayer, Burdi & Peacock, 2016). Interestingly, Lonn and Teasley (2009) found that students and teachers valued the communication tools in Learning Management Systems more than they valued all the interactive tools for innovating existing practices.

The Australasian Council on Open, Distance and e-Learning (ACODE) recommends that learning activities are aligned with

the intended learning outcomes (constructive alignment) so that students can develop and finally demonstrate what they have learned (ACODE, 2017). In a field like mental health nursing making this strong alignment is particularly important because some of the concepts in this field are broad and not easily grasped by students new to the field.

A social presence which can be created through audio, video and written interactions contributes to a sense of being part of an online community. “The reported lack of interaction in most online learning environments coupled with the limited use of appropriate technologies are areas that nurse educators should consider as they design their online courses” (Stanley, Serratos, Matthew, Fernandez & Dang, 2018). Microblogging (an online communication using 140 characters) can be used to encourage informal and process-oriented learning, allowing students to become part of a “murmuring community” (Ebner, Lienhardt, Rohns & Meyer, 2010).

Online courses in nursing are increasing but Gazza (2017) notes that little has been done to discover what it is like to teach online, with one informant noting a level of intimacy not present in classroom teaching and another saying they felt even more engaged than in the classroom; however all informants noted the amount of time required and the need to be accessible and available at any time of the week. Another study found that preparation of students for simulation and fidelity of the session could be improved, while pedagogical principles and debriefing were satisfactory (Kable et al., 2018).

Online teachers require emotional intelligence and self-efficacy, concepts which are intertwined and complementary (Ali, Ali & Jones, 2017). Effective online teachers require “presence, interaction, respect, encouragement, and timely interaction” (Frazer, Sullivan, Weatherspoon & Hussey, 2017) and the relationship between them and their students can be seen as a kind of choreographed dance, during which sometimes the teacher leads, and sometimes the student leads. In a study by Smith and Crowe (2017) educators saw an interconnection between student engagement, knowing students and supporting students to meet their own needs, with staff-student relationships being crucial and some face to face meeting important too. Teaching online requires more time than face to face (Sword, 2012).

Simulation-based workshops and experiential learning were identified as the most usual training for educators. Competencies for simulation educators include planning and designing, facilitating in a “safe” environment, expert nursing knowledge, use of evidence-based practice and demonstration of professional identity and professional values. Compartment allows the educator to maintain authenticity in an artificial situation and is made up

of a range of skills (Topping et al., 2015).

To what extent does the curriculum dictate the design or choice of stimulus material?

Contemporary curriculum documents reflect the requirements of the national regulatory authorities and thus have similarities in expression of graduate outcome statements. Despite differences in nomenclature, most include a focus on nurses as good citizens, tolerant of cultural differences in consumer needs (especially those of Indigenous Australians), information and communication fluency, collaborative and therapeutic practice, informed, evidence/enquiry-based learning and practice, and a professional approach to remaining open to emerging models of care and associated knowledge. Of particular concern to the accreditors of curricula is the extent to which agreed outcomes are assessed. But whatever the philosophical underpinning of a curriculum blueprint, there should be application of theory to simulation-based education. The components of well designed and facilitated PBL include all of the above but particularly enhance students' critical thinking disposition and thus enhance the likelihood of them thinking critically (Martyn et al., 2014; Kong et al., 2014).

The concept of abilities becomes the organising principle for effective performance as a nurse and this concept needs to integrate higher education and the workplace. 'Abilities' thus encompasses a wide range of knowledge, skills and attributes and has been defined by the Alverno College Faculty as

multidimensional or more specifically, as complex combinations of skills, motivations, self-perceptions, attitudes, values, knowledge and behaviours (Rogers & Mentkowski 2004).

Effective stimulus material will be strongly linked to the curriculum. The Simulation Cycle (Bartlett, 2014) allows simulation to be embedded into the curriculum. A literature review conducted by Brown (2015) found that in mental health nursing use of simulation can increase student skills in therapeutic communication, critical thinking, problem solving, decision-making and risk assessment, as well as decreasing anxiety about nursing mental health patients.

Simulation, once viewed as a technology, and then as a technique (Gaba, 2004) has become a pedagogy and its principles and practices may be summarised by the mnemonic SIMULATION (structured, innovative, magical, unforgettable, learning-focused, aesthetic, transformative, immersive, outcome-focused, needed) (Levett-Jones & Guinea, 2017).

Simulation needs to be based on a sound pedagogy and demonstrate an increase in critical thinking skills. The Practice-Based

Simulation Model (PBSM) has five elements: Practice situation, simulation, structured learning, inquiry process and assessment, with the goal of the practice situation being authenticity, with pre- and post-concept mapping used to develop critical thinking. However summative assessment is recommended only for final year students, with formative assessment being used until then (Park et al., 2013).

Instructional design rather than the simulation itself may be crucial to the development of critical thinking (Park, Conway & McMillan, 2016). What is important is the interface between users, simulator and professional or institutional context.

Students need to understand what the simulation actually simulates and authenticity comes from interactive achievements. Simulation is related to work practice rather than to a game, although there must be rules of irrelevance too. "The design of simulation activities needs to account for the possibilities of participants understanding the specific conditions of the simulation and the work practices that the simulation represents" (Rystedt & Sjoblom, 2012). Clinical simulation should be scaffolded, i.e. accompanied by sufficient support when skills are first introduced so as to allow learning (Higginson & Williams, 2018).

A systematic review found that higher fidelity simulation had the potential to increase learning outcomes immediately; however, there was insufficient evidence to demonstrate this effect weeks or months later (Sherwood & Francis, 2018). Inconsistency in how simulation is evaluated creates challenges in demonstrating its benefits; robust evaluation tools which are linked to professional practice standards need to be developed (Kunst, Henderson & Johnston, 2018).

Can we find stimulus material which is suitable for all countries and all cultures?

Video clips from YouTube may be used as a substitute for actors; however these may not always be culturally appropriate. A clip made in England by the University of Nottingham showing a young man with psychotic symptoms being interviewed by a psychiatrist includes mention by the young man of "MIS". While this reference to the government Secret Service agency may be familiar and meaningful to British viewers, it would be less meaningful to people from other cultures. Similarly, stories suitable for the Australian context may not be so appropriate educationally for international students.

METHOD - Using authentic clinical anecdotes as culturally appropriate stimulus material

Clinical anecdotes told by nurses experienced in mental health can reveal aspects of the profession not easily discovered in text-

books or through simulation. These anecdotes, that are different from a case study, allow for variety and for the essential “messiness” of real world clinical practice to be investigated by students. They are authentic but may not always have true fidelity as defined above by [Bland, Topping and Tobell \(2014\)](#). Their very unpredictability can provide a rich source of material for understanding the nature of mental health nursing as it is practised. They present the sort of situation that has occurred in the real world of mental health nursing and encourage the student to move from what is already known to what needs to be learned as well. Clinical anecdotes can be selected for their alignment with learning objectives as well as for their cultural appropriateness and can incorporate problem-solving and critical thinking; students can collaborate, taking the sort of team approach to patient care which is the basis of much nursing work in wards today. Their very authenticity, messiness and contextual nature can provide a type of stimulus material which a purpose-written scenario cannot, although as the overview of types of simulation in current use shows, clinical anecdotes are not in common use.

In a project which received Ethics Approval from both the University of Newcastle and the University of New England (H-2016-0269) undergraduate mental health nursing students were presented with three authentic clinical anecdotes (see below) and invited to write their responses to them based on a framework of six questions (What are the consequences of the actions described? What are the intended consequences? What results are beneficial? What results are not beneficial? How could things have been done better? What results were unexpected?). An invitation to participate was made at the Moodle site for the first course, by individual email sent by the Unit Co-ordinator to all students enrolled (the Unit Co-ordinator was not one of the authors) and face to face during intensives and tutorials. Participant information and a link to the three stories and the framework for responses was provided at Moodle; students were advised that clicking on the link implied consent. Approximately 350 students were enrolled in the first course. Their understandings and interpretations of key mental health nursing concepts were sought through their responses to these authentic clinical anecdotes. It was not anticipated that students could come to any harm by reading the stories but information about how to access counselling was provided in the participant information. Students responded at the end of the trimester in 2018 in which they undertook their mental health nursing course. Only two students responded; both were Australian. The framework was used to analyse their responses by comparing the content of what they wrote in their interpretations of the stories. The framework was developed as part of one of the authors’ PhD studies ([Treloar, McMillan & Stone, 2015](#)).

The stories used were selected as they best illustrated work done by mental health nurses at its deepest level ([Treloar, McMillan & Stone, 2017](#)).

All students used Moodle to access lecture notes and course material as well as to read announcements relevant to their study. They submitted their major assignment through Turnitin and undertook an online quiz to complete the compulsory assessments for the course. The off campus students attended a two day “intensive” of lectures and tutorials; the on campus students had weekly lectures and weekly tutorials. All students therefore had some familiarity with on online learning platform so it could be assumed that participating in the survey would not have been challenging for any of them.

RESULTS

The stories were selected as being open to many interpretations and to these interpretations being made by students from different cultural backgrounds. In Story No 1 ([Appendix 1](#)) mindfulness of the breath can be understood not just by Australian students who have learned this technique either as part of a mental health nursing course or for their own personal development; in Story No 2 ([Appendix 2](#)) cultural beliefs about suicide and cultural constraints about nurses showing emotion in front of patients can be rich sources of discussion; and in Story No 3 ([Appendix 3](#)) the idiomatic “the smallest violin in the world playing just for you” might puzzle Australian students as well as students from other countries because the literal meaning of this expression does nothing to suggest what it actually means when used ironically in a context such as the one described in Story No 3.

The focus of one Australian student’s response to Story No 1 was on “high risk of suicide” with the comment made about the synchronous breathing as “not really a key aspect of the appointment”; the focus of the response to Story No 2 was “you need to cope”; and the focus of the response to Story No 3 was “small things that may not affect us can affect or tip someone over the edge”. For this student the complexities contained in the first two stories were missed, although understanding was deeper for the third story as this student noted “the patient opening up about her past”.

Another Australian student showed very different responses to the three stories, commenting on Story No 1 that the patient “leaves with no interventions”, on Story No 2 that “it is still described as something secret/hidden” (though this student did not define whether “it” referred to suicide or to a nurse crying in front of a patient’s family) and for Story No 3 noting “the turn-

around in hostility to bonding” (thus demonstrating an appreciation of the establishment of a therapeutic relationship). It was not possible to attract participants from other countries during this preliminary phase of the research, although the cohort of students invited to participate included a large number of international students.

CONCLUSION

Students today are likely to be familiar with the online environment and their workplaces demand that they be information fluent in preparation for evidence-based practice and to appropriately manage patient information and co-ordinate care processes. Their clinical education needs to be where possible integrated with key concepts presented in other learning activities and be engaging, relevant and applicable to their future workplaces. It also needs to be linked to learning outcomes and easily assessable based on these outcomes. Well-selected and authentic clinical anecdotes cases incorporated in stimulus material reliant on multi-media can be presented for online discussion, in face-to-face tutorials, and used in both formative and summative assessment tasks that are consistent with the curriculum philosophy and methodology. “Constructivist principles provide a set of guiding principles to help designers and teachers create learner-centered, collaborative environments that support reflective and experiential processes” (Jonassen, Davidson, Collins, Campbell & Haag, 1995). Authentic clinical anecdotes are a good fit with these principles which guide selection criteria around choice of stimulus material and will assist those preparing and implementing learning events including assessment tasks. To students, assessments equate to learning. Students see assessment as the main driving activity of completing a course of study. Well constructed assessment can equate to the best learning stimulus but much of the poorly constructed assessment requires recall of knowledge rather than application to practice. This is the value of the authentic anecdotes as assessment in that it uncovers the student’s capacity to apply their understanding.

This overview of the myriad ways in which educators use stimulation and stimulus materials has shown that there is a great deal of creativity applied to the design of teaching material which will stimulate and interest students. Less certain is how this material furthers the objectives of the curriculum or prepares students to meet the challenges posed by the various expressions of mental health settings across a wide range of health contexts.

If “context, construction, collaboration, and conversation” (Jonassen et al., 1995) are the keys to establishing a constructivist learning environment, then using authentic clinical anecdotes

can effectively provide all these. However, the challenges of situating learning materials realistically in a contemporary health environment may mean that students especially those from different cultures miss the ethical complexities posed. They may also miss illustrations of key mental health nursing concepts and skills.

Part 2 will focus on the development of authentic stimulus material and the response of ‘international’ students to it with a particular emphasis given to ways to ensure all students from local but diverse backgrounds are able to readily adapt to different cultural expectations around societal and professional responses to people experiencing mental illness and distress and other requirements of regulatory and professional bodies in their adopted countries.

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Appendix 1. Story 1

It was in a provincial community health centre in New Zealand where I was working as Mental Health Nurse.

For some weeks a young man with a diagnosis of personality disorder had been presenting for weekly centre-based sessions of about an hour.

They had started subsequent to him having self-harmed enough to warrant a short admission to the local psychiatric unit.

On this particular Monday morning the afterhours staff had been called out to his home over the weekend where he had set up a situation of trying to hang himself.

Part of the deal of him not being readmitted was that he present for this appointment.

Unlike previous sessions he was hostile, silent and not making eye contact.

Because I did not know what to say I said nothing. Nor did he for the entire hour.

What I did notice is that we fell into a rhythm of breathing at the same time. Our inspirations and expirations were concurrent.

Appendix 2. Story 2

In response to a colleague's distress whilst telling his story, I'm reminded of my own tears re a client.

He died by suicide.

He was recovering from a drug-induced psychosis. Beautiful young man, gorgeous family. Employed. Had everything going for him.

His family invited me to his funeral. I went hoping to sneak off

before anyone saw me. This did not happen. I was trapped and overcome by sadness and distressed at this loss.

His family hugged me and thanked me! The tears flowed more.

I had conflicted emotions about crying in front of patients/families and sought supervision. She told me about her own experiences with emotion and the only two other people that she knows have admitted to crying in front of clients' family – both were well-respected psychiatrists. I was validated and normalised.

Appendix 3. Story 3

I was working in a group therapy based voluntary inpatient unit, dealing mostly with patients with non-psychotic mental health issues.

One patient (who had a borderline personality disorder and dissociative disorder) who I had been working with for several weeks was complaining extensively about a minor issue on the unit (something like the water in the shower not being hot enough). I jokingly said, "Here is the smallest violin in the world playing just for you". She became extremely distressed and angry. She then told another staff member that her father, who abused her severely as a child, played a record of violin music when he was abusing her.

I immediately apologised profusely for upsetting her, and we talked about how she felt, and what I had intended. This incident formed a foundation of a very good therapeutic relationship as no man had ever apologised to her before.