Mature care?

An empirical study of interaction

between psychotic patients and psychiatric nurses

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Preface

Writing a PhD thesis takes a long time, and many feel quite lonely during this time. My scholarship period started in February 2002 and in total lasted for five and a half years. The process included a six-month pre-qualifying scholarship from the Ethics Programme at the University of Oslo (UiO), somewhat more than a year's employment as a research fellow at the Section for Health Sciences, Faculty of Medicine (UiO) and the actual PhD scholarship. For me, these years have not been lonely. On the contrary, they have been joyful and demanding years in contact with many others. It became obvious to me that it was neither possible nor desirable for me to work on my PhD thesis without having well-meaning people and positive energy around me. Thus my personal experiences during these years correspond with the study's basic assumption, namely that we as human beings are basically relational beings. There are a large number of people I would like to thank. They belong to three significant contexts that are, of course, closely intertwined: the research context, the clinical context, and the private context.

The research context

The Section for Health Sciences helped me to learn how to think and work in a scholarly and scientific manner. It has been an unbelievable pleasure for me to experience the kind of hard, serious work, combined with a lot of good humour, evident at the Section day after day. Professor Nina Vøllestad, the head of the institute, has an amazing ability to create good working conditions that are distinguished by trust and mutual consideration. In this working milieu, my admirable supervisor, Professor Kristin Heggen, plays a very special role for me. She displays a combination of wisdom and efficiency, of friendliness and discipline, and of good humour and great seriousness. She guided me into the incredibly exciting and fascinating world of research, always showing respect, trust and generosity. She is the best supervisor I can imagine! In addition to research cooperation I have benefited a great deal from the collaboration with her teaching and supervising duties. My second supervisor, and co-author, Professor Per Nortvedt, Section for Medical Ethics, UiO, contributed to the study

with his perspective that has added to essential aspects of the study. Our discussions led to a clarification of my own viewpoints. I am also ever so grateful for the cooperation with Knut Ruyter, leader of the National Committee for Medical Research Ethics (NEM) and Professor II at the Faculty of Theology, UiO. He was an early and important discussion partner regarding the research ethics questions that turned up in connection with my study. This resulted in writing two articles together. His analytical clarity and his professional courage inspired me to go much further than I thought I could. Professor Harald Grimen, Centre for the Study of Professions (CSP), Oslo University College and Professor II at the Section for Medical Anthropology and Social Medicine, Faculty of Medicine, UiO, was responsible for a number of graduate courses I had the pleasure to attend. I benefited again from his broad theoretical knowledge when I worked with the final version of the study, because earlier in the year he read the entire manuscript and suggested important comments.

I was extremely lucky that I could share my office at the Section for Health Science with Hilde Stendal Robinson. Our academic companionship included almost everything from professional discussions to everyday's great and small events, from early morning coffees to the joint operation of the doctoral students' bar in the late afternoons! The fact that we work in very different ways, regarding both subject matter and methodology, was an important eye-opener for me concerning my perspective on research. Truls Juritzen has also been a good academic colleague of mine for many years. His awareness of power and care as well as care and power brought about many inspiring discussions and exchanges. In this context our cooperation with Kristin Heggen in the course "Care, power and dignity" in the Master's programme has been of great importance. In addition, I was also partly responsible for the course, "Analysis of qualitative data-material", in connection with the Section's Master's programme. The cooperation between staff and students has been very important for my own analytical work and for increasing my understanding of qualitative analysis. Working with others - with members of the staff, with PhD students and with Master's degree students - has provided me with a wide scope of knowledge and experience, which I greatly appreciate.

The Ethics Programme has not only funded my project, but has also been an important and stimulating professional point of orientation for me, especially in reference to the regular colloquiums and the yearly seminar at Hadeland Hotell ("Hadelandseminaret"). Early in my project, Tom Eide, then coordinator of the Ethics Programme, and Rolv Blakar, leader of the steering group, have been very supportive of my work, and Kristin Dobinson, secretary of the

Ethics Programme, has supported me in many different ways during the entire period. In graduate courses held by postdoctoral Research Fellows Jens Erik Paulsen and Henrik Syse, I learned a great deal about ethical theory and reflection. Paulsen and Syse have also been important critics of some of the articles that are part of my study. In different ways and at different times, doctoral students Kari Gran Bøe and Vigdis Ekeberg, with Professor Thomas Pogge, commented on my study in very helpful ways. I would especially like to mention postdoctoral Research Fellow Tove Pettersen here. Her wise and considerate way of leading the interdisciplinary Research School of the Ethics Programme has been of great importance for my personal development. She has an amazing ability to see and understand every single one, and she is a visionary and a courageous and creative philosopher whose contributions have direct significance on the contents of my study. She recommended many relevant suggestions concerning the articles, and I very much appreciate the helpful ideas she had concerning how I could incorporate her perspectives on the subject matter into my thesis

I also feel very much indebted to the cooperation with the Faculty of Theology at UiO. Among other things, especially through my participation in the seminars held at Åsgårdstrand, I received valuable comments on my thesis from Professor Svein Aage Christoffersen, Professor Trygve Wyller, Professor Ulla Schmidt, and Associate Professor Anne-Lise Middelthon.

The librarians working at the Library of Medicine and Health Sciences (UMH), UiO, have been very supportive and efficient; they helped me considerably, both by searching for literature and by lending literature. Regarding language help, I had valuable support from Alison Olsen, and from Svanhild Storbråten, Ruth Johnson, Erik Hansen and Karin Lillehei in Akasie kurs og veiledning.

The clinical context
At the hospital I was able to develop my own expertise in clinical practice. The patients I met and the colleagues I worked with during my ten years of employment at the psychiatric acute ward have turned out to be of great significance to me. The psychotic patients in particular made a strong impression on me. Later, when I was more experienced, I became more and more aware of the range of human dramas that I confronted in the encounters with these patients, dramas that were almost completely revealed. Although the psychotic patients could be difficult to understand, it was nevertheless obvious to me that the patients' dramas dealt

with the phenomena of everyday human life including fear, despair, confusion, shame, helplessness, insult, but also joy, hope, trust, courage, gratefulness, and devotion. All this, combined with the wisdom and expertise from colleagues and leaders made this work place a fantastic arena for personal and professional growth.

I very much appreciate everyone's good will – staff members as well as patients – at the two hospitals where I collected my empirical data, who – in different ways and on different levels – were involved in my project. I cannot address them personally, not even some of them, because I have to protect their anonymity, but I would like to mention that a number of helpful leaders contributed to the organization of the data collection by solving all kinds of practical problems in an outstanding way. Last but not least, I would like to thank all the patients who – in a very generous way – allowed me to share their daily lives on the wards, and I would like to thank the twelve nurses who – with considerable good will and over a long period of time – included me into their daily work with patients. It was incredibly exciting for me to be back in the clinical field because of my project; without the patients and the nurses the project simply would not have encompassed the width and breadth that it developed into.

The private context

Life for me in the years that have elapsed has been more than working with a doctoral dissertation. Good friends helped me to remain in contact with many different aspects of life. I am especially grateful for the respect and acknowledgement I received from Hege Kaspersen and Bent Kristiansen, and from Bjørn Erik Ramtvedt, who is a loyal family friend. In addition, I must mention Britt Eriksson and Helge Poulsen for their warmth and their wisdom! Various activities, walking tours, meals, and fine conversations with everyone I cannot address here personally added a great deal of meaning and joy to my life. The most important person is my husband, Peter Schröder. I am very impressed with his commitment to me and our relationship throughout all the time it has taken to write this dissertation. His academic background has personally been very valuable, both because of our discussions, and through his feedback and help with the language. Most of all I am very grateful for all I have learnt from our life together, which also has been important for the work with this dissertation.

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Marit Helene Hem

Abstract

This dissertation has emerged from an involvement in the controversial topic of what constitutes the distinctive character of nursing in general and psychiatric nursing in particular. In the Scandinavian countries there is a widespread notion that nursing can and should be characterised as altruistic actions of care and value-conscious services provided in the best interest of others. Do the experiences of patients and nurses reflect this notion of care? Does this represent an appropriate professional self-conception for the individual nurse as well as for nursing as a profession? These questions are at the core of the empirical studies conducted for this dissertation and for the discussions of principles of care.

The studies have been conducted in two locked wards in acute psychiatric departments in two hospitals. The focus for the collection of empirical material has been placed on the content of the interaction between the patients and the psychiatric nurses. Participant observation and interviews with patients and nurses have been used as research methods. These methods provide a basis for elucidation of the experiences gathered by both patients and nurses in the interaction between the two groups. In addition, undertaking fieldwork among psychotic patients gave rise to problems of research ethics that needed to be addressed both in principle and in practice. Accordingly, the dissertation includes a published article on challenges associated with obtaining informed consent from the participants in the study.

In addition to this article on research ethics, the dissertation consists of five articles that address various fundamental principles for interaction between psychotic patients and psychiatric nurses. One article thematises compassion – which in 2001 was included in the Norwegian Code of ethics for nurses – and discusses the core narrative of the Good Samaritan in the light of empirical findings on relationships and communication between a nurse and a specific patient. The following three articles are based on a set of specific and instructive guidelines on how psychiatric nurses should relate to patients. Here I investigate and discuss three different, but related, therapeutic principles. In the first of these articles, I investigate how nurses behave and reflect with regard to balancing the needs for proximity and distance,

between being a fellow human and a professional, in relation to patients. The subsequent article shows how nurses practise and describe the requirement of providing the patient with reality orientation in order to help the psychotic person "back to reality". In the third of these three articles I thematise an imposition of limits, where I elucidate the problems associated with transgressions of the patient's zone of the untouchable. The most recent article in the dissertation is based on the view that trust is a necessary precondition for the relationship between nurses and patients. A pervasive empirical impression is that distrust is a prominent feature of the relationship between the giver and the recipient of care, and this is documented and discussed in the light of the ideal of trust.

In the introductory discussion in the dissertation I draw parallels and lines between specific empirical findings and the notion of nursing as altruistic care. I present the challenges, difficulties and, to a certain extent, impossibility of complying with the intentions of good psychiatric nursing. I argue that the altruistic notion of care conceals the demanding nature of acute psychiatry, for patients as well as for nurses. Further I discuss how this notion of care may serve to idealise and camouflage the exercise of power and afford immunity to criticism. As a follow-up on this criticism, I ask whether the altruistic notion of care that prevails in the nursing profession ought to be revised. Mature care, as interpreted by C. Gilligan and T. Pettersen, is proposed as a possible alternative. Inherent in the concept of mature care is an idea of the importance of balancing one's own needs and interests against those of others. By also considering the caregiver's interest, the idea of mature care provides an opportunity to incorporate perspectives of power in acute psychiatric nursing practices, including the complex interconnections between power and care. I emphasise the importance of increasing the space for critical reflection, with a view to developing concepts of care within the profession. This could have an impact on training and guidance as well as research related to nursing.

1

Introduction

1.1 Background and idea

For more than twenty years I have been involved in acute psychiatry, with a particular interest in the care and treatment of psychotic patients. I graduated as a nurse in 1986, and realised my dream of working in psychiatry. I chose acute psychiatry and an isolation unit for acutely psychotic patients who needed intensive treatment. Encountering people in extreme distress made me feel important, I was full of fervour and zeal, and I had a great interest in understanding the world of the psychotic patient, and I was involved in discussions on how nurses could best help the patients overcome psychosis. In acute psychiatry, nurses and other professions confront face to face people who are in extreme distress, and who often are on the borderline between life and death. As I gained experience, I felt doubts and questions arise over how I best could use myself in the encounter with various patients, and an even larger question loomed: What kind of activity is psychiatry, and how could I and others understand the therapeutic work undertaken in psychiatric healthcare? As a profession, nursing is often perceived as care, in which the relationship and the communication between the nurse and the patient are decisive for the healing of the ailing person. The prominent Norwegian nursing philosopher K. Martinsen (1989) defines the characteristic of nursing as care, and claims that care consists of practical and relational work in which moral values are at play. There are parallels between notions of care on the one hand and ideas about psychiatry on the other, as activitites founded on a particular knowledge about relational and communicative structures in human interaction. Today, we can note that there is a reorientation in medical science towards a biological interpretation of mental illness, and the relational aspects are possibly

relegated to a more peripheral position. For many years, I have worked within this complex and, to a certain extent, contradictory landscape, moving gradually towards investigating the work of nurses in psychiatry. Let me first describe the beginnings and roots of my research interests and the starting-point for this dissertation.

I was, and still am, particularly impressed by the naked encounter with the drama of life in the field of acute psychiatry. Even though the patients' psychotic expressions were sometimes difficult to understand, it was nevertheless obvious to me that the patients' dramas involved basic human phenomena. They expressed anxiety, despair, confusion, shame, helplessness and violation as well as joy, hope, trust, courage, gratitude and belonging. Working within this field was highly rewarding, both personally and professionally. However, it was also exhausting. For ten years, on a daily basis I was confronted with people suffering from serious mental disorders, with an acute and comprehensive need for care. This was a tough school for a nurse and a young woman. I felt that I needed to constantly keep a watchful eye on myself: what is the best and most appropriate action to take in relation to individual patients. How does this person affect me, and why? Sometimes I succeeded in "hitting upon" the right answer, on other occasions I "missed" – or so I believed. Often I wondered what was right or wrong, or best, for the patients. On some occasions, I employed a personal intimacy to which the patients were unable to respond. On other occasions, I was distant, because I was too exhausted and unable to relate to the patients' struggles. I could impose limitations in a much too inflexible manner that offended the patients, or I could provide reality orientation to psychotically confused patients in a manner revealing that I had forgotten how engrossed they were in their terrifying delusions. On the other hand, occasionally I failed to draw clear restrictions, and became manipulated by the patients. However, there were also situations in which everything fell into place: I felt that I was in charge of the situation, I had the energy to respond to the patients' deeply felt pain, and possibly provide some comfort and hope. I had the experience of being dynamically present, in a manner that enabled me to do whatever was important there and then. Through the years, I found it meaningful to share these experiences with colleagues. Gradually I discovered that such experiences had also been described in the professional literature, for example by Benedetti (1974), Karon & VandenBos (1985), Haugsgjerd (1990) and Monsen (1990).

Coinciding with my clinical work I underwent training in psychiatric nursing and read works on nursing theory. The writings of K. Martinsen, K. Eriksson and J. Travelbee appealed to me

and gave me a great deal of inspiration. Even though these authors are very different, I found their somewhat poetical narratives – or colourful descriptions – of the patients' situation, the encounter between the patient and the nurse, and the human condition in a broad sense, highly appealing. Suddenly, I realised that there was a wider space to be explored beyond my daily work on the ward. However, maybe this margin was too wide? The authors described visions and ideals to which one could aspire, but how might these ideals be turned into reality in the daily grind of practical work? The question is in itself possibly too encompassing. The altruistic notion of care appealed to me, but at the same time I had the gnawing feeling that my own activities would fall pitifully short of this ideal. I did not know whether this was caused by my notions of care, whether it was caused by demanding patients, or possibly by a combination of the two. Perhaps my experiences were associated with circumstances of which I had no knowledge.

The nature of nursing in general and psychiatric nursing in particular, is a controversial issue. In the Scandinavian countries there is a widespread notion that nursing can and should be characterised as altruistic acts of care and value-conscious services to the benefit of other people. The basic values of nursing are associated with humanism. In psychiatric nursing emphasis is also placed on the importance of using one's own personal qualities in a therapeutic manner. In accordance with psychodynamic thinking, nurses are trained to work with their understanding of the messages from the patient, and how these affect, and possibly interfere with, the work they are doing. I learned that it was essential for us to make an effort to distinguish between which problems were the patients' and which were our own. These recurring reflections were integrated into our method of working. I ascribe this to the fact that I entered psychiatry in a period when – and in an institution where – psychodynamic ways of thinking and working were still evident. Psychodynamics emphasises the communication between the patient and the helper (Cullberg 2006). One example is found in the drawing of boundaries between being close and distant, between being a fellow human being and a professional at the same time. Closeness is required in order to be able to empathise with the patient's problems, while at the same time remaining sufficiently distant to be able to dispassionately assess what the patient needs. I ask myself whether it might be a problem that this balancing act was assumed to be such a simple matter. From the literature one gains the impression that nurses should be able to pinpoint where the right balance is struck without any problems (Strand 1990). I therefore wonder whether nurses might be bearers of a double legacy, both in terms of the idea of (altruistic) care and in terms of the idea of using oneself

therapeutically. Both of these function as professional ideals to strive for. However, at the same time – as I also experienced – it might be that there is a discrepancy between professional ideals and what occurs in reality in the interaction between patients and nurses.

Psychodynamics was gradually replaced by ideas that Wifstad (1997, p. 24) refers to as "biological reorientation". This change of course in the way of thinking, along with structural and organisational measures enacted during the 1980s and 1990s (for example, the reduction in the number of places in institutions), had an impact on everyday life in my field of work. Patients who gradually came to suffer more and more, with increasingly complex disorders, came and went at an increasing pace. Patients could be deeply offended by being forcibly committed, and therefore angry. They could be dangerously intoxicated, and might resort to threats and extreme behaviour. I often felt that I failed in my encounters with these patients, because my notion of providing care on occasions turned into a helpless contrast in these rough encounters with the patients. It was also interesting to note that the workplace culture – our way of talking about these incidents – to an increasing extent indicated that these are things we must learn to live with; such is the nature of this work. We can strive towards the ideals, but they can never be fully realised. Such was the manner in which the workplace culture attempted to reconcile opposites that appeared irreconcilable.

Gradually these various experiences created a feeling of confusion, and this confusion drove me towards obtaining further training. I was worried and exhausted, but felt a strong commitment to the profession. I discovered that the processes of gaining new knowledge that I underwent in the subsequent years provided me with tools in the form of theories and concepts. I found these meaningful for undertaking a further critical review of acute psychiatry.

1.2 Purpose and research problem

The purpose of this dissertation is to discuss the notion of care, and the implications of this notion for the care which is provided in the light of experiences gathered by psychotic patients and psychiatric nurses in their interaction in the context of acute psychiatry. My purpose with the dissertation is to provide a critical contribution to ideas of care and nursing.

The dissertation will seek to answer the following questions:

- How do psychotic patients and psychiatric nurses experience the interaction between these two groups?
- How can we understand the patients' and nurses' experiences in the light of certain selected therapeutic guidelines/principles that are at the heart of psychiatric nursing?
- In what ways can empirical findings challenge the altruistic ideal of care in nursing?
- What opportunities are provided by an alternative notion of care – mature care – to shed light on the demanding relationships between patients and nurses?

1.3 The structure of the dissertation

First I will describe the topics to be presented in the six articles that constitute this dissertation, and then outline the further direction of the discussions that I sketched in the introduction.

The dissertation consists of five articles that address various fundamental principles for interaction between psychotic patients and psychiatric nurses. The first article (number I) thematises compassion – which in 2001 was included in the Code of ethics for nurses – and discusses the core narrative of the Good Samaritan in light of empirical findings on relationships and communication between nurses and a specific patient. The following three articles are based on some specific and instructive therapeutic guidelines for how psychiatric nurses should relate to patients. Here I investigate and discuss three different, but related, therapeutic principles. The first of these articles (number II) reviews how nurses manage and reflect on the balance between closeness and distance, between being a fellow human and a professional, in relation to patients. The subsequent article (number III) shows how nurses reflect on, and act in accordance with, the need to provide reality orientation to the patient, in order to help the psychotic person "back to reality". Imposition of limits represents a recognised therapeutic measure, and this is thematised in the third of these three articles (number IV), in which I describe the problems associated with transgressions of the patient's inviolate zone. The practices associated with both reality orientation and imposition of limits may possibly be perceived by patients as an exercise of "impersonal professional routine", and not as caring and compassionate acts. This may in turn lead to transgressions of integrity

or of the inviolate zone. On the other hand, these therapeutic strategies may also contribute to a reestablishment of the patients' boundaries and maintenance of their inviolate zone. The last and most recent article (number V) of the dissertation is based on the idea of trust as a fundamental basis for the relationship between patients and nurses. A pervasive empirical impression is that distrust is characteristic of the relationship between the recipient and the caregiver, and this observation is documented and discussed in the light of the ideal of trust. The fragility of both distrust and trust implies that both of these can easily turn into its opposite. The establishment of trust between nurses and psychotic patients is therefore very hard work.

Undertaking research that involves patients who are extremely vulnerable represents a particular challenge. The selection of fieldwork methods to be used among psychotic patients prompted problems of research ethics that required thorough consideration and difficult choices. Particular challenges were associated with obtaining informed consent from the participants in the study. The dissertation therefore comprises a final discussion of the complicated nature of obtaining consent from patients (article number VI). Here I argue that field research involving vulnerable patients requires a complex competence on the part of the researcher in order to assess the issue of consent. I follow up this discussion in the chapter on methodology (cf. chapter 3).

The comprehensive introduction to the articles of the dissertation merges the various threads, and parallels are drawn between specific empirical findings and the notion of nursing as altruistic care. The dissertation presents the challenges, difficulties, and to a certain extent, impossibility of complying with the intentions of good psychiatric nursing. I argue that the altruistic ideal of care serves to conceal the demanding nature of acute psychiatry, for patients as well as nurses. I further discuss how this notion of care may contribute to idealise and conceal the exercise of power, as well as provide immunity to criticism. As a follow-up to this criticism, I ask whether there is a need to rethink the altruistic notion of care in nursing. Mature care, as interpreted by C. Gilligan and T. Pettersen, is proposed as a possible alternative. Inherent in the concept of mature care is an idea of the importance of balancing one's own needs and interests against those of others. By also considering the caregiver's interest, the idea of mature care provides an opportunity to incorporate perspectives of power in acute psychiatric nursing practices, including the complex interconnections between power and care. I emphasise the importance of increasing the scope of critical reflection, with a view

to further developing concepts of care within the profession. This could have an impact on training and guidance as well as research related to nursing.

2

Contextualisation of the project

2.1 Introduction

Acute psychiatry constitutes a field which is interwoven into a broad spectrum of contexts of meaning, and in this chapter I will present some of these contexts. First, I will place the research project within a theoretical and empirical context. I will do so by providing an overview of recent theory and research in this field, starting with theoretical perspectives on psychiatric nursing, followed by clinical research. I will describe the current understanding of the particular characteristics of psychiatric nursing and of psychosis as an affliction, as well as characteristics of the acute ward and the experience of patients and nurses with the patient-nurse relationship. These questions will comprise the first part. In the second part I will make a more detailed investigation of current understandings of care. I will present the altruistic ideal of care as a theoretical foundation on which (psychiatric) nursing relies heavily, followed by a review of the concept of mature care. Later (in Chapter 5) I will discuss these two understandings of care in relation to my empirical material in the way it is presented in the different articles.

2.2 Perspectives on psychiatric nursing

A fundamental premise in psychiatric nursing is that the nurse uses him-/herself therapeutically, and that the nature of the relationship between the patient and the nurse should be therapeutic. Because of the emphasis on the nurse's therapeutic use of him-/herself, the practice necessarily involves personal features to a considerable extent. The content of

these personal features has been investigated by a number of researchers and authors of textbooks (Lützén 1990, Peplau 1992, Porter 1992, Forchuk 1995, Gijbels 1995, Cleary & Edwards 1999). The background for this emphasis on the therapeutic relationship is closely related to the difficulties encountered by the patients in communicating and establishing close relationships. For this reason, Porter (1992, p. 453) argues that we need to regard "therapeutic interaction ... as the essence of psychiatric nursing". Stuart (2005, p. 16) uses the concepts "self-analysis" and "self-awareness" in order to describe key personal qualities that nurses need to possess, and the concept "interpersonal process" (p. 5) on the relationship between the nurse and the patient. Mereness & Taylor (1982, p. 10) stress that the therapeutic role of the psychiatric nurse not only is a matter of "routines and procedures ... it must also be discussed in terms of attitudes, feelings, relationships, and understandings". The purpose of the relationship between the nurse and the patient is to investigate and gain familiarity with the patient's understanding of his/her situation and background, and to contribute to strengthening his/her self-esteem, identity and ability to bond with others (Peplau 1992, Müller & Poggenpoel 1996, Stuart 2005). The nurse uses him-/herself therapeutically, first by having contact with the emotions and reactions evoked in the meeting with the patient, and seeks to separate what is hers from what belongs to the patient. Second, she uses this knowledge as a basis for her encounter with the patient in a manner that can challenge him/her with regard to what his/her problems are. Hummelvoll (2006) describes cornerstones that he asserts are the foundation on which the relationship between the nurse and the patient rests. One of the cornerstones he defines in this manner is equality. Equality is the guiding principle of what he terms the patient-nurse community. If this is perceived as a norm for psychiatric nursing, we immediately run into a key problem. In opposition to emphasising the caregiver's ability to unselfishly place him-/herself in the other's shoes and serving him/her, this idea underscores the equality between the recipient and caregiver. However, it could be difficult to imagine such forms of equality and community in situations where the patients' perception of reality is opposed to that of the nurses', and where the relationship is characterised by conflict and opposition. A parallel to this understanding of psychiatric nursing can be found in Travelbee's description of phases in what she refers to as development of an interpersonal relationship between the patient and the nurse (Kirkevold 1992, Kristoffersen 1996). Through an interactive process consisting of five phases, mutual understanding and contact are established between the patient and the nurse. A close and mutual understanding between them is decisive for the patient's confidence in the nurse. "The experiences shared by the nurse and

the ailing person are meaningful and consequential for both of them" (Kirkevold 1992, p. 106).

The essential aspects of psychiatric nursing are commonly understood and described in this manner. It is also interesting to note the connections between nursing in general and psychiatric nursing. The most recent edition of a major Norwegian textbook for nursing students emphasises the importance of a well-functioning interpersonal relationship between the patient and the nurse in psychiatric nursing (Kristoffersen & Nortvedt 2005). Further, reference is made to basic values, which are humanistic and altruistic, "meaning that nursing as an activity is based on a humanistic view on human life, and on values like charity, compassion and care" (ibid, p. 137). Here as well, emphasis is put on the personal qualities of the nurse.

Turning to ethics, the image of nursing as a – fundamentally speaking – humanistic and care-oriented activity in Norway has mainly been promoted by ethicists like Nortvedt (1996), who focuses on closeness of personal relations, and Martinsen (1989, 1993, 1996), who focuses on care. Nortvedt (1996, 1998, 2003) is strongly influenced by the French philosopher Levinas ("the Face of the other") and the Norwegian philosopher Vetlesen (mutual dependence) (Henriksen & Vetlesen 1997, Vetlesen 2007). In her philosophy of care, Martinsen bases her views on, among others, the Danish philosopher and theologian Løgstrup's (1997a) thoughts on the mutual dependence of human beings. In this perspective, nursing consists mainly of responses to the patient's vulnerability, helplessness and neediness. I will return to the various positions in chapter 2.3.1.

A parallel to the emphasis on dependence and care in nursing, which also has inspired nurses, can be found in medical ethics. Pellegrino (1991), Pellegrino & Thomasma (1993), Toombs (2001) and Zaner (1991, 1993) are some medical ethicists who have investigated medicine as a moral activity. Kleinman (1988, p. 54) argues that at the core of medicine there is an existential commandment to be with the ailing person. Pellegrino (1991) on the other hand, as well as several others, has been preoccupied with the phenomenon of trust in the doctor-patient relationship. Trust is of particular importance in relationships between the patient and the helper, because the patients' need for help renders them vulnerable. The patient becomes dependent on what the helper can provide (Zaner 1991, Pellegrino 1991, Illingworth 2002). The patient's trust can be understood as trust in not having his/her vulnerability exploited

(Pellegrino 1991, Baier 1986, O'Donovan 2000). The patient's vulnerability is connected to the dependence on the other's good will, intentions or motives (Pellegrino & Thomasma 1993). Thom, Hall & Pawlson (2004, p. 125) state the following: "... trust is the acceptance of a vulnerable situation in which the truster believes that the trustee will act in the truster's best interest". This also implies that the person who is the object of trust is interested in earning that trust (Hardin 1993, O'Donovan 2000). This is a very common interpretation of trust in the medical sciences: without the patient's trust in the helper, providing treatment and help in the best manner is rendered difficult (Donovan 2000, Pellegrino 1991). The Norwegian philosopher H. Grimen (2001) has focused on the theme that trust and power are closely related and condition each other, and he also discusses the relationship between trust, vulnerability and power (Grimen 2004). Grimen (2001, p. 3617) claims that analyses of trust that exclude power are naive, and that analyses of power that neglect trust are shallow. Linking perspectives of power to analyses of trust provides a richer theoretical framework for understanding the social conditions for establishment, development and erosion of relationships of trust (ibid.). The perspectives sketched by Grimen provide some interesting opportunities for analyses of trust, vulnerability and power in relationships in acute psychiatry, and I will return to this point below.

As regards the specific professional competence that the nurse needs to possess when working with psychotic patients on an acute ward, methods and approaches aimed at establishing safety, calm and perspective are given particular emphasis. Especially through nursing approaches aimed at strengthening the ego, the purpose is to strengthen an ego which is highly fragile and unstable, possibly even in dissolution (Strand 1990, Moller 2005).

2.3 Relationships between psychotic patients and psychiatric nurses in the psychiatric acute ward

2.3.1 Some features of psychiatric acute wards

Psychotic patients can either be extremely withdrawn or highly contact-seeking. Often the affliction impairs the ability to tend to basic physical needs, like the need for food, elimination, sleep and hygiene. The patients can be angry, manipulative and oppositional. This might lead to violent or extreme behaviour, or they might be difficult to contact because

they are engrossed in their own psychotic delusions, and therefore isolate themselves (O'Brien & Cole 2003). Psychotic delusions can include the feeling of being monitored, hearing voices, or fearing that somebody wants to harm them. Common to them is that they feel extremely scared and unsafe, and not having full control of who they are or who others are can be very painful (Strand 1990, Monsen 1990, Cullberg 2006). Being psychotic means a lack of control, to some extent, over thoughts, feelings and/or actions, which understandably leads to strong anxiety (Strand 1990, Monsen 1990, Ryan & Bowers 2005, Cullberg 2006). Thorgaard (2006) uses the concepts "loss of control" and "loss of trust", and these are interconnected. Monsen's (1990, p. 98) definition of psychosis contains a summary description of the dimensions described above:

> Being psychotic implies attempting to master a very strong anxiety and the intensity of this emotion more or less amounts to terror and panic. On occasions, the person may experience this panic in a conscious manner, but the ability to experience is characterised by strong confusion, and the person is to a very limited extent able to articulate his/her own experiences. The confusion and disturbances are prominent to the extent that they also manifest themselves through actions, reactions in relation to others and in the pattern of behaviour in general. (My translation).

It is therefore not surprising that nursing on an acute ward with an emphasis on psychotic patients can be a very complex undertaking. Cleary & Edwards (1999) and Deacon (2003) state that nursing mainly consists of hard work to maintain routines and perform duties. Deacon (2003, p. 466) points to the conflict between "therapeutic nursing" and "custodial nursing". Such wards are also strongly occupied with various safety measures, like confiscation of patients' belongings, searching patients and visitors, use of alarms, locking doors and regulating the patients' activities (Bowers et al. 2002). Such wards cater to the needs of the most acutely suffering persons, who accordingly are the most vulnerable and "socially troublesome" (Deacon 2003, p. 465). These wards could be described as wards for psychiatric intensive care, or wards for patients who require intensive psychiatric treatment. In international literature, this type of ward is referred to as "psychiatric intensive care units" (PICUs) (O'Brien & Cole 2003). The atmosphere in the wards can often appear to be "disturbed, chaotic and over-occupied" (Deacon 2003, p. 467), and the wards have gradually turned into "a non-therapeutic 'dumping ground'" (Lelliott & Quirk 2004, p. 297). Godin (2000, p. 1396) describes this work with persons who are troublesome or dangerous as "a dirty business". The staff's focus is on risk management (Lelliott & Quirk 2004) and "managing crisis rather than giving care" (Quirk & Lelliott 2001, p. 1567). Johansson,

Skärsäter & Danielson (2006) demonstrate how the control or lack of control on the part of both the personnel and the patients interconnect in complex ways. For example, patients attempt to actively gain control wherever they feel that the balance of power between the patients and the nurses is unacceptable (ibid.). A recent Norwegian study shows how isolation as treatment and control within psychiatric acute wards is encumbered by complex tensions (Norvoll 2007). Professional knowledge and the organisation of hospitals both support the view on isolation as proper treatment, while patients experience this type of treatment as punishment and deprivation of liberty. The study also renders visible the tension between optimistic ideals of treatment and the actual organisation of the isolation, which is more characterised by coercion than what is propounded by the ideologies. Norvoll (ibid.) also shows what she describes as the responsiveness problem of the institutions, meaning that the hospitals' ideologies and organisation to a too limited extent capture the patients' life projects and the experience of their need for treatment.

The exposition of psychiatric acute wards given above first and foremost leaves the impression of a field which is extremely complex and which shows human expressions that span from helplessness and despair to overwhelming rage. In the face of this reality, thinking in terms of ideals of care, trust and compassion is rendered difficult.[1] Although the ideals

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[1] The concepts "ideals" and "realities" with regard to psychiatry will naturally direct attention towards a PhD. dissertation, which has been made into a book and subsequently has achieved the status of a "classic" in the field of institutional sociology: Yngvar Løchen's *Idealer og realiteter i det psykiatriske sykehus. En sosiologisk fortolkning* [Ideals and realities in the psychiatric hospital. A sociological interpretation]. Løchen's main idea is that "the psychiatric hospital needs a mechanism that can dampen the effects of the collision between ideals and roles (1976, p. 243). This mechanism he terms "the diagnostic culture". Diagnosing patients implies ascribing to the patients those problems that occur in the interface between ideals and the prevailing realities in the hospital. The illness of the patients, and not features of the institution, makes it difficult to handle the tension between ideals and realities in psychiatric hospitals. In my thesis, I do not make use of Løchen's work directly, even though it has inspired my critical thinking, for example about the violation experienced by the patients when their perception of reality is devalued. This devaluation consists in focussing on the patient as the psychosis, and not the patient as a person with a (psychotic) message, at the forefront of the nurses' attention. Another sociological classic is Erving Goffman's *Asylums*, published in 1961. Goffman's analysis of the total institution, in the form of the closed psychiatric hospital in his study, concludes that the most consequential factor for the patient's development during his/her hospitalisation is not related to his/her disease, but rather to the institution. Both Løchen's and Goffman's studies have from very early on served as major sources of inspiration for me when it comes to looking critically, in a theoretical as well as practical sense, at a type of activity that I have been engaged in for many years. The critical approach promoted by their studies is still valid. At the same time, during recent decades we have witnessed major changes in, for example, the organisation of psychiatric treatment. As a consequence of de-institutionalisation and establishment of open therapeutic centres based locally, psychiatry today appears very different from the 1950s and 1960s when Løchen and Goffman undertook their studies in closed institutions. I still believe that their thoughts are useful to have in mind, in order to be able to pose challenging questions with regard to current psychiatric practices. For example, could it be that current thinking with regard to serious mental disorders even today – or perhaps even to a larger extent today than around fifty years ago – is characterised by the idea of the individual as a carrier of the disorder, and that treatment still implies protecting society against the ailing/mad person? The difference being that today, treatment (and protection?) is provided through the use of effective chemical agents, as opposed to previously,

point out the symmetry or equality between the patient and the nurse, the above description shows that the relationship between psychotic patients and nurses in acute psychiatry first and foremost is characterised by a fundamental asymmetry: On the one hand, we have the influence, power and control of the nurses, on the other hand, we see patients with extreme helplessness and pronounced need for care. In other words, we see a situation in which professional ideals collide with, for example, various forms of coercion. During the last fifteen years, considerable research has been undertaken in order to elucidate how patients and nurses experience acute psychiatry. The experiences of both patients and nurses appear to reflect the conflicts and the complexity described above.

2.3.2 Nurse-patient relationships in the eyes of the patients[2]

Patients see nurses as friendly, but often perceive this friendliness as an impersonal social attitude, not as a sign of personal commitment related to the therapeutic relationship (Müller & Poggenpoel 1996). The same authors report that patients experience nurses as custodians, without empathy, who only follow rules and regulations. Some patients mention the use of defence mechanisms on the part of the nurses, and that they felt rejected (ibid.). These observations correspond with reports from patients who have the feeling that the nurses are vague, distant, and neither physically nor emotionally available when they need them (Gallop, Lancee & Garfinkel 1990, Peplau 1992, Candefjord, Lampinen & Ängfors 1994, Hellzén, Norberg & Sandman 1995, Müller & Poggenpoel 1996, Lindström, 1997). Several studies point out that patients search for a "deeper connection" (Thomas, Shattell & Martin 2002, p. 105) with the staff, for example, one study shows that psychotic patients perceive the care given to them as not reaching them in their "inner world" (Koivisto, Janhonen & Väisänen 2004, p. 273). Patients tend to feel lonely on the ward (Lindström 1997, Lepola & Vanhanen 1997), and develop a feeling of not belonging to the community on the ward (Pejlert, Asplund & Norberg 1995). When patients experience nurses as being "close" to them, they appreciate it (Hellzén, Norberg & Sandman 1995). Consequently, patients appreciate nurses who are

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when high fences and locked doors were used on a more permanent basis than is the current practice. Godin (2000) points this out in an interesting and thought-provoking manner. Quirk & Lelliott (2001) write about a process of reinstitutionalisation referring to a growth in the use of secure units in the community, together with an increasing preoccupation with security and risk management.

[2] Part of the research referred to here concerns acute psychiatry in general, meaning that not all studies have a specific focus on psychotic patients. The studies are still perceived as relevant reference material since they concern conditions in acute psychiatry. We may assume that studies that focus on psychotic patients on isolation units would be able to capture themes that are of particular relevance for this group of patients in particular.

empathic and tolerant, spend time with them and are available (Beech & Norman 1995, Hellzén, Norberg & Sandman 1995, Cleary & Edwards 1999, Wallace, Robertson, Millar & Frisch 1999, Lelliott & Quirk 2004). Patients report that they felt offended, due to the use of power and constraint and the lack of support (ibid.). Offence can also be caused by "empathy", when the nurse employs "empathy" in order to make the patient comply with the rules of the ward and the therapeutic concept (Wackerhausen 1998). Another possible reason for offence is diagnostic labelling (Reich 1999). Patients express a need to understand themselves and their problems (Thomas, Shattell & Martin 2002), but for some, hospitalisation turns into an experience they would rather forget (Fagin 2001). Other authors also mention exhaustion and the feeling of being lost (Benedetti 1974, Karon & VandenBos 1985, Haugsgjerd 1990, Monsen 1990). Johansson & Lundman (2002) point out the complex nature of the experience of coercive hospitalisation: it is perceived both as a support and as a violation. The authors (ibid., p. 639) claim that the patients' experiences can be interpreted as a "balancing act between good opportunities and great losses".

Based on these studies, it appears as though the patients' experiences span from relative satisfaction to dissatisfaction and criticism, but the impression remains mainly negative. One notable feature is that the patients, who on the whole are satisfied and perceive the nurses as friendly, still wish that they had been met with a friendliness of a more personal, including and convincing kind. This experience could reflect a learned friendliness, but it could also be caused by having to deal with patients who have a particular need for contact, attention and understanding.

2.3.3 Nurse-patient relationships in the eyes of the nurses

As regards the nurses, the majority of studies focus on their working conditions on the ward. Especially in the case of very ill patients and a high patient turnover, nurses complain about the hard working conditions (Delaney, Ulsafer-Van Lanen, Pitula & Johnson 1995, Ryrie, Agunbiade, Brannock & Maris-Shaw 1998). Nurses are often under stress and have the feeling that "something always comes up" (Cleary & Edwards 1999, p. 477). Accordingly, nurses define themselves as "managers" (Gijbels 1995), above all preoccupied with handling the daily work on the ward, and they accomplish this mainly by resorting to administration and coordination (ibid.).

Some studies, however, also deal with the manner in which psychiatric nurses react to and experience their relationship with the patients. The experience that "something always comes up" apparently represents barriers to establishing a therapeutic relationship with the patient, the pressures at work making the nurses insensitive to interpersonal processes and relations (Emrich 1989, Cleary & Edwards 1999). Bray (1999) found out that to work with very ill patients is regarded as emotionally very tough and demanding by the nurses, and that they therefore maintain distance from the patients.

Deacon (2003) points out that the nurses' work in acute wards is characterised by an absence of limits, both physically and in terms of communication. The complexity of tasks and the competence required are often underestimated. Deacon's (ibid.) findings show that nursing targets three areas: acting in order to help the patient, sharing co-responsibility for the daily operation of the ward, and relating to both previous and future patients. Physical and mental presence is required in order to assist patients with their practical and emotional challenges and problems, and good communication skills, as well as intimate knowledge of oneself and one's own limitations, are needed. Sensitivity to the patient's situation and needs are essential in order to be able to help. Tolerating rejection from a reclusive patient involves returning on repeated occasions with an invitation to contact and provide help. Having continuous attention focused on moods, body language and actions is decisive in order to be able to intervene preventively with regard to self-mutilation, threats of violence or overt violence. Being able to cooperate well with colleagues is a requirement, as is the ability to plan, set priorities and reassign priorities in accordance with various situations and changeable circumstances (Strand 1990). I perceive Quirk & Lelliott (2001) and Deacon (2003) as calling for a closer research-based elucidation of this complexity. They claim that ethnographic studies in particular, analysing everyday life and the routine work in the interface of "care and control", will be particularly suited to elucidate the complexity and many-faceted aspects of this field. A contribution in this direction was recently published by the Norwegian philosopher G. Lorem (2005, 2006). Based on participant observation in a psychiatric rehabilitation centre, he concludes that the greatest challenge faced by helpers is to attempt to understand the meaning expressed by language. His premise is thereby that the psychotic language is not a separate language, but a method of expressing psychotic experiences in a language already known to us (Lorem 2006). This involves a shift from focusing on the illness to focusing on the person experiencing the illness (ibid.).

I will now shift the attention from theoretically and empirically based descriptions of the field towards a closer presentation of care, interpreted first as altruistic care and then as mature care balancing between the needs of others and the needs of the self, respectively.

2.4 Caring and the ethics of care

Ethics of care is a newcomer to the field of ethics, and the emergence of ethics of care can be interpreted as a wish to emphasise care as a meaningful ethical perspective, and at the same time as a reaction to "the theoretical deficiency of ethics of close relationships" (Pettersen 2006a, p. 152 (my translation)). Because care and the ethics of care can be understood in different ways, I will first turn to the most prominent understanding of care, altruistic care, before taking a closer look at another way of interpreting care, which is mature care.

2.4.1 Altruistic care

In chapter 2.2 I noted that trendsetting theoreticians in the field of nursing in Scandinavia, and in Norway in particular, have defined care as the very core of nursing. In its most fundamental aspects, nursing consists of providing care. Nursing is basically about taking care of, protecting and defending people who for some reason need it. Its purpose is to alleviate suffering and promote the human dignity of the other, when the issue for the patient is either to be healed, live with the illness or die. However, opinions differ regarding what constitutes care and how care can be understood and justified. In my interpretation of Martinsen (1989, 1993) (cf. chapter 2.2), she is a defender and spokesperson for care in its altruistic (unselfish, self-sacrificing) sense[3]. Nursing consists of altruistic attitudes and actions in the best interest of the needy person. The caregiver is important in the sense that he/she administers the care that the other person needs.[4] Nortvedt (1996, 1998, 2003) (cf. chapter 2.2) also, as I see it,

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[3] Altruism is interpreted in various ways, and altruism appears in many gradations. In a broad sense, altruism means to take the interests and needs of others into account. In this sense, the concept is "unproblematic". However, difficulties arise when the other person (almost) always is given first priority. See also footnote 14 and 18.

[4] Since the seventies, K. Martinsen has published a number of works that have exerted a considerable influence on thinking in the field of nursing in Scandinavia. In various ways and with various theoretical perspectives, she has demonstrated that nursing fundamentally is concerned with care for the weak. She provides the altruistic notion of nursing with a content, which I find appropriate to discuss in this thesis. My approach, discussing altruistic care in relation to mature care, could evoke the impression that I perceive Martinsen's altruistic

subscribes to this understanding of care.[5] While Martinsen to a significant extent is inspired by Løgstrup in her analyses of care (1993), Nortvedt turns to Levinas (1905-1995) (cf. chapter 2.2.). For example, Nortvedt (ibid.) emphasises the appeal from the face of the Other as a fundamental aspect that prompts care, to heed the call for help from the other. In my opinion, both Martinsen and Nortvedt focus primarily on an altruistic concept of care, and claim that care is to provide a service to those who need it without claiming recompense. Focus is placed on the needy person.

In her classical book *Caring, nursing and medicine* (1989), Martinsen states that care is a relational, practical and moral activity. This is a normative interpretation of care, and she thereby focuses on what care ought to be. Subsequently, she has expanded on the concept of care in the book *Fra Marx til Løgstrup* [From Marx to Løgstrup] (1993), in which she states that care is the basis for existence, and care is demonstrated through sovereign life utterances. Care is an ontological phenomenon, and basic to all human life. People are basically dependent, and this dependence requires a human response in the form of care (Kirkevold 1992). Applied to the relationship between the nurse and the patient, she states the following: the patient's 'is' is nursing's 'should' (Martinsen 1993, p. 142). Martinsen takes a collectivist view on human life, focusing on common life-forms and the principle of responsibility for, and solidarity with, the weak (Kirkevold 1992, Kristoffersen 2005). Martinsen's emphasis on the relational aspects of care emerged more clearly following the closer association of her thoughts with Løgstrup's phenomenology of creation (Bruun 2000). Life is created, we are intertwined into each other's lives, we have a responsibility for taking care of each other and not controlling and dominating each other (ibid.). Care as the ideal of altruistic responsibility for the other has a form of being, or a deeper value (Dybbroe 2006). As a result of the emphasis on care as a basic part of life, care represents a realisation of what is ethically good.

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perspective exclusively in terms of self-sacrifice. My approach is based on the necessity of limiting the field of study, and I am fully aware that Martinsen's ideas are more complex and comprehensive. For example, she has written about the "audacious and strong-hearted deaconesses" (the title of a book published in 1984). Martinsen has also highlighted R. Nissen's struggle to establish nursing schools in the latter part of the 19th century, and thereby to create vocational training opportunities for women at a time when education was a male privilege. Martinsen also highlights Nissen's training manual in nursing as a method for rendering visible "independent and bold women" (Martinsen, quoted in Heggen 2004, p. 21 (my translation)). However, Martinsen's ideas have been widely debated. For example, Kirkevold (1998) has directed fundamental criticism against what she sees as unsettled and unclear premises and assumptions in Martinsen's anti-scientific approach to nursing.

[5] Like Martinsen, Nortvedt's research interests are complex. For example, he is inspired by Blum's (cf. footnote 7) notion of altruism, which does not imply any neglect of the interests of the caregiver. He has also discussed care ethics and the problem of justice in health care (2007). My description of Nortvedt's position is also prepared taking into account a view to limitation of the field of study.

Morality is to serve the other person when an appeal from a needy person is made. The experiential world of the senses constitutes the foundation of ethics. Life within relationships creates the ethical demand for care (Martinsen 1993). The other person makes an impression on me, and in this impression there is an appeal to take care of the other person's life (ibid.). In our preoccupation with the desire to serve the other person, we forget ourselves: "Caring is directed outward toward the situation of the other" (Alvsvåg 2006, p. 175). Martinsen (1999, p. 243) states that:

> … the demand comes from the outside, it is unsolicited and given. I am addressed by the other. The address has the character of an appeal, an experience that strikes, touches and moves me. I am moved and touched by way of the senses. In the affection of the senses I am without distance, without protection. (My translation)

Bruun (2000, p. 145) interprets this directedness towards the other person in this manner:

> Care in nursing is when the nurse is concretely and specifically present in the situation. This means to be in motion away from oneself, towards the other, in a compassionate way, without the nurse herself having an awareness of being compassionate, because she is so engaged in alleviating the situation of the other person. (My translation)

The emphasis on Løgstrup's thoughts on the sovereign life utterances – trust, hope, compassion and the openness of speech – also serves to support the focus on the other person. The life utterances are universal and pre-cultural, and constitute the foundation for human coexistence, thereby being preconditions for care, and they imply a movement away from the person him-/herself. Martinsen (2000) relates what she refers to as the basic human calling to unselfishness and the orientation towards the other person at the juncture where the caregiver and the patient come together.

Martinsen is inspired by Løgstrup's writings, which are in a phenomenological, and at the same time Danish, philosophical tradition. As a theologian he belongs to Protestantism. His point of departure entails relationships between people and their mutual dependence, and he focuses on the everyday experiences of people (Christoffersen 1994, 1999). Løgstrup's contribution to ethics is a forceful confrontation with "a long philosophical tradition claiming that human beings are driven by egotism, fear and distrust" (Vetlesen 2007, p. 88 (my translation)). Contrary to a number of key philosophers, Løgstrup (1997a) claims that we confront each other with a natural trust. Løgstrup's idea is not that distrust does not exist or should not exist. What makes trust a basic ethical phenomenon is that "the vulnerability of the truster poses an ethical demand to *the other*, the trustee" (Vetlesen 2007, p. 91 (my

translation)). In this connection, Vetlesen points to a famous quotation by Løgstrup, describing how we as individuals hold a part of the other person's life in our hands. This part can be small or large (Løgstrup 1997a, p. 17), but his point is that we are inside each other's worlds and each other's destinies. Having another person trust me releases a demand within me to take care of that trust, to support the other person's existence, and not exploit this exposed vulnerability for my own ends (Martinsen 2006). Life is created, and is a reality that I have no right to remake. "I am involved, quite simply by force of being faced with another human being" (Vetlesen 2007, p. 91 (my translation)). Interdependence, the mutual dependence between people, is thereby a basic phenomenon of existence. We are intertwined into each other, we are exposed to each other. "Care and consideration flow from a common vulnerability and mutual dependence between people" (Nortvedt, submitted (my translation)). Løgstrup belongs to a position of ethical realism, because he notes that phenomena like demands, power and responsibility have an inherent normativeness. The phenomena referred to by Løgstrup as sovereign life utterances (hope, trust, compassion and the openness of speech) possess a normative character by force of their own nature. They are created, they belong to existence itself prior to any definition by any person, and they belong to a world which at all times is ethically charged (Vetlesen 2007). The appeal emerging from the life utterances "and the world of basic conditions of which they are a part, a world of conditions which are given" (Vetlesen 2007, p. 97 (my translation)) imply a demand on each individual to heed this appeal (Løgstrup 1997a). However, a key point in terms of action-oriented ethics is that even if ethical demands have an inherent normativeness, this does not mean that human subjectivity with its intentional capabilities are exempt from a responsibility to take action. This imperative for action is clearly present in the above quotation, and Løgstrup's use of the hand as a metaphor serves to demonstrate that ethics are connected to actions. There is a ambiguity in this, as the hand can symbolise power, in the sense of having someone in the palm of your hand, or it can refer to care, in the sense of lending someone a hand (Hansen 1998; Jensen 2007). Against the background of Løgstrup's few remarks on the caregiver, apart from the responsibility to heed the other person's appeal for help, I interpret Løgstrup's concept of care in an altruistic sense.

Nortvedt (2003) founds the analyses mainly on the writings of Levinas. He claims that Levinas' metaphysical ethics comprise certain moral intuitions that are crucial to health work (ibid.). Nortvedt's ethical project consists of expounding on why we care for others, and why we care about ethics. His response, inspired by Levinas, is that the face of the Other stirs the

responsibility. The vulnerability, neediness and nakedness of the Other call for an ethical responsibility. Responsibility involves a response to, and being receptive to, the reality of the other person's suffering. The otherness of the Other stirs my responsibility to him. The otherness of the Other, through the face of the Other, is the incarnation of a moral imperative. The face is vulnerable. The face is an expression of vulnerability (Nortvedt 2003). According to Levinas (and Nortvedt), ethicality is constituted in the encounter with phenomena in the world. Ethics is about being faced with an appeal to help the other person. The responsibility is "unasked for, and comes to us like thief in the night, robbing us of our freedom" (Nortvedt 1998, p. 18 (my translation)). Levinas' archetypal description states that the Face is that "place" on me that more than any other represents a kind of exposure. I am in the world as a face. It is up to others to interpret the appeal sent out by the Face. Therefore, I am vulnerable to the actions of others.[6]

Levinas and Løgstrup have many features in common, but there are also major divergences. The most prominent commonality consists in both of them seeking to justify a basis for ethics, not in terms of principles or theories, but in receptivity to experience-based phenomena, faces and vulnerabilities as demands. Løgstrup locates this demand in the relationships between people, while the demand propounded by Levinas is metaphysical, an ego called to responsibility by otherness. Therein also lies the most likely main difference between the two (Nortvedt, submitted).

Henriksen & Vetlesen (1997, p. 25) claim that care is a response to the basic human condition: "Care is directed at other people, care is about basic human vulnerability, dependence, fragility and mortality" (my translation). The need for care is determined by these non-chosen basic conditions of being human (ibid.). In its most basic form, care consists in protecting life. However, Henriksen & Vetlesen (ibid.) go one step further, claiming that care not only consists in sustaining life, but in maintaining a dignified life: "Providing care is a qualitative matter: it implies 'responding' to the sufferer's need for dignity" (my translation). Furthermore, the authors state that imbalance, or asymmetry, is a structural

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[6] If these authors were to be categorised with regard to theories of ethics, Martinsen would belong to an ethics of care (Pettersen 2004, p. 129). Løgstrup and Levinas represent an ethics of proximity (ibid.), as does Nortvedt. However, in my description, I will not emphasise the distinction between "ethics of care" and "ethics of proximity", and I will refer to my topic as "ethics of care". The purpose of the description is to demonstrate how different theoreticians focus on the normative aspects of close relationships, in which "care" is a key concept used to characterise this normativeness.

feature of every relationship involving care, and professional care in particular. In these relationships, dependence and powerlessness are evident. The ailing person is in some cases "to an extreme extent entrusted to the abilities and opportunities of others to support his or her existence" (ibid., p. 26 (my translation)). This is the case with psychotic patients. Henriksen og Vetlesen (ibid., p. 29) state that in those parts of the health services where the patients' dependence is particularly evident, we need "concepts of care, responsibility and human dignity (in particular), that are sufficiently grounded in reference to the aspects of dependence of human life" (my translation). For example, loss of autonomy characterises psychotic patients, but "loss or absence of the ability to maintain autonomy does not mean loss or absence of dignity" (ibid., p. 31 (my translation)).

2.4.2 Altruistic care in the textbooks

As regards nursing in general, chapter 5 in the first volume of the revised edition of *Grunnleggende sykepleie* [Basic Nursing] from 2005 is devoted to a presentation of various aspects of the relationship between the nurse and the patient. The opening sentences of the chapter state the following:

> A good interpersonal relationship is of major importance in nursing practice ... Establishment of relations in nursing is based on values. The basic values are *humanism* and *altruism*, meaning that nursing as an activity is based on values like charity, compassion and care (Kristoffersen & Nortvedt 2005, p. 137 (my translation)).

The chapter refers to both Christian and secular values. As regards the Christian values, reference is made to *Lærebog i sygepleie for diakonisser* [Textbook of nursing for deaconesses] by R. Nissen, published in 1877. Here, the pre-eminence of the patient in nursing practice is clearly stated. Kristoffersen & Nortvedt (ibid.) also refer to the book by E. Hagemann from 1930, *Sykepleieskolens etikk* [The ethics of nursing school], which describes the relationship between care and ethics. Hagemann conceived care as a basic way of being, a mindset to be expressed through practical work. "Good and appropriate actions develop from a good will or a good disposition" (ibid., p. 145 (my translation)). Hagemann goes into a great deal of detail in describing what is needed and why with regard to the nurses' efforts to develop their personalities. Nurses and students were obligated to work with themselves and to promote certain attitudes and qualities, the proper "kind-heartedness" (ibid., p. 146 (my

translation)), and that the nurses should commit to undertaking "an effort to cultivate their own character" (ibid., p. 145 (my translation)).

The authors provide a thorough presentation of these historic works, which they assert have had a major importance in developing an understanding of the basic values of the nursing profession (ibid., p. 145). The basic values of nursing, or its views on human life, are altruism and humanism. Emphasis is placed on giving priority to the interests of others, over and above one's own. The purpose is to increase the other's well-being, or to alleviate his discomfort or suffering (ibid., p. 147). With reference to L. Blum, the authors state that altruism is to do good for the sake of others.[7] The original altruistic values of nursing are associated with "thoughts of *charity* and *compassion*, inspired by Christianity" (ibid., p. 147 (my translation)). Altruism is closely related to the notion of nursing as a calling. Altruistic motives and emotions have been revitalised in the nursing field in recent years, contributing to "a reassessment of an important aspect of the traditional basis of nursing as a care profession" (ibid., p. 147 (my translation)). The Christian values of nursing are inspired by *The Golden Rule*, in order to render visible charity, *the double commandment of love*, meaning that love of your fellow man is as important as the love of God. In the same vein, ideas of compassion are included in the parable of *the Good Samaritan*. The founder of modern nursing in Norway, C. Guldberg, described nursing as an act of love. The concept of caritas is the Latin expression for love and compassion, and "is currently closely related to the nurse's altruistic care of the patient" (ibid., p. 148 (my translation)). Care motivated by altruism is understood in the context of the historically close connection between nursing and the Christian tradition of hospitals, based on love of your fellow man (Vetlesen & Nortvedt 1996).

Historically speaking, the normative basis of nursing has in this manner been founded on an attitude of compassion for the ailing person. The ethics of nursing has targeted mindsets and the importance of nurses possessing the correct attitudes and qualities of character (Nortvedt 1998). In his analysis of the historical and ideological foundations of nursing, Nortvedt (ibid.) emphasises, in addition to the legacy of the Catholic orders and the deaconesses, the understanding of nursing propounded by F. Nightingale. Nursing consists in facilitating

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[7] Strictly speaking, Blum's position does not amount to a defence of the notion of altruism in the sense of unselfishness: "… to say that an act is altruistic is only to say that it involves and is motivated by a genuine regard for another's welfare; it is not to say that in performing it the agent neglects his own interests and desires" (Blum 1980, p. 10).

natural processes, meaning that: "Nursing is an assistant, proper nursing fundamentally means to facilitate the self-restitution of the body and the person (ibid., p. 67 (my translation)). Nortvedt (ibid.) emphasises the cognitive precondition that the view on nursing as a "restitutive force" assumes, namely the understanding of what it means to be ill. Nurses must be able to imagine the experience of the patients, to "switch roles" (ibid.) and use their wisdom and sensitivity in order to be able to act appropriately.

Returning to chapter 5 of *Grunnleggende sykepleie* [Basic nursing] (2005), the authors also emphasise care and altruistic emotions in their exposition of the secular values of nursing. They argue in favour of the affective aspects of care, and gradually for the activity dimension of care and for its moral aspects as well. This trisection of care into emotions, practices and morals appears to be inspired by Martinsen's (1989) interpretation of care as relational, practical and moral (cf. chapter 2.4.1) (Hem 2000). The authors clarify the ontological basis, which resides in the interconnectedness and interdependence of human beings, and accordingly nursing "to some extent represents a response to the vulnerability of human life and the mutual dependence of human beings" (Kristoffersen & Nortvedt 2005, p. 151 (my translation)). The ethical demand is underscored, as is the centrality of the development of the ability to provide ethical care in the care professions (ibid.).

As regards expositions of psychiatric nursing, Stuart (2005) includes a paragraph on altruism in her chapter 2. She relates altruism to the question of why we want to help others. A good helper is interested in people, and provides help on the basis of a deep love of humanity (ibid., p. 19). However, she also goes one step further, by saying that it is a fact that everybody seeks to obtain a certain degree of personal fulfillment from their work; the goal should be to balance these two needs. Further, she outlines some risks that she perceives to be inherent in the altruistic ideal.

First, she claims that altruistic motives for help can constitute dangerous tools in the hands of naive and zealous helpers. Second, she relates to an extreme view on altruism: altruism is to be engaged in the well-being of others, but this should not be taken to mean that adequate compensation and recognition should not be expected, because this is not solely a matter of self-sacrifice. In order to be a good helper, the nurse must attend to his/her own needs. Third, she includes circumstances pertaining to social responsibility by saying that altruism can also be perceived in the sense of changing social circumstances in order to attend to people's needs

for welfare. We should place our focus on having a humanitarian society that facilitates personal growth and development. Nurses should strive to change social structures, with a view to strengthening people's health and well-being. This is a conception of altruism other than the traditional emphasis on the virtues and qualities that are needed in order to alleviate the suffering of others. It goes in the direction of mature care.[8]

I believe that an understanding of human life as vulnerable, of our dependence and being at the mercy of others, and that care should emerge from a sensitivity for the situation of others is perceived as intuitively correct by many. This perspective also appeals to me, and also to large sections of the health care community, so it appears. I perceive my research to have loaned considerable inspiration from this ontological position. At the same time, these views assume an importance for our understanding of psychiatric nursing as a profession and practice. Here, I have in mind the tendency to idealise one's own practice of nursing. Such idealisation, or as Heggen (2000) calls it, romantisation, represents a problem. For example, an idealistic focus on one's own practice may serve to conceal the fact that nursing also comprises the exercise of power, in a positive as well as a negative sense. A further problematic point is related to the fact that an altruistic understanding of care places a one-

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[8] It is worth noting that this description of psychiatric nursing is taken from an American manual. In current nursing practice the idea of care appears to have a particularly strong position in Scandinavia. In the USA, for example, literature strongly emphasises the nursing process as an ideal for clinical practice: "They contain guidelines presented as normative and prescriptive ideals/rationales for action that are ideal for clinical nursing, and that otherwise appear to be seen as synonymous with nursing in practice" (Adamsen 2001, p. 20 (my translation)). Manuals have a strong focus on guidelines for practical use, with an emphasis on procedures and instrumental aspects of clinical nursing. The books reflect a linear understanding of nursing as "to observe/diagnose-decide-implement-evaluate" (the nursing process) (Adamsen 2001, p. 20). This mode of thought and behaviour is also clearly expressed in psychiatric nursing in the USA. In the last edition of the well-known work edited by Stuart & Laraia (2005), *Principles and practice of psychiatric nursing*, all chapters that describe nursing in relation to various types of diseases are systematically organised in accordance with the nursing process: assessment, (nursing) diagnosis, outcome identification, implementation and evaluation. The fields of nursing that have been relevant to classify are thereby the key components of the nursing process: the problems encountered by nurses, the actions that nurses take and the results that nurses seek to achieve (von Krogh & Dale 2001). Within Norwegian psychiatric nursing, von Krogh (ibid.) in particular has been engaged in these issues. Classification systems represent abstractions of the field of knowledge that nursing has at its disposal, and their purpose is to express and delimit nursing's field of knowledge and action. Classification systems constitute "systematic expositions of concepts that are specific to the nursing profession, and that have been developed on the basis of comprehensive research. The background for starting these classification efforts in nursing was the need for a set of concepts that could give a shared content to professional concepts and serve as guidance for the quality and development of the nursing profession" (von Krogh & Dale 2001, p. 146 (my translation)). The focus on classification can be related to development trends in the health services, like quality assurance and evidence-based practice, with a view to achieving the highest possible degree of specification, precision and standardisation. "Accurate knowledge" is a concept often used in this connection (Willman 2001 (my translation)). In other words, various development logics here run in parallel and interact in complex ways. With a view to maintaining focus and delimiting the field of study I restrict my description to pointing out the influence from the USA.

sided focus on the needy person, which may entail a less pronounced focus on the provider of care. Even this may serve to conceal aspects of power. At the same time, an emphasis on the patient as needy may entail criticism of psychiatric nursing practices, as noted by my co-authors and myself in the articles. On the other hand, a critical focus may serve to conceal the fact that nurses are also exposed and vulnerable, or that human relations in general are vulnerable. This implies that we possess the power to hurt each other.

One might ask whether I, by relating my understanding of altruism this closely to self-sacrifice, provide an overly simplistic account. In a moderate sense, altruism is an expression of a certain intentional "directedness" towards a person's well-being, but without sacrificing oneself (cf. footnotes 7, 14). Is my insistence on the necessity of unselfishness in this perspective equal to "kicking in an open door" (cf. chapter 5.3.6)? In chapters 2.4.1-2.4.2 I claim to be able to refer to key nursing literature that emphasises descriptions of self-sacrifice and unselfishness as aspects of altruism. What I want to discuss is the particular interpretation of altruism in nursing literature and in the conception of care in the nursing profession. In doing so, I make no statement on the diverse interpretations and discussions that have been going on for several years with regard to the understanding of altruism (Pettersen 2004; cf. chapter 2.4.3, footnote 3, 14).[9] To be more specific, I wish to problematise the interpretation of altruism as self-sacrifice in the context of nursing. Based on the key nursing literature referred to above, it appears as if the legacy of Christian thought has been given the major emphasis in presentations of the concept of altruism. The necessity of questioning altruism as self-sacrifice emerges directly from my own empirical material. For example, prominent phenomena like distrust and the use of power (cf. chapter 5.2.2) challenge an understanding of nursing as unselfish altruism. A characteristic of proper professionalism is to have the best interest of the patient as a point of departure, without letting oneself be degraded or manipulated. In this complex practical field, I believe that a discussion of nursing should have a broad focus.

The one-sided focus on the recipient of care has been countered by the Norwegian philosopher T. Pettersen (2004) through her concept of mature care. In the following chapter I

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[9] In this connection, it is interesting to note that Fink (2006, p. 235) claims that Løgstrup, contrary to Aristotle, associates what is ethical with unselfishness. Løgstrup's focus on "fulfillment of life" is related to that of the other person, and not one's own (ibid). In other words: one of the many philosophers who has inspired the nursing profession claims that we are facing a demand to act in the best interest of the other person for the other person's sake (ibid.).

will review prominent parts of Pettersen's argumentation. In chapter 5, I will also discuss altruistic care in relation to questions of idealisation and concealment of power.

2.4.3 Mature care

Pettersen's (2004) point of departure is the question of what "care" really means. Her answer emphasises the ambivalent understanding of care that has prevailed throughout history. The stoics perceived care necessary for development, while the Romans saw care as a burden. This perception of care is reflected in the studies of the American moral psychologist C. Gilligan.[10] She notes that women tend to associate care with safety, while men think in terms of obligations, subservience and burden. By including women in her studies, she arrives at the main conclusion that first men strive to break free, while women want to affiliate themselves. Second, that when facing moral dilemmas men emphasise fairness, while women are mostly preoccupied with care (Gilligan 1982).[11] Based on Gilligan's studies, Pettersen (ibid.) undertakes a moral-philosophical analysis of the ethics of care. Against this background, and in line with Gilligan's ideas, she argues in favour of a concept of mature care, which is different from an understanding of care as altruism.[12] [13] [14]

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[10] Gilligan's book from 1982, *In a different voice. Psychological theory and women's development*, has achieved the status of a classic. The book has spurred a wide interdisciplinary debate, and has been lauded and criticised. The book is a criticism of the work of L. Kohlberg, who was her mentor at the university. In particular, Gilligan seeks to rectify and supplement his "stage theory of moral development" (Pettersen 2004, p. 18) and his "male bias" (ibid., p. 18). Gilligan wanted to demonstrate the aspects that research has neglected in omitting girls and women from theory-generating research in the field of developmental psychology. She has a different notion of the ego and of what constitutes morality. She characterises two different moral voices (care and justice) and interdependence – an ontological point of view – as fundamental assumptions regarding the nature of human beings. Relationships are basic to human life. However, self-perception can take two forms: as "interdependent and connected with others, and as independent of others" (Pettersen 2004, p. 29). The idea of human interdependence may have implications for traditional moral philosophy, because this idea challenges "the moral point of view", moral ontology and moral epistemology.

[11] Gilligan has been criticised for having a gendered notion of care (Pettersen 2004). Her exposition can be perceived as reflecting a notion that particular qualities are associated with women and men respectively, which is problematic with regard to its possible simplification of gender complexity.

[12] Ethics of care as a particular type of ethics or ethical philosophy has similarities with classical ethics of virtue, in that both theories emphasise the well-being and development of the individual in relation to others (and in fair institutions) (Vetlesen 2007). In her thesis, Pettersen (2004) also refers to ethics of virtue. She (ibid.) notes that in the ethical landscape, the Aristotelian ethics of virtue are most closely related to Gilligan's ethics of care. Ethics of virtue emphasises character development, the faculty of assessment, and the development of a sense for what is good in itself, not for the individual, but for the *human being* (Vetlesen 2007). "Doing good and living well are two sides of the same coin ..." (ibid., p. 139 (my translation)). Practising virtue is not only a means to a good life, but part of its content. An ethical theory must be able to form the basis for actions. Ethics of virtue has the development of the human being and the human potential at its focus. Morality, self-interest and happiness are not opposites (ibid.). I can see the relevance and the interesting aspects of including perspectives on ethics of virtue (in the sense of development of virtues and development of one's own character) in a systematic manner in this thesis. With a view to a delimitation of the topic and perspectives I nevertheless leave these issues aside,

Based on the so-called "abortion study", Gilligan (1982) revealed different "levels" of development of care. She identified three levels of development that women went through when taking a decision of whether or not to have an abortion. The first level relates to personal survival and to taking care of oneself and one's own interests, "selfish care" (Pettersen 2004, p. 33), understood as "self-protection against hurt" (ibid., p. 32). At the second level, focus is shifted to the interests of the other person, and here, altruism and compassion are key aspects, social norms and the expectations of others are taken into account. According to Pettersen, Gilligan claims that women have a tendency to remain at this level, "selfless care" (ibid., p. 33). However, at this point, problems related to renunciation and self-sacrifice enter the scene. Forms of care on the first and second levels, "selfish care" and "selfless care", are described as "immature care" (ibid., p. 33), and may even become pathologic (ibid., p. 79). On the third level, on the other hand, the connectedness between self and others is realised, the person takes into account, or balances, everybody's interests, he/she exercises "contextual sensitivity" and "mature care" (ibid., p. 33). This way of handling complex social situations is a result of development, meaning the ability to exercise balanced care, mature care. "Mature care is a synthesis of acting in one's own interests and acting in the interests of others" (ibid., p. 99). Mature care is ethical care (ibid., p. 79). A core feature of moral maturity is found exactly in the ability to assume different perspectives, to balance interests, and to pay attention to all persons involved. "Mature care … pays attention to as well as weights the interests of self and others" (ibid., p. 33). Gilligan explicitly wishes to develop ethics of care founded on the form of care found on the third level: "… I describe a

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even though I on some occasions will mention points of similarity between ethics of virtue and ethics of care, and include some aspects of ethics of virtue.

[13] Pettersen (2004) also makes it clear that ethics of care is not an exhaustive theory; it addresses certain fields of life. For example, ethics of care is well suited to elucidating phenomena in close relationships between people, and relationships represent the target area of ethics of care (Pettersen 2006a). On the other hand, ethics of care is less suited for elucidation of ethical dilemmas raised by the need to make priorities in the health services or in relation to questions of global justice.

[14] The concept of altruism refers to a broad field of debate, cf. chapter 2.4.1-2.4.2. Pettersen relies on Gilligan, who according to Pettersen uses altruism synonymously with "selflessness" and "self sacrifice" (ibid., p. 32). Pettersen associates this notion with T. Nagel's definition of altruism as "pure altruism", i.e., "the direct influence of one person's interests on the actions of another, simply because in itself the interests of the former provides the latter with reasons to act" (ibid., p. 32). Further, she refers to what is often understood as the opposite of altruism, namely egotism, again referring to Nagel: "that each individual's reasons for acting and possible motives for acting, must arise from his own interests and desires, however those interests may be defined" (ibid., p. 32). According to Pettersen, Gilligan claims that human beings possess the capacity for both altruism and egotism, and further that both altruism and egotism represent stages of moral development (cf. level 1 and 2). At the third level altruism and egotism are balanced against each other, or have become modified: "instead of a pure altruism, which means that the caregiver's own interests are neglected, the caregiver's other-concern endures, but it is not unlimited. Self-concern, within limits, at stage three is considered legitimate" (ibid., p. 32). An understanding of altruism that does not emphasise self-sacrifice is also found in the work of the philosopher L. Blum (cf. footnote 7).

critical ethical perspective that calls into question the traditional equation of care with self-sacrifice" (Gilligan 1993, p. 209). Ethics of care thereby must be founded on mature care, and mature care distances itself from a notion of care as self-sacrifice. Gilligan's notion of care involves care for oneself as well as care for others (Pettersen 2004, p. 47).

Pettersen's moral-philosophical analysis of the concept of mature care, as described by Gilligan, is a contribution inspired by critical thought around the altruistic notion of care. Therefore, Pettersen's (ibid.) idea of care represents a critical-ethical perspective, which is different from those of both Martinsen (1989, 1993) and Nortvedt (1998, Kristoffersen & Nortvedt 2005). Martinsen and Nortvedt understand care as altruistic, in the sense that they have their attention focused on the interests of the other person, and the interests and needs are placed at the forefront (cf. Gilligan's second level). According to Martinsen (1989, p. 16), professional care is an expression of "generalised reciprocity". Care is determined on the basis of the recipient's situation, and the carer expects nothing in return. No mention is made of equality or compensation; care is released by altruism, not relationships (ibid., p. 72, Pettersen 2004, p. 148).

Martinsen's and Nortvedt's ontological interpretation of the human being is embedded in the conviction that people are interdependent (cf. chapter 2.4.1-2.4.2). Even though Pettersen (2004) emphasises the concept of mature care, she still shares her understanding of the basic human condition with Martinsen and Nortvedt:[15] according to Pettersen, ethics of care has a particular sensitivity with regard to those existential aspects that can be characterised as human vulnerability, connectedness and dependence. We are surrounded by, and are part of, a "a web of relationships" (ibid., p. 197), and ethics of care addresses the fact that we are "stuck" in these relational webs. Given this relational vulnerability and the dependence that stems from the fact of being human, we possess the power to hurt and harm each other. And this is exactly Gilligan's intention: to describe what goes on in human relationships. In other words, Gilligan's ideas can be interpreted as an attempt to understand the specific problems that occur when people are dealing with each other, be it in private or professional relationships. Pettersen (ibid., p. 187) states the following: "In particular, certain features of human interaction are highlighted – the presence and absence of care. These features are ethically relevant as they concern the principle of non-maleficence, and the opportunity for

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[15] This also applies to the philosophers who have inspired Martinsen and Nortvedt, like Vetlesen, Løgstrup and Levinas.

human growth and flourishing". The vulnerability inherent in these relationships is a key concern for Gilligan: "Her ethics focuses first and foremost on a particular kind of vulnerability displayed in human relationships, namely psychological and emotional vulnerability" (ibid., p. 187). Human vulnerability is associated with care: care is a feature of – and decisive for – all relationships (ibid., p. 197), and furthermore: care is "*a relational activity between persons*" (ibid., p. 67).

With reference to Gilligan, Pettersen underscores that the key issue in the concept of mature care is the perspective of both-and. Care constitutes a balance between concerns for oneself and for the other person, it is a kind of thinking "which flows back and forth connecting self and other, mind and body, past and present, consciousness and culture" (Gilligan 1990, p. 19). It is a development process for the ego, "and results not in an isolated, and separate self, nor a self without boundaries between self and others, but in a self-consciousness of its connectedness with other people through relationships, as well as of its independence and autonomy" (Pettersen 2004, p. 122). Contrary to Martinsen and Nortvedt, she emphasises that the human being is both dependent and independent, both connected and self-reliant. The human condition is basically ambivalent. One of these perspectives, that of human dependence, has been favoured within traditional moral philosophy.[16]

Mature care represents a form of middle ground between two extremes, an intermediate position between "selflessness" and "selfishness", in which the interests of both oneself and the other person are taken into account. This could be perceived as a virtue.[17] A key notion of this idea is to reconcile opposites (ibid., p. 219). Care cannot be interpreted as either care for oneself (egotism) or as care for others (altruism) (cf. footnote 9). Mature care is neither a purely egotistical nor a purely altruistic project, since attention is directed at both the recipient and the caregiver (ibid., p. 59). Care is concerned with the welfare of others as well as one's own (ibid., p. 221). A guiding principle for mature care is that this type of care "protects against harm" (ibid., p. 19), but also actively "promotes well-being and human flourishing" (ibid., p. 197). As regards the caregiver, this concerns development of a particular attitude. Therefore, the parable of the Good Samaritan (as an expression of spontaneous care for the needy people one meets) cannot function as a paradigmatic example in the context of Gilligan's ethics of care, because the parable does not refer to balancing the one's own

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[16] Clarification in personal communication with T. Pettersen in August 2007.
[17] Cf. footnote 12. (Mature) care can be perceived as a virtue.

interests against those of others. A response to care that involves self-sacrifice would violate the ideal of mature care. Moreover, emphasis is put on the ability to correctly assess the situation, so-called "contextual sensitivity" (ibid., p. 160). Care will vary according to, for example, the recipient's situation, the giver's ability to provide care, and the giver's familiarity with the other person.

Gilligan's ideas have a dynamic aspect: the search for the reconciliation of opposites involves the search for a middle ground (Pettersen 2004), which can be understood as an ambition to preserve harmony. Inherent in this idea of a middle ground is an implicit relational ontology: the human being is "interdependent and connected with others" (ibid., p. 221). In this perspective, which claims that the human being is not an atomised and isolated individual, it is natural to see concern for the self and concern for other persons as connected. Therefore: "concern for others is also concern for oneself (and vice versa)" (ibid., p. 221). Here, care is understood as a middle ground between two extremes. "The right kind of care" is synonymous with mature care, and means "taking the interests of both self and others into account" (ibid., p. 219).

As regards the caregiver, Pettersen emphasises, with reference to Gilligan, that this person does not act on impulse. On the contrary, reflection is a salient feature of mature care: "it is a reflection on how to act in order to prevent harm or restore health and promote well-being and flourishing in human interaction (Pettersen 2004, p. 78). In this perspective, care can be conceived as "a cultivatable, relational virtue with social, intellectual and moral aspects. Its performance is guided by the expanded principle of not hurting" (ibid., p. 78-79). Gilligan has more confidence in the care of mature persons when it comes to handling moral dilemmas and situations, exactly because contextual factors have been reflected into the situation (ibid., p. 121).

Pettersen argues that Gilligan's concept of care is appropriate for an understanding of professional care, because the provider of care interacts with certain other persons, possesses the contextual knowledge about the person who is in need of care, and strives to alleviate suffering and promote growth and development. She provides two arguments against altruistic

care and in favour of mature care: (1) The care provider is not required to be unselfish.[18] Mature care underscores the importance of emphasising the integrity and autonomy of the provider of care, which in itself is important in professional care situations. (2) Because of the historically conditioned gender segregation in the care professions, mature care has the benefit of not associating care with women's willingness to self-sacrifice. Further, Pettersen (ibid., p. 150 ff) also formulates a possible problem connected to mature care: the balancing of self-interest and the interests of others may create problems in asymmetrical relationships. Can unequal conditions be adapted to a conception of care that emphasises equality? She points to the obvious complications, since balance is a key concern in mature care. Asymmetrical relationships imply that one part, the provider of care, occupies a superior position in terms of, for example, resources, status and position. Similarly, in these relationships there is not an expectation of mutuality or compensation. Here, Pettersen claims, it might be that the giver receives some compensation, even without the recipient knowing it. This could be the joy of seeing the recipient develop in a positive way, or that the patient is cured for his/her pains. However, Pettersen's main argument in favour of mature care in asymmetrical relationships is that the maturity of the caregiver helps him/her realise that what is given and what is received in such relationships is not equal, or not even of equal value. A mature provider of care is further capable of distinguishing between self-sacrifice on the one hand, and selfishness on the other. Both of these may entail exploitation of oneself or of others. Mature care does not involve total unselfishness, and the needs of the other person alone do not determine the content of the care provided. This leads to a further point: care has an inherent value. If care is motivated by, and exercised on the basis of an ideal of care, which is to protect from harm and promote growth and development, these actions are not undertaken with thoughts of compensation. The caregiver will provide care, irrespective of whether the recipient repays or even is aware of the care that has been provided. The decisive element in asymmetric care is the caregiver's attitude to the beneficial actions taken: mature care, which implies a balance between self-interest and the interests of others, does not presuppose equality between the giver and the recipient of care. Neither does it require full self-denial, but it requires the ability to assess whether it is reasonable to expect something in compensation, and perhaps what and when. This is important in order to avoid being exploited (ibid., pp. 151-152). In

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[18] According to Pettersen, altruism may well be a motive for provision of care. However, she argues against making it the only dominating one. When the altruistic motive dominates, she refers to the care provided as altruistic. Cf. footnotes 3 and 14.

other words: there is an altruistic component in mature care, but this component does not dominate, and therefore will not entail self-sacrifice.

2.4.4 Summary

In this chapter, I have placed acute psychiatry in a broad field of various contexts of meaning. Many development trends can be traced, and some of these follow diverging paths. For example, I have pointed out that an altruistic conception of care is characteristic for the field, while at the same time development trends pointing towards classification and standardisation can be identified. This is one of many features that makes the field complicated and complex. The key issue illustrated by this chapter, however, is the necessity of debating and problematising the conceptions of care. I have referred to two different approaches to the understanding of care, altruistic and mature, respectively. In my opinion, the key distinguishing feature of these two approaches is their description and involvement of the provider of care. This point will serve as the basis for the further discussion in chapter 5. At the same time, however, the heavy burden of tradition in psychiatric nursing, which emphasises the importance of using oneself, one's own person, therapeutically, creates some challenges with regard to the status I believe the provider of nursing care should have in the field of acute psychiatry.

3

The research process

In this chapter I will present an explanation for and discuss the choice of theoretical positions that influenced my study. I will describe the research field and the data and the methods I used with the latter. Significant importance is attached to rendering an idea of how I proceeded and how I reflected upon my way of proceeding in the course of my analytical work. At the end of the chapter, I will discuss aspects of validity and ethical problems in research, especially with regard to informed consent. In my presentation I will particularly place stress on the research process as being influenced by unlike analytical movements that alternate.

3.1 Reflections upon the theoretical positions that motivated the study

Qualitative research is a heterogeneous field that involves "many schools of thought, integrate[s] many disciplines, and tap[s] many philosophical roots" (Ponterotto & Grieger 1999, p. 49). Relevant theoretical reflections include the questions that address the kind of activity one is occupied with as a researcher and reflections upon the kind of status the knowledge brought about through research. The theoretical debates are very often complicated and difficult to overview, and disparate theoretical positions trigger a great variety of different discussions rooted in different philosophical traditions.

Phenomenology (Bengtsson 1990, 1999) is one of the fundamental elements. Phenomenology is not a homogeneous philosophical school and is used in health science and medicine in many different ways. In general, I would like to point out that Husserl, in his revised concept

of phenomenology, introduced a new understanding of the subject and the subject's existence in the world. The development of ways to reflect upon reality within the phenomenological tradition centred on concrete experience and in the taken-for-granted reality of our everyday lives. Life world, or what Husserl called "the world of the natural attitude" (Bengtsson 1999), is to be regarded as one of the central concepts in phenomenology. Life world is the world in which we live with others, the world with which we communicate and to which we relate; life world is not a concept derived from a reflective and theoretical perspective or attitude towards the world. Life world refers to our being bodily situated in the world, in a spontaneous, concrete and context-dependent way. The starting point for my perspective of patients and nurses was the assumption that they always undergo the experience through their personal interrelationships and through structures inherent in psychiatry as an institution. Moreover, others will experience them in a similar manner. I have been engaged in investigating how patients and nurses experience, apprehend, handle and understand their behaviour when they interact. The phenomenological approach to relations between patients and nurses makes it clear that patients and nurses are not "objects out there", existing separately, but that they are involved in complex processes of mutual understanding. My own understanding of what transpires between them becomes relevant to the manner in which I encounter him or her, and vice versa. In human relations, the partners influence one another mutually.

As a researcher, I actively participate in these interpretative processes. In addition to understanding previously interpreted relations, I had a participant role in what was happening. I participated in social encounters where experience was interpreted and where social meaning was created (Järvinen 2005, Järvinen & Mik-Meyer 2005). The kind of reality I refer to here is a reality that we – as participants - create and experience. Birch & Miller (2002, p. 93) write about reciprocity and negotiation as central elements in the research process: "… the researcher must acknowledge their own part as a co-producer in such stories … And it is this dynamic and constituent nature of the research encounter in which data is generated that necessitates the need for all participants to be visible in the research process". As I was present in the situations with the participants, together we brought about the prerequisites for something to happen in a certain way, and for something to be understood in a certain way. The relationship between the researcher and the participants is the context where data, i.e. knowledge, is produced (Maher 1999). Patients and nurses interact according to the meaning they ascribe to their experience. Moreover, I cannot separate my own constructions from those of the participants, because the focal point is that meaning emerges through a

collaborative process, meaning is produced cooperatively (Sciarra 1999). In the case of my project it is produced by me as a researcher and by the patients and the nurses. This implies that the meaning we produce in our analyses has to be regarded as adaptable, flexible, unstable, and ambiguous. The phenomena we deal with in this kind of research do not represent invariable entities (Mik-Meyer & Järvinen 2005). On the contrary, as researcher, I reshape them again and again. In my opinion, Løgstrup's understanding of phenomenology and his idea of the basic conditions of human life can help considerably in shedding light upon the empirical world that has been created in the course of the project. Meaning is a relational phenomenon and can only be recognised by including the situation and the social context in which things happen (ibid.). As researcher, I am an integral part of what I analyse, and by this I mean that I ascribe a certain meaning to what occurs in the field, because I am a researcher with a certain perspective, related to a certain position and a certain starting point for my research. Knowledge of social life on the one hand includes an understanding of the meaning the participants ascribe to something and, on the other hand, every analytical reconstruction is rooted in a certain perspective that influences the analysis (Warren & Karner 2005).

3.2 Qualitative research design – field, methods, and empirical material

3.2.1 Research field[19]

I obtained access to the field, primarily because I am a psychiatric nurse with clinical experience from acute psychiatry. This fact was related to me more or less explicitly on both wards. Relative to unit 1, I obtained access through an acquaintance who was leader of the ward. He functioned as the "key-person" (Davis 1986) or "gate-keeper" (Miller & Bell 2002).

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[19] This presentation of the research field includes both wards in which I collected data. In the following, the ward where I carried out the first study is referred to as unit 1 (1999). The empirical data from this ward provided the basis for my Master's thesis (Hem 2000). After I was employed at UiO and associated my research work to Section for Health Sciences and the Ethics Programme, I continued to work with these empirical data and used them for articles published in international scientific publications. As it turned out later, the first three of these articles are – regarding subject matter – closely related to my doctorate. Accordingly, I included them in the thesis. The other ward is referred to as unit 2 (2003-2004). The description of unit 2 is more detailed, because the fieldwork we carried out in this ward turned out to be more extensive, both regarding time and the kind of data we collected, although much of what I write about the routines or attitudes on unit 2, for example, also applies to unit 1.

I was not familiar with the ward beforehand. On the contrary, this was the case with unit 2: I was given access because the leaders of the department knew me as an earlier employee.

Both wards can handle five to six patients at a time, and they are both locked wards within an acute psychiatric department. The departments are situated in and in the vicinity of a large city. Unit 1 is an admission ward, whereas most patients in unit 2 had been transferred from the admission ward of the same psychiatric department. All patients are in need of quiet and protected environments. In other words, most patients on these wards are psychotic or nearly psychotic. In addition, there are the suicidal patients who need close attention and who are therefore often admitted to these wards. Many of these patients are worn out, i.e. they have suffered from psychic problems for many years and/or they suffer from a combination of drug addiction and psychic problems. In unit 2 especially there were many patients living in poor social conditions. Many of them were non-native Norwegians with a poor command of Norwegian. Consequently, it was often necessary to use an interpreter in conversations with them.[20] The average length of stay in these wards is one week, but the actual length of stay varied considerably, i.e. from a couple of hours to several weeks. Both wards were quite easy to oversee, but unit 2 was planned and constructed with special regard to this requirement.

In unit 1 there are two corridors with doors that led to the five single rooms for patients and to other rooms, such as a wash room, a shower room, a toilet, a room for fresh towels and bed linen, a "wet room" and a storage room. This part of the ward reminds me somewhat of a typical dark hospital corridor. The other part of the ward gives the impression of being more open, lighter, and friendlier. The common room for staff and patients is situated here; it is furnished with a sitting group and a television set, and with a dining table, chairs, and a sideboard where the patients can have their meals. From the common room you can also access a small balcony with a beautiful and magnificent view. The door leading to the nurses' station is open most of the time, or is at least not completely closed. This makes it easier for the patients to contact the staff. From the nurses' station it is possible to oversee only one part of the ward, i.e. the common room. There are some easy chairs placed in different areas of the "corridor" section of the ward, and often one of the staff members is present to ensure that the staff knows what is going on in this area.

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[20] All patients who participated in the project, as well as those who are referred to in the different analyses, are native Norwegians (from a genetic standpoint); the most important reason for this is that it was much easier to establish contact with them than it would have been with non-native Norwegians.

Unit 2 appears to be somewhat worn, although it is obvious that this ward is comparatively new (i.e., completely refurbished ten years ago) and the intention was to make it a light, neatly arranged, and friendly looking locked ward. Furthermore, this ward is part of an old building with large windows that allow abundant daylight in almost every part of the ward and in this way contribute to favourable lighting conditions. This ward also has two corridors: one bright and broad, and one much shorter and somewhat dark. The nurses' station, which is bright and pleasant, is situated on the corner where the two corridors meet. The room is quite full: there is a long work desk full of papers, folders, and office supplies, a table surrounded by chairs (often used by 10 to 12 persons in connection with the daily team meetings), and there are many other things placed in the room. Quite often, especially during the day, the room is full of people and teeming with activities. From the nurses' station you can access a large patio through a large door. The nurses' station has windows on all sides of the ward enabling the staff to observe the whole ward, including the common room. The common room is bright and large, but appears somewhat substandard with only a few, quite worn pieces of furniture. There is a sitting group, a dining table with chairs, where all meals are served, and two cupboards. The TV is placed in a cupboard that can be locked. The corridors have doors along both walls, and there are five rooms for patients - two of them with a separate bathroom. The two furthest patient rooms are situated near the entrance to the ward and can – together with a visiting room – be separated from the rest of the ward by closing or locking a door. This happens quite frequently, when the staff members want to separate patients from one another, for example in case of restlessness or a disturbance on the ward. The patients who need the most protection and control (often restrained by bed-belts) have priority with regard to the patient rooms that have separate bathrooms. Those two patient rooms are situated close to the nurses' station. In addition, the ward has a kitchen, a common bathroom and toilet, a smoking room with an exit to the large patio (used deliberately in therapeutic contexts, for example, when the aim is to expand a patient's radius of movement or activity in a controlled manner), a room for fresh towels and bed linen, a "wet room", and a staff toilet. All rooms, with the exception of the patient rooms, the bathroom, the common room, and the smoking room, are locked at any given time. In other words, only the staff members have key access to these rooms.

I carried out my field studies and the interviews with patients and nurses on these two wards. The table below gives an overview of the period of time for data collection, the amount of

hours I spent in the field, and the amount of hours used for interviewing the nurses and the patients.[21] In addition, the table shows the amount of text pages extracted from the original field notes and the amount of pages of the transcribed interviews.

Period of data collection	Empirical material[22]		
	Participant observation/field notes	*Transcribed interviews (nurses)*	*Transcribed interviews (patients)*
Study no 1: September-November 1999 (Unit 1)	65 hours 48 pages	6 participants 4 hours 42 pages	-
Study no 2: November 2003-June 2004 (Unit 2)	213 hours 193 pages	Group interviews: 3 participants •2 5 hours 59 pages	5 participants 6 hours 91 pages

Table 1: Overview of the empirical part of the project

The empirical data in total add up to 433 pages. In chapter 3.3 I will provide details about how my co-authors and I worked with the material. Qualitative research methods are described as "experience near" (Warren & Karner 2005). It has been my explicit aim to try to get as close as possible to the patients, the nurses, and to what happened between them (ibid.). In the following section I am going to describe and explain in more detail my action, movements and behaviour in the field and during the interviews.

3.2.2 Participant observation[23]

Dewalt & Dewalt (1998, p. 260) define participant observation as "a method in which an observer takes part in the daily activities, rituals, interactions, and events of the people being studied as one of the means of learning the explicit and the tacit aspects of their culture". Concerning field research Warren & Karner (2005, p. 1) state: "Field research … involves present-time face-to-face interaction in a setting … The field researcher enters and spends a certain amount of time interacting and observing in the setting". In accordance with the basic

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[21] Patients and nurses were only interviewed once.
[22] Field notes and transcribed interviews: single spaced, point 12.
[23] There are many expressions used in the literature for explaining that a researcher shares the situations with those he or she is studying, among them especially "participant observation", "field research", and "ethnography". In my thesis I use the three expressions mentioned above at random.

assumptions in field research (Tedlock 2003), my presence in the wards was meant to elicit knowledge about what went on between psychotic patients and nurses, about what they thought, about the type of experience that influenced their behaviour, and about their intentions. I was present on the wards every day of the week, both during the day and in the evenings. In both wards I felt quite at home; I was familiar with the professional way of thinking, the work itself, and the routines. There are, in my perception, two things that have changed on unit 2 since I stopped working there seven and a half years ago (at the time of observation): first, the working tempo has increased and, second, there was much more focus on medication and on early and accurate diagnosis. However, on the whole, I managed to find my way around the ward quite well, both with regard to the patients and to the staff.

On the other hand, although I was familiar with almost everything and did not really feel like a stranger, in a way I had the impression that at times I was "an element" that did not quite fit. For a researcher doing fieldwork there is no matter-of-course position in such surroundings. I had to try to create a role or position for myself that was natural, for me, for the patients and for the staff members. This could be quite challenging. Often, when I felt uncertain and uneasy, I solved the problem by sitting in one of the chairs in the corridor, right next to the nurses' station. There I used to feel quite at ease. There I was virtually in the centre of everything (i.e., from there I could observe much of what was going on, and almost all those who entered or left the ward had to pass by). A daily paper ("Aftenposten") helped me – at least to some extent – to conceal that there were no official tasks assigned to me and that I had actually no place on the ward. At the same time, this was the part of the ward where both patients and members of the staff liked to relax, so at times it was quite a lively atmosphere and I could make many fine informal contacts there. Part of the material, for example, we present in article VI (Hem, Heggen & Ruyter 2007) originates from this setting. On unit 1 I let myself be guided by the same considerations, and I often sat down there in a chair in the sitting group in the common room. However, I was not able to observe as much as I was able to in the other ward.

It was often quite calm and silent, both on unit 1 and unit 2. Sometimes I had the impression that nothing was happening. The patients were usually in their rooms. Occasionally a patient passed by, perhaps on his/her way to his/her own room or to the smoking room, and the staff were usually in the nurses' station. However, as a rule one of the staff members was always sitting somewhere in the corridor area or in the common room. As it was so calm, I could

become quite bored. I had no idea of what to do in order to make the time pass by after I had finished "Aftenposten". Later I started to wonder whether these feelings could be regarded as relevant information about what was happening on the ward. Several times it struck me that I was lucky, because I was free to leave, if I could not manage to be there any longer. The more I contemplated this situation, the more I realised that a natural conclusion could be that these feelings might provide insight into the way some patients might experience being an inpatient on an acute ward. I also observed, for example, that some of the patients complained and made comments such as: "nothing happens", "the staff only stay in the nurses' station", "I am not allowed to do anything". One patient said: "My whole life is locked up". The feeling of everything coming to a halt, and of inactivity, which is so striking to me, is (to some extent) part of the therapeutic concept on the locked units; the guiding assumption is that the patients need rest and peace in order to recover. The fact that the nurses at the same time were busy with all kinds of tasks, struck me as an interesting contrast. They also told me that it is often very hectic when they are on duty. On the whole, it looked as if it was quite a notable contrast between the nurses' and the patients' daily lives on these wards.

At times, however, there could be numerous activities going on in the common area. Patients and employees are often busy with many different activities, and, as a rule, this would be accompanied by considerable activity back and forth in the area. At times, especially at shift changeovers and during staff meetings, I observed that there was a large gathering of patients in front of the nurses' station. They often knocked on the door, craving attention. Sometimes the curtains were drawn on the inside, as the employees tried to ensure undisturbed working conditions. This developed into another situation that by degrees developed into an idea - the idea that nurses and patients, in many different ways, live in worlds of their own. The nurses were extremely busy, they had established a common ground in the nurses' station, they had an adequate apprehension of reality, and they represented a kind of professionalism that provided them with insight into what is best for the patients. The work in the nurses' station was important and meaningful. The patients were idle, vulnerable, worn-out, with a vague apprehension of reality, locked up and shut out at the same time, and completely dependent. I had a conspicuous feeling of uneasiness, whenever the curtains inside the room were suddenly drawn. This was a powerful form of rejection that arose out of a situation where the staff members obviously felt their work was disturbed. It is possible that the patients were caught up in restlessness or excitement caused by expectations in connection with what the staff were discussing or deciding, matters concerning their lives on the ward or concerning those who

were supposed to leave the ward or those to be admitted. The patients were also occupied with which staff members were present at any given time.[24]

I deliberately included my feelings during the fieldwork. One day, after I had left the ward, I had another powerful experience that made me aware of the significant difference between patients and staff: I took the bus from the hospital to the city centre. It was just before Christmas, and the city was full of Christmas decorations, lights, and Christmas music. The positive feelings associated with the celebration of Christmas caught hold of me. The contrast was striking - from the misery in the somewhat shabby psychiatric ward to the warmth and prosperity of the surrounding world. This is, in fact, a good example of the way I was emotionally affected by what I experienced during fieldwork. In a way, I was extremely vulnerable (Behar 1996) during this period. I think I took this attitude quite intuitively, because the field actually invited me through all the different manifestations and facets of human existence I participated in and experienced almost daily over a long period. I wanted to rely on these experiences as significant for my personal involvement and commitment to the field and the project. I did not feel any urge to suppress this type of experience. This entire phenomena is quite stimulating in the light of recent literature, especially on fieldwork, and on qualitative methods in general, where there is a clear tendency towards explicitly including the researcher's feelings and private experience (Davis 2001, Harris & Huntington 2001, Gergen & Gergen 2003, Rager 2005); the notion of autoethnography is a good example of this tendency (Tedlock 2005). The empathetic approach grounded in the researcher's feelings is liable to intensify his or her sensitivity to what is happening in the field (Rager 2005). "The issues are not so much objectivity, neutrality, and distance, as they are risk, the possibility of failure, and the hope of success", says Tedlock (2003, p. 182). In other words, there seems to be a shift towards "observation of participation" (Tedlock 2005, p. 467) within an area in the field of ethnography.

The way I behaved in the field varied, depending on the circumstances; at times I was quite active and took the initiative, and at times I tried more or less to withdraw. The question of assessing how close and participatory or how distant and observant one can or should be in

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[24] The issues I am addressing here can already be looked upon as an analysis of the empirical data. This is, of course, just the beginning, but here I content myself with a reflective description of traits, which I detected in the field. Originally I planned to continue these analyses and work with the material in a systematic way in order to use them in an article. However, I chose different subject matters for the articles included in this thesis. In any case, the situation I describe here shows an interesting paradox that characterises the field and the relations between patients and nurses and could be a promising perspective for further analyses.

one's field of study is being discussed extensively by the community of investigators (Dewalt & Dewalt 1998, Tedlock 2003). Dewalt & Dewalt (1998, p. 262) mention Paul, who points out the following dilemma: participation requires emotional involvement, whereas observation requires distance. In my fieldwork I experienced a tension that was extremely challenging; on the one hand, the tension between participation and emotional involvement increased to such an extent that I was almost in danger of "going native" and, on the other hand, observation and distance escalated to such a large measure that the researcher bias risked being minimised. Dewalt & Dewalt (1998, p. 263) point out that participant observation in itself is a paradox, because as a researcher one "seeks to understand the native's viewpoint, without "going native"". Sciarra (1999, p. 44) contends that the qualitative researcher must "constantly negotiate issues of closeness and intimacy because they are necessary consequences of the serious qualitative endeavour".

I had to assess the closeness-distance question continuously. When a conflict between a patient and an employee was about to escalate, I tried to keep my distance in order not to interfere with the job the employees had to do. The role of participant observer was interesting and challenging in several ways. For example, it meant being present, and that I was obliged to become involved in situations where limits were to be set, were exceeded, and attempts made to re-establish them. This was a very privileged research position that produced valuable data while at the same time frequently provided me with firsthand experience of how challenging it is to handle patients on a ward of this kind. In the case of a young maniac woman I met on unit 2, for example, it became quite natural that I did certain things with her and that I performed some of the duties (that would normally have been carried out by one of the employees). Some of the episodes, to which I am referring here, are presented and discussed in the article about setting limits (Hem, Nortvedt & Heggen 2008). Here I would like to point out that this instance of participation demanded a high degree of awareness of myself and of what was going on in the situations (Davis 1986). What happened in this encounter again clearly shows that, in field research, participation fluctuates between "the participant-observer role" (active) and "the observer-participant role" (passive) (Davis 1986) – you could also call this the closeness-distance question.

Taking field notes requires consideration of closeness and distance. From my experience as a nurse I know a lot about how one should act and behave on a ward of this kind and this knowledge will undoubtedly have a significant impact on taking field notes. By sitting there

and making notes in a pad, I easily could have irritated the patients. Although this method of data collection would have yielded still more details from the field than I managed to record. Consequently I felt quite tempted to proceed in this way, but I dropped the idea and instead chose to make notes in the lavatory about what had happened during the last one or two hours. Davis (1986) and Dewalt & Dewalt (1998, p. 53) point out that the question of whether to take notes or not, while the participants are present, should be linked to the importance of the participants feeling comfortable, when the researcher minimises his/her "obtrusive" role. The topics I describe above also shows that field access is not an "everlasting" or stable condition. Access to the field must be regarded as a process that occurs continuously, and trust - as an important prerequisite for fieldwork – has to be permanently negotiated. Trust can be impaired, when the researcher makes notes in an apparent way, especially in a field where there is so much fear and uncertainty as in acute psychiatry. This was at least my assessment of the situation. Davis (1986, p. 49), for example, points out that it is not only a question of "getting in", but just as much a question of "staying in". In article VI (Hem, Heggen & Ruyter 2007) we provide episodes from the empirical data demonstrating this situation.

Taking an insider's perspective in a matter-of-fact way was perhaps an advantage for me, both for access to the field and participation in the field. However, once I began to analyse the data, I had to make conscious efforts to establish distance. This turned out to be a challenge in the analysis of the material from both units. I will return to this in chapter 3.3.

Another significant aspect regarding closeness and distance in fieldwork has to do with the fact that I am closer to the nurses than to the patients. An obvious reason was that I could move around without restrictions, because I had the keys. In this connection I also have to mention that my personal security had to be taken into consideration and that I was equipped with an alarm. I would not have carried out the fieldwork without these security measures. There is an obvious danger of being threatened or injured on a ward of this kind, and my health and security risks had to be assessed in a realistic way (Dewalt & Dewalt 1998). The keys and the alarm, however, made me feel reasonably safe, and consequently I could spend quite a lot of time with the patients. Without this equipment I would have been afraid, and the patients would have realised this. Unless I had appeared almost like one of the employees, it would have been difficult for the patients to assess me, and this could have made them insecure, uncertain, and restless. The patients regarded me as a member of the staff; I was not one of them.

In this chapter I have dealt with different aspects of my field work; I have stressed my experience from unit 2. In actual fact, my experience from unit 1 is quite similar. The next chapter concerns the interviews I carried out in the course of my project.

3.2.3 Interviews with patients and nurses

Individual interviews with nurses in unit 1, Autumn 1999

On unit 1 I carried out interviews with six nurses; these were nurses I also accompanied while they performed their duties on the ward. The interviews lasted between 20 and 60 minutes, most of them between 40 and 45 minutes. I tape-recorded five of the interviews; one of the nurses did not like her interview to be recorded, and I therefore made extensive notes from that interview. Inspired by Ramhøj (1993) and Knizek (1998) (among others), I called the interviews "narrative interviews". The narrative interview has an open character and is based on the universal structure of storytelling, consisting of an opening, a set of events, and a final part containing an interpretation or an evaluation (Knizek 1998). The interviewees are asked to tell a story (or several stories) about a given subject matter. The idea behind the open character of the interview is to grasp the concept of "subjective meaning structure … and thematically deep material" (Knizek 1998, p. 41 (my translation)), that is not available through systematic questioning (Knizek 1998). In the narrative interviews the nurses talked openly and spontaneously about how they experienced communicating and interacting with psychotic patients. My idea was to illuminate their personal standpoints regarding the issue, their individual understanding of and attitudes towards the relationships between themselves and psychotic patients (Hem 2000). The story that provides the material for our article *Being professional and being human: one nurse's relationship with a psychiatric patient* (Hem & Heggen 2003) is told by a nurse who managed to exploit the form of the narrative interview in a convincing way when talking about her subjective experience, her thoughts and beliefs, and experiences she made while working with patients (cf. chapter 3.3.1).

I interviewed five patients and six nurses from unit 2.

The patients were asked whether they were willing to let themselves be interviewed after they had been hospitalised for some time. Three patients had been transferred to the open ward. I addressed the department's senior doctor and asked him whether I was allowed to contact the patients in this matter. The fourth patient had been an inpatient on the locked unit for a long period of time. It had been decided that he should stay there until there was a vacancy at another institution, and this would take quite a while. In this case as well, the senior doctor and the nurse in charge granted permission for me to contact the patient in this matter. The result was that the patients were interviewed after the acute phase was over. In the case of the fifth patient one of the nurses in charge helped me to contact her. Many years ago, this person had been an inpatient on various psychiatric wards quite frequently, and this had occurred over a period of several years. In addition, this person was not psychotic, although the loss of control in quite a few situations must have been considerable. At least, this has been my understanding. The interviews I carried out with these patients were individual interviews and lasted between 20 minutes and 2 hours and 20 minutes. Three of the patients were interviewed in their rooms, one patient was interviewed in his private home, and one patient was interviewed in my office.[25] The interviewees themselves chose the locations for the interviews.

This time I did not define the type of interview in advance, for example, by developing them as narrative interviews as I did in the case of the other interviews. I was, however, eager to organise them in a way that enabled the interviewees to feel relaxed and ready to talk freely about what was important to them. These interviews can nevertheless be called narrative interviews, because they provided me with a number of different stories. Two of the interviewees related long and consistent stories about the time before they were referred to hospital and about what happened during referral to the psychiatric ward. The interview with one of the interviewees took only 20 minutes, and in the course of the interview he presented several comparatively short accounts. The longest consisted of only one main story, split into several smaller episodes. All interviewees were highly motivated and eager to be interviewed. In their experience, they felt that they contributed something significant to the study. Four

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[25] The participant who was interviewed in my office was the one who had been an inpatient many years ago. As she had not been an inpatient on a psychiatric ward since that time, her way of talking about and reflecting on her experiences as a psychiatric patient showed distance, the distance brought about by time. Since she had last been hospitalised, she had begun a life with a job, partner, and children. This means that she – in many respects – differed from the other four interviewees. These four were still inpatients and I had contact with all of them during participant observation on the unit.

inpatients I interviewed in particular showed an extremely critical attitude towards psychiatry. I had the impression that their idea was (and some of them stated this explicitly) to use me, the researcher, as a means to express their criticism. This raises the question of how to assess the status of empirical data that have been collected in situations with patients, who were (partly) psychotic at the time of the interviews. What status should one ascribe to the accounts given by the social participants? Malterud (2003) poses the question in the following manner: "What is the truth in this?". These accounts are true insofar as they mirror what the patients experienced when they - in a state of acute psychosis – were referred to the hospital, stories related at a certain point of time, namely some weeks later, when the storytellers were still inpatients. Beyond this, it immediately strikes me that the interviews with the patients (or nurses) should not just be taken as accounts of their experiences: they should be looked upon from a much broader perspective. Storytelling is also a "cultural device for the expression of self and experience" (Warren & Karner 2005, p. 24). Telling one's own story can be a very powerful means - "for simply the purpose of telling" (Maher 1999, p. 194). In other words, stories accomplish more than just mirroring events and feelings; stories are woven into a complex of personal, social, cultural, and temporary meaning (Warren & Karner 2005).

Group interviews with nurses in unit 2, Winter/Spring 2003/2004

The interviews with the nurses from unit 2 were conducted in the form of two group interviews, with three nurses in each group. They were the same nurses I accompanied in the field. The interviews were prepared and conducted by my supervisor, K. Heggen, and myself. Before each interview, we worked analytically with the relevant field notes in order to spot subjects that we could address with the nurses. We were especially interested in asking the nurses about how they managed to work to ensure and maintain the patients' dignity in a field that is full of offence and humiliation. However, we were also interested in asking the nurses about their opinions concerning responsibility and cooperation. The interviews provided a considerable amount of data in connection with these questions. It was especially interesting that the nurses mentioned patients I also knew from participant observation. In this way I gathered different versions of the same events in my empirical data. The interviews lasted two and three hours, respectively. As the setting for the interviews, we had chosen the meeting room in a restaurant; a meal was served and there was something to drink. Both my academic supervisor and I were extremely content with both of the interviews. The way we had arranged the interviews had a very favourable effect on the situations; in both cases, the situations developed into pleasant, interesting, and serious conversations about professional

issues. This was exactly what we had had in mind – and inviting them out was our way of thanking them for their support of the project.

The empirical material – a summary

The field notes I took turned out to be wide-ranging and full of details; they included accounts of situations and episodes that are alike, or at least resemble each another. However, at the same time they cover a wide variety of different situations. The group interviews were especially successful because the nurses stimulated one another in their engagement in the situation, supported and prompted, as it were, by comments and questions from both K. Heggen and myself. The individual interviews differ considerably; some of them are private and self-revealing; some of them recount detailed accounts of events, including personal opinions and evaluations, and two of them turned out to be very "thin", seemingly affected by cautiousness on the part of the interviewee. This applies both to patient and to nurse interviews.

Before discussing aspects of data analysis, I would like to comment on the status of the written material used in the analyses. With the exception of the five interviews conducted with the nurses from unit 1, which were transcribed by another person, I invested considerable work in transcribing the interviews and recording the field notes. I experienced this part of the project as quite challenging, both because I had to handle large quantities of text, and because I worked with positioning myself in the material. Often I worked with the field notes the very day I had been in the field; sometimes I finished the work the following day. I also used to transcribe the interviews over the course of two or three days.[26] As regards the written material in general, I attached great importance to "writing myself into it", being aware of writing about my own actions, thoughts, and feelings, both in the field and during the interviews (Sciarra 1999). With this kind of approach, "reflexive ethnographic writing" (Dewalt & Dewalt 1998, p. 289), I would like to highlight an essential analytical aspect I will return to in various ways during the course of this chapter, namely, that I as researcher am part of what I examine.[27]

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[26] In the last five to ten years there has been a growing focus on the assumption that to transcribe qualitative interviews is an interpretative process. To transcribe means to create a representation of something or a construction. This standpoint challenges the assumption that qualitative research requires a stable social reality, which can be examined by a stable, objective, and scholarly observer (Lapadat & Lindsay 1999, Forbat & Henderson 2005).

[27] Although it is apparently only a question of a difference in degree, I nevertheless would not assert that I work along the lines of what Warren & Karner (2005, p. 15) call "autoethnography": "Autoethnography puts the self

3.3 Analysis – creating meaning from the data

In qualitative research projects, analysis means creating patterns or structures and coherence in the data material. Analysis can be described as a "strenuous creation process" (Heggen & Fjell 1998, p. 86). To account for the analytical process is quite demanding, because these processes very often are not linear; on the contrary, they include movements in all directions within the empirical data, criss-crossing back and forth. Looking back upon my analytical work, I realise that the way I worked with the material from unit 1 differed from my approach in connection with the material from unit 2. For example, in the material from unit 1, in a way I worked more "according to prescription". By "according to prescription" I mean what I was able to detect and describe from today's perspective, i.e., I proceeded step by step. In my analyses of the material from unit 2, I let myself be guided by intuition to a greater degree, leading me in certain directions and deciding how I should work analytically, while I worked my way through the material (Haavind 2000, Gubrium & Holstein 2003, Silverman 2003). In this chapter I shall account for the analytical processes the current study is founded upon, first in relation to my work with the material from unit 1.[28]

3.3.1 Analysis of the material from unit 1

The first stage could be called the "close-reading stage", during which I worked my way through the material by "just reading" it. The idea was that in this way I could increase my awareness of the material's content. I accomplished this task with great intensity and read through interviews and field notes again and again. While I read, and afterwards, I considered questions such as: What is the material about? What are the essential themes? At times, I discontinued the reading in order to create distance from the material. Later I moved back and

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at the center of sociological observation and analysis. The autoethnographer uses his or her engagement in the interaction, or reflections about the interaction, as the data. Two general approaches to autoethnography are emotional … and analytic …". I am using my reactions as data, but I do not prioritise my position in the data. As to data status, there is no significant difference between my reactions and my observations and understanding of what is going on between the other agents in the field (cf. chapter 3.4).

[28] In this account I am going to deal with the analyses of the material from unit 1 in a more detailed way, because in the corresponding articles (I-III) we do not dwell on this sufficiently. As regards the analysis of the material from unit 2, however, the approach is thoroughly accounted for in articles IV and V and does not need to be discussed in detail here. This, however, does not apply to article VI, and the analyses, carried out in connection with this article, again have to be accounted for carefully in the current chapter.

forth through my data, while choosing various theoretical perspectives. Accordingly, one can visualise the analyses as a continual process of abstraction (Heggen & Fjell 1998). New questions arose, the material was re-read again and again, and I tried to relate my findings to the relevant literature. What struck me from the very beginning was that the nurses were engaged in the patients' "weal and woe". Both in the interviews and in informal conversations between the nurses and myself, and in conversations I overheard, they said, among other things, that it was important to take care of the patients and to understand and respect their feelings and experiences. In many different ways, the nurses focused on the patients' inability to master their lives, either economically or socially, in their families or in their education. The patients were to a large extent described as suffering, in need, worn-out, lonely, but at the same time as demanding, manipulating, and liable to exceed limits. The patients, for their part, when relating their experiences, reported instances of offence and incapacitation, episodes where they felt inferior and completely helpless, and they complained that they were underprivileged. Another distinctive trait manifest in my empirical data is that the nurses tended to refer to the doctors and their authority. All decisions were made with a doctor. This could cause considerable frustration among the patients. My written observations up to point can be viewed as the first identification of traits in my empirical data and can be understood as a data-condensing process. I tried to combine the essential traits of the material. I proceeded in the same way as in the interviews I conducted with the nurses, although in that case, I approached the material with five primary questions. In the course of my project I became more and more convinced that communication has something to do with the interactive production of meaning and that this production of meaning includes both an understanding of the self and the other. The five questions I asked were developed against the background of these theoretical underpinnings and take into account the essential traits that, as far as I could see then, characterised the interview texts - traits concerning the relations between patients and nurses. The questions were (1) How do the nurses characterise the patients' circumstances? (2) What expressions and concepts do the nurses resort to, when they describe the purpose of the patients' stay on the ward? (3) What explicit and implicit categories and concepts do the nurses use when they talk about their work with the patients? (4) How are the patients' experiences of their circumstances referred to? (5) How do the nurses cope with the fact that they and the patients have different perceptions of reality?

The overall result of my reconstructions of interactive processes between nurses and psychotic patients is that the relations between them are contradictory and ambiguous. My

reconstructions show how fragile and changeable the relations are, that the nurses continually balance between being fellow humans and professionals, between taking responsibility and avoiding responsibility, between treating the patients as individuals and treating the patients as cases (Hem 2000). In other words, while doing their work, the nurses are involved in situations full of contradictions, situations where it is difficult or almost impossible for them to know how they should conduct themselves or how they should act. Accordingly, one could contend that the relations between nurses and psychotic patients are affected by dilemmas, and therefore my main concern throughout the analytical stage of the project was to detect the conflicting purposes and interests the nurses had to grapple with, and to detect how they met the challenges, tackled the conflicts, and coped with their uncertainty (Hammersley & Atkinson 1996).

Field notes and narrative interviews formed the basis when, in the next step, I wrote a number of exemplary case descriptions which were supposed to show a variety of problems that arise in interactions between nurses and psychotic patients. Each case had been thoroughly examined and evaluated with the help of categories that reflect the tensions, fine distinctions, and contradictions inherent in this material. This work provided the point of departure for the analyses, which we (i.e., the co-authors and I) conducted and which we used in articles I, II, and III. It was especially the ambiguous, unresolved, and dilemma-bound character of the circumstances in the situations that caught our attention. These analytical endeavours led to a deepening of insights I had arrived at in my analyses during stage one.

One case aroused our special interest because the story it contained could shed light on how the ideal of compassion challenges nursing practice. Accordingly, article I, *Is compassion essential to nursing practice?* (Hem & Heggen 2004b), became a case analysis and discussion that elucidated the concept and ideal of the Good Samaritan in order to illustrate an instance of today's nursing practice. We conclude this article by pointing out that there is a productive and critical potential inherent in the ideal of compassion, that provides an important tool for thought for the nurses in their encounters with patients. The study as a whole is meant to convey a critical discussion of a number of normative directives and ideals. This does not apply to the article on compassion. This article argues in favour of an ideal and underlines its importance to nursing practice and, in this way, differs from the rest of the articles. It is therefore not easy to assess the position this article has within the whole study. On the one hand, in the case of this article, we did exactly the opposite of what I/we did in the remainder

of the study, where we argue in favour of a less idealistic and less normative understanding of nursing practice. On the other hand, the article raises an issue central to the entire study at hand: my personal commitment with regard to the demanding and challenging task to encounter the psychotic patients' deep pain and suffering. This article deals with considering the patients' needs and despair seriously by treating them with care, empathy, and compassion. However, this, of course, does not mean that there is a contradiction between arguing in favour of more objectivity, and at the same time, being very involved in the best possible care for patients (cf. footnote 36).

In article II, *Being professional and being human: one nurse's relationship with a psychiatric patient* (Hem & Heggen 2003), we are focusing our attention on how the nurses tackle the contradictory demands of being fellow humans and health professionals at the same time. In this article we chose a different analytical perspective; instead of spotting coherence and characteristic features in the empirical data, we focused on exceptions to the overall tendencies – quite an efficient change of approach to the data, as it turned out. As a result of this change of perspective, we conceived the story that provides the basis for article II. The nurse's story about how she almost lost control over herself while working with a patient is a unique story in my empirical data, because none of the other nurses ever talked about how working with patients could challenge their personal integrity and their feelings. We, the co-author and myself, realised that this story could provide the point of departure for discussing the nurses' continuous balancing between being a fellow human and a health professional in their work with the patients. The nurse's story analysed in article II complies with our own clinical experience, and although the empirical data provide only one instance of this experience, we are convinced that this is a relevant aspect of acute psychiatric nursing.

In article III, *Rejection – a neglected phenomenon in psychiatric nursing* (Hem & Heggen 2004a), we again discuss characteristic features that appear in the empirical data. We attempt to draw attention to a recurrent phenomenon in psychiatric nursing: what the nurses do, when they follow their professional knowledge and routines, can be understood as rejection by the patients, i.e. rejection of their psychotic perception of reality. For example, when the nurses try to help the patients with reality orientation by clarifying that the patients' psychotic reality and "everybody's actual reality" do not match, or even clash, they sometimes do this in a way that gives the patients the impression that their experiences and sensations are not acknowledged and not treated with respect.

3.3.2 Analysing the material from unit 2

Two concepts, dignity and offence, formed the point of departure for analysing the material from unit 2. My idea was to spell out recurrent patterns and characteristic features related to these concepts; the two key questions are: What in nurse-patient interaction adds to the patients' sense of dignity, and what in the nurse-patient interaction is experienced as an offence by the patients? I was particularly interested in unspectacular everyday situations, not in instances of obvious infringement of the patients' dignity, such as physically holding them, possibly with many staff members involved, or forced medication. With this in mind, I embarked on an analysis of my data, and proceeded along these lines for quite a while. Gradually, however, I realised that this approach was not without problems, as I could not manage to grasp what, I thought, was inherent in the material – I could not spell it out. I had reached a state in my analytical work where I felt like an engine idling; there I sat with my pompous concepts, unable to move, trapped in platitudes like "Dignity is what we support; offence is what we are against".[29] This experience led me to re-orientate my analytical perspective by introducing the notion of "power dynamics in care relations". The new analytical focus enabled me to face the material in a more open way, making me aware of its richness, diversity, ambiguity, and inherent tensions. Nurse-patient relations are basically asymmetrical, and this results in a considerable imbalance of power between them. Therefore nursing care is at the same time a form of exercise of power. Care depends on power; power is one element of care. Depending on the way "power dynamics in care relations" is handled and applied, it can either be experienced as an infringement or it can promote patients' dignity. Both in care and in power – "power dynamics in care relations" - there are destructive as well as productive potentials. This new analytical perspective made it easier for me, for example, to distinguish items of dignity in the asymmetrical relations between nurses and patients. Furthermore, it became more apparent how fragile the situations between patients and nurses were, and how easily they could suddenly change and head in the opposite direction. For example, trust can easily change into distrust and vice versa (cf. article V).

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[29] This is the way Professor Trygve Wyller, Faculty of Theology, expressed this experience, when he commented on my manuscript on 16 December 2004 during a colloquium arranged by the Ethics Programme at UiO. I am very grateful for this tip, because it added dynamics to my analytical endeavours.

In comparison to the earlier articles, the analytical work put into article IV, *"Only a manic depressive!" The zone of the untouchable and exceeding limits in acute psychiatric care*, and into article V, *Pervasive distrust. The hard work involved in creating trust in an acute psychiatric ward* was, to a larger extent, guided by reflection and a dynamic attitude. I used myself in a more explicit and analytical way. The co-authors and I myself agreed on the importance of accounting for these analytical processes in a detailed way in the articles themselves (Hem, Nortvedt & Heggen 2008, Hem, Heggen & Ruyter, in press).

Article VI, *Questionable requirement for consent in observational research in psychiatry* (Hem, Heggen & Ruyter 2007) originates in circumstances quite different from those in the other articles. In the project's introductory stage, we were confronted with significant challenges regarding research ethics and, in this connection, we came into close contact with K. Ruyter, Secretary of the National Committee for Medical Research Ethics (NEM). The way we tackled an injunction we obtained from the Directorate for Health and Social Affairs affected vital ethical problems in research. These problems, especially related to consent and the competence to consent, were demanding and difficult to handle. We realised that it was necessary to discuss these questions in a separate article. However, before we felt prepared to determine the main focus for the article, we wanted to scrutinise all the field notes. At first, as first author, I went through the field notes from unit 2 (193 pages) and marked all passages relating to the researcher's role and to my experiences as a researcher in the field. The highlighted material totalled 38 pages. These pages were read by all three of us, and provided the point of departure for our work with the article. We identified a number of issues, ethically relevant to research, which the field notes were likely to shed light upon. Some of the issues included the researcher's power or closeness and distance in the researcher-participant relation. We decided to focus on the problem of consent, because it was in this context that we were confronted with special challenges, but also because we had rich data illustrating the issue - these two reasons are probably closely connected. Quite early, we realised that the kind of empirical work completed within the current project more or less demands a discussion of how problematic it is to require informed consent as a necessary condition for fieldwork. The empirical data we had at our disposal seemed likely to challenge prevailing views and theories concerning informed consent. What happens when we are actually in the field, prepared to heed the requirement of informed consent? Three detailed descriptions of patients in my data in particular help to answer this question. There were patients with whom I interacted often over a long period of time. With each of them I had a

different relationship and, accordingly, in each case the problem of informed consent arose in a different way. The challenges I had to face in connection with these patients could not be tackled with the help of "valid consent"; their vulnerability and helplessness were so apparent that this would have been impossible. Should we have concluded that it was not advisable to use them as informants in research? Or should I just stop asking for consent and continue to conduct my research, and for the rest, let myself be guided by the code of professional ethics? In any case, asking the patient for consent would by no means have been sufficient to maintain his or her dignity. In addition, is it not also a serious problem if research-based insights into the world of nurse-patient interactions are prevented by eliminating research from the field? The latter would have happened if we had followed the injunction of the Directorate for Health and Social Affairs (cf. appendix 8) in every respect. Discussing this and a number of similar questions kept us going when we completed the analytical and conceptual work for article VI.

I have now accounted for the way the co-authors and I have proceeded analytically. In the following I will discuss different aspects of the researcher role, with special regard to joint analytical work.

3.3.3 Researcher role and research cooperation

Concerning the role of the researcher in general, and analytical work specifically, our scholarly work is based on the idea that the researcher investigates from a certain standpoint (Fontana & Frey 2003, Richardson 2003, Tedlock 2003, Warren & Karner 2005). Our choices of what we determine to be meaningful, and our choices as to how we should do this, depend on this standpoint. My standpoint is related to two vital issues: I know the field from clinical practice, and I have remained in the field as researcher (Letherby 2000). I was a participant in a social world, which I observed and studied at the same time (Rapley 2001, Angrosino & Mays de Perez 2003). The data we have collected can be regarded as an outcome of the collective meaning created by me and the participants (ibid., Ellis & Bochner 2000, Engelsrud, 2005). There is a difference in the way we/I write about these issues in the articles from the first stage (based on the material gathered in unit 1) and those from the second stage (based on material from unit 2). This difference to a large extent is due to the manner in which I insert myself into the texts. In articles IV, V, and VI (cf. chapter 3.3.2), I use myself

as an analytical tool more overtly and more explicitly. In this connection, I made ample use of the rich personal notes that are part of the field notes.[30] In the same way, I took advantage of the notes I recorded of my experiences during the interviews.

The cooperation between two or three researchers has, in our (the co-authors' and my own) opinion, resulted in a broader approach to the phenomena we deal with in the articles. To some extent, we share the same background, i.e. with respect to both theory and to research experience, but there are also differences. Together we cover a wide range of knowledge of health science in general and of acute psychiatry in particular, clinically, theoretically, and with regard to qualitative research conducted in the field. Writing the articles in cooperation with co-authors meant that the second and the third author had to accept many of my premises concerning the analytical work for the simple reason that it was me as first author who was present in the field.[31] On the other hand, the additional perspectives and research interests the co-authors represented introduced new modes of understanding of and approaches to the analytical work. Although we started the cooperation from different points of departure, the articles and the case studies that went into them are products created by our joint efforts. In this way, we – as researchers – are simultaneously related to the special thematic issues addressed in the single articles (micro-perspective) and to a macro-context as agents in a field of knowledge and power. This implies that the meaning and understanding that we ascribe to the phenomena we are dealing with represent a collective cultural understanding (Warren & Karner 2005). This is the reason why the meaning we constructed by means of our analytical work cannot be arbitrary. On the contrary, it has to stimulate recollection – within the clinical field and within the community of investigators (cf. chapter 3.4). Viewed from this epistemological perspective, it is an advantage of the current study (cf. the discussion of validity in chapter 3.4) not only that the articles included were written in cooperation with other researchers, but also that the empirical data were examined by other researchers in interdisciplinary discussions.[32] In addition, all the empirical data from unit 1 were read and

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[30] The field notes were arranged as observation notes (ON), method notes (MN), theory notes (TN), and personal notes (PN) (Richardson 2003).

[31] In the case of unit 2 the interviews with the nurses were conducted in cooperation with K. Heggen (cf. chapter 3.2.3), and in addition, K. Heggen joined me in the field for two days. The idea was that she, as the primary supervisor, wanted to gain a personal impression of the field.

[32] In this connection I would like to mention that throughout my work with the two studies (Master's degree thesis and PhD dissertation) I attended various interdisciplinary meetings where my empirical data and article drafts were discussed, meetings at the Section for Health Sciences, at the Research School of the Ethics Programme, UiO, and at seminars held in Åsgårdstrand (cooperation between the Faculty for Theology and the Section for Health Sciences in 2004 and 2005). One advantage of the current study is therefore that it has been

commented on by a qualitative researcher from a different discipline. On the whole, the material has been commented on and discussed in a thorough and detailed way over a period of several years.

Another important aspect I would like to mention here is that the theoretical concepts chosen for the analytical work turned out to be a helpful means of highlighting various traits inherent in the data, functioning like searchlights, as it were. For example, the use of a number of K. E. Løgstrup's concepts as theoretical spectacles has affected the analyses considerably. In other words, even the theoretical framework selected for the study has an impact on the analytical processes. If we had chosen different key theoretical concepts as searchlights, the empirical data consequently would have appeared in a different light.

There is a third aspect I would like to draw attention to in connection with the analytical work: The way we write about a research process could give the impression that the research process has been organised in discernible steps, clearly detached from one another. This is not the way our research process has proceeded. Although we, as researchers, are obliged to advance analytically, both with regard to theory and methodology, it is in large measure for presentation purposes that we write about fieldwork, analytical work, interpretation and discussion of results as – at least partly – separate processes. Gradually, as the study progressed - from the preparation stage, via presence in the field (data collection), to systematic and analytical work with the data collected - we became more and more inspired by the realisation of how the different stages in the research process were closely related to one another. Taking account of the researcher's basic ontological and epistemological assumptions that guide his/her work at all times, it is moreover quite problematic and unnatural to divide the stages of data collection, of analytical work, and of interpretation and discussion of results.

3.3.4 Single-case methodology

In the chapters above I have accounted for the thematic choices made for the different articles. In this chapter I shall comment on and account for the choice of single-case methodology for

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commented on by researchers from different disciplines, especially from theology, philosophy, social anthropology, medicine, and health sciencec.

my analytical work. The topics addressed in the current study, and single-case analysis as the method I decided to use, are closely interrelated, insofar as the method limited the range of topics that emerged during the analytical work. However, although we decided only to draw attention to a limited number of phenomena, the study at hand sheds light on relevant aspects of nurse-patient relations (the field). An obvious advantage of choosing the single-case analysis as an analytical tool is the depth of insight we gained, although initially only in "one case". In this way, we avoided superficial and category-oriented descriptions of large amounts of material. In Flyvbjerg's (2006) opinion, the type of in-depth approach enabled by single-case analysis is suited for finding "black swans". What, upon first sight, appears to be white can after a meticulous, in-depth analysis turn out to be "black". In my opinion, article II (Hem & Heggen 2003) is an example of this situation. The nurse's story analysed in this article could – upon first sight – appear to be the typical story of an inexperienced nurse unable to control her vulnerability in a challenging encounter with an extremely demanding patient, but who nevertheless manages to find the balance between closeness and distance. After close scrutiny, however, we realised that her obvious vulnerability can be understood as strength displayed in the encounter with the patient she is talking about. This nurse discusses experiences none of the other nurses mention; she must therefore be regarded as an untypical case (Stake 2005) from which we can learn something special with regard to using oneself as a therapeutic tool. Another aspect of the single-case-analysis approach is that it yields "rich ambiguity" (Flyvbjerg 2006, p. 237). The purpose of this approach is not generalisation, but to discover and describe all possible nuances of meaning inherent in one single case, i.e. its ambiguity. Articles IV, V, and VI are examples of this situation. At the same time these articles show that to describe the whole range of meanings that exist in one case requires experience and the use of intuition. The first three articles reveal our (the co-author's and my) comparative lack of experience with this analytical method. Since then, as researchers, we have undergone a learning process that gradually enabled us to employ single-case analysis more effectively than in the case of the first three articles, i.e., uncovering the richness of the phenomena and nuances of what we were analysing. The third aspect I would like to mention here revisits Stake (2005), who distinguishes between two contrasting types of case study: "intrinsic case study" and "instrumental case study". That is, one can either be interested in a case, because the case itself has certain interesting qualities ("intrinsic"), or one can engage oneself in a case, because it could help one to increase one's knowledge and understanding of something else ("instrumental"). The co-authors of the articles and myself worked along both lines. We were interested in the particularity of each individual case; but at the same time, the

analytical work we put into the individual cases was guided by the intention to contribute to a better understanding of certain phenomena. According to my experience, it is difficult to separate these two aspects the way Stake (ibid.) does. In addition, to a large extent this is due to the fact that we understand and interpret the cases both as researchers and from various standpoints.

3.4 Quality in qualitative research[33] – on validity

Assessing and evaluating the validity of a qualitative scholarly work must be regarded as a process that occurs between the researcher and his/her field, and validity, i.e. practical or communicative validity, is checked in discussions among researchers. Checking validity in qualitative research is a never-ending interactive or communicative process, and maintaining this discussion is itself a goal (Schweizer 1998). Accordingly, validity in the case of the current study is not a question of establishing or checking what is true about the reality of nursing in acute psychiatry (Merrick 1999). In this chapter I want to show how the study's validity is linked to the relationship between myself as researcher and my informants, as well as to the relationship between myself as researcher and "the interpretive community" (Merrick 1999, p. 30).

The purpose of ethnography is to position certain events and encounters in a larger context of meaning: "… to produce historically, politically, and personally situated accounts, descriptions, interpretations, and representations of human lives" (Tedlock 2003, p. 165). This way of understanding validity is based on a central epistemological assumption underlying qualitative research, i.e. the assumption that the social agents construct social worlds in relation to time and place. Therefore generalisability in this field of research is established by posing (and answering) questions such as: To what extent does the social practice at issue, such as care for example, occur and become relevant, in more than one setting or interaction. One purpose of ethnography is to find recurrent patterns in social interactions and social life. Ethnography provides broad descriptions that are suited for illustrating that the interpretations are adequate and convincing. Data, in the case of the current study, the interview transcripts, and the field notes, are symbolic representations of social reality. As symbolic representations, the data reflect my interpretations and my choices as well as the participants'

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[33] I borrowed this phrase from Merrick (1999, p. 25).

lived experience, and they therefore cannot claim to be objective descriptions of reality. One of the essential features of qualitative research therefore is that the findings or the results are always related to and dependent on a standpoint or perspective: "They are not unmediated "snapshots" of an objective reality" (Warren & Karner 2005, p. 10).

In this connection, Polkinghorne's (in Nielsen 1994, p. 197) notion of horizon becomes relevant: the horizon reaches beyond the concrete social event. One could therefore contend that the structure of meaning or "the horizons" provide the appropriate level of abstraction that enables generalisation (ibid.). The text comprises horizons or structures of meaning, and analysing a text means providing a meaning. This does not happen if the analysis entails the purely descriptive level, if it is unstructured and incoherent (Nielsen 1994, p. 201). An analysis means to elucidate something, make it clearer; after you have carried out an analysis, you know more than before, and the text gains meaning through interpretation. However, neither is there an indefinite number of possible interpretations. Therefore, interpretation must be looked upon as a balancing act between the reader's expectations and experience on the one hand, and the reader's perception of the text meaning on the other. The material that needs to be understood is not a matter hidden behind the text, but "the world inherent in the text" (Nielsen 1994, p. 204), or, as Haavind (2000) states: There is a close relation between what is understood and the one who understands. My activities as a researcher are at the same time "part of the social order" (Warren & Karner 2005, p. 25).

Conducting research in one's own field

What are the advantages and disadvantages of conducting research in one's own field, because this is essentially what I did? I was extremely conscious of this fact, and during all stages of the research process, I worked a great deal at positioning myself. Bell & Nutt (2002, p. 70) use the expression "divided loyalties" in order to describe the double role that emerges, when one conducts research in a field one knows well. It was difficult for me to decide to whom I should be loyal. I often asked myself whether it was even possible to combine loyalty to patients with loyalty to nurses and vice versa, taking into account that their perceptions of reality differ considerably. This has been a great challenge during the project: on the one hand, there were situations in which I felt inclined to take the patient's side against a "psychiatry of encroachment" and a patient's neglect of psychiatry. On the other hand, again and again I failed to see the relational perspective and drew upon the patients' illness to explain difficulties in the interactions with them. The intensive analytical work has initiated

reflective processes that by degrees enabled me to see my position in the field in a more differentiated way; I realised that it was necessary to understand the nurse-patient interaction in a larger social context, as part of the overriding structures or patterns. My experience of being torn between two positions possibly reflects my understanding of the field as fragmented and disjointed and dominated by views and notions that can differ considerably. Viewed in this light, my position of closeness as one who is familiar with the field has been an advantage. The project required that I be able to establish closeness to my informants and to follow a perspective directed towards the informants' world. However, it definitely was necessary to create an analytical distance as an indispensable prerequisite for understanding the phenomena at issue in a larger context. In my opinion, the field of acute psychiatry is an extremely demanding field. Since so many meaningful human processes are involved, as a researcher I often come into contact with these processes in many different ways. For example, I noticed that I could develop an attitude of intensive kind-heartedness towards some individual patients, whereas others caused embarrassment. This reminds one of Sciarra's (1999, p. 45) use of the concepts of "involvement" and "detachment" for describing the fluctuation between closeness and distance to the subject of one's study. By creating the data and producing the written material myself, with the exception of the interviews from unit 1, (i.e., the interview transcripts), I became well-acquainted with the material. This knowledge of, and familiarity with, the material – in combination with the necessary analytical distance – enabled me to perform "mental movements" (Haavind 2000, p. 36 (my translation)) within the material and to ask the following critical questions: What do I understand in this situation? Why do I understand this in exactly this way? In what manner can this be understood in a different way? The young woman, Maria, for example, was one of the patients I experienced as provocative and who raised dilemmas that gradually turned into analytical perspectives (Hem, Nortvedt & Heggen 2008). In this way, I think I have managed to avoid the alternative of either lingering in one-sided criticism of psychiatry or defending existing professionalism. Cooperation with other researchers has been a decisive factor in the process of creating a more distanced and a more analytical focus on the matter at hand (cf. chapter 3.3).

Researcher power

It is an important aspect of the use of interpretative methods (in acute psychiatry) that the researcher be able to approximate the informants' perception of reality. Relationships between researchers and informants are often established by sharing private and personal experiences over a certain period of time. An obvious problem related to this kind of proximity is the

researchers' power. Birch & Miller (2002) point out that this closeness between researcher and informants can lead to the impression of equality between them and in this way elicit subtle forms of power. Equality can veil deeper and more dangerous forms of exploitation. The empathetic researcher, full of understanding, can pave the way for subtle forms of power use, which are difficult to recognise. Birch & Miller (ibid., p. 103), for example, point to the researcher's "right" to interpret the informants: "If we constantly permit interpretations that depend upon the researcher and the academic community and ignore the participation of the 'research participant', we may be in danger of reinforcing particular ways of knowing and particular forms of knowledge". Maher (1999, p. 189) refers to Min-ha who contends that it is "… mainly a conversation of 'us' with 'us' about 'them' in which 'them' is silenced. 'Them' always stands on the other side of the hill, naked and speechless … 'them' is only admitted among 'us', the subjects under discussion, when accompanied or introduced by an 'us'". The position Min-ha refers to implies that research and the research community objectify the research participants and silence them. In my opinion, these authors draw attention to something that is very relevant to my study. I mean that I, in cooperation with my co-authors, made legitimate use of the researcher's freedom, a freedom that entitles us to interpret what happens in the research field (cf. chapter 3.3). At the same time our interpretations have to be plausible and justifiable, and they have to arouse recollection. The statement above, however, is primarily about researcher-researcher "co-constructions", because it refers to the analytical work conducted after the fieldwork is over, and to a lesser degree, about the researcher-field "co-construction" that Birch & Miller (2002) refer to. Birch & Miller (ibid.) must be praised for raising the problem of the researcher's interpreting power. This is also what Brinkmann & Kvale (2005) do when they refer to researcher power as one aspect of the asymmetrical relations between researcher and research participant. Maher (1999) points out the danger of objectification due to the fact that we draw a dividing line between "them" (participants) and "us" (researchers). Forbat & Henderson (2005) discuss the possibility of showing the interview transcripts to the participants, after the transcripts are completed and/or when the transcripts are incorporated into a manuscript. I have two remarks on this: (1) I considered both possibilities, but eventually came to the conclusion to drop them both. Would the study's validity have increased if I had included the research participants in the analytical work, after the fieldwork was over, by asking them to acknowledge or possibly correct the transcripts? They might have contributed with helpful corrections, but I am not sure whether this would have strengthened the validity. The study's validity might even have been weakened, because the research participants could have been tempted to censor the transcripts by trying to hide

unpleasant sides of the field. Forbat & Henderson (ibid.) point out that it is important to be conscious of one's potential choices with regard to including research participants in the analytical work, and suggest that these considerations should be founded upon ontological and epistemological discussions on truth. As a matter of course, it is important that we as researchers are aware of – and critical toward – the power we have in our hands when we interpret social life. In this connection, the obligation to be as transparent as possible in all stages of the research process becomes significant. In this context, Doucet & Mauthner (2002) use the notion of "knowing responsibly", and with this hint at the importance of making transparent how ontology, epistemology, theory, and personal assumptions are related to one another. (2) One could assert that showing transcripts to the research participants is comparatively irrelevant to the question of validity. However, we could turn the whole issue topsy-turvy and ask what kind of additional data material the informants' reactions could have provided. What does it tell us about the research participants, if they, for example, want to censor the transcripts? The fact that they demonstrate something else can also mean that they have developed, perhaps as a result of having been an informant in the project.

The subject matter I commented on in this chapter is complex, and there is an intense discussion unfolding in the research community (Gergen & Gergen 2003). In a summation of my discussion, I refer to Warren & Karner (2005, p. 5) who point out that the question is not whether the knowledge one produces is objective or subjective. On the contrary, it is intersubjective: "... based on the shared meanings and understandings of the people being studied, and the shared meanings and understandings of the disciplinary community … doing the studying". In other words, validity is a question of inter-subjectivity.

3.5 Research ethical challenges and assessments

3.5.1 Introduction

In article VI (Hem, Heggen & Ruyter, 2007) we discuss the question of consent in research. The article was occasioned by the challenges facing us regarding consent and access to confidential information (Directorate for Health and Social Affairs 2005, cf. appendices 8-11). Our conclusion in this article is that conducting research on vulnerable patient groups requires a complex competence on the researcher's part, including clinical experience,

research experience, and a thorough knowledge of research ethics. In the following I will discuss the question of which values the principle of informed consent is supposed to protect and, in addition, I will problematise some other aspects of the project relevant to research ethics that the article (ibid.) does not address. In addition, I ask whether we should not, to a much larger extent, discuss the problem that to do research on humans means to exploit their goodwill, and that instances of seduction and hidden persuasion cannot be prevented. Finally, I will refer to the guidelines for including patients with no or impaired ability to consent, that NEM developed two years ago (Guidelines 2005); in this context, I shall also include the solutions and arguments proposed in three similar studies from Norway, Sweden, and the United Kingdom, respectively.

3.5.2 Informed consent

Which type of values is the principle of informed consent supposed to protect?
The requirement for consent in medical research is determined in an internationally and legally obligatory way (article 7 of the International Covenant on Civil and Political Rights describes the requirement of consent to medical experiments, Declaration of Helsinki 2004), and has been included in Norwegian law (NOU 2005:1, p. 63). Article 7 in the above-mentioned covenant was initiated by the Nuremberg Codex. The purpose is to protect experimental subjects against risky or dangerous medical experiments. The focus on personal integrity, protection of the individual, and on the participants' self-determination is strengthened. Since World War II there has been a change in focus from endeavouring to avoid physical harm to a broader focus, i.e. to avoid infringement (Simonsen & Nylenna 2004).

The individual's right of self-determination is a fundamental value in our society, and is equally valid in patient treatment as in medical and health science research. The purpose of research is to produce knowledge to benefit the individual as well as to benefit society. However, how to combine the individual's interests with society's interests is a point of issue more relevant in research than in patient treatment. The principle that the research participants' security, their personal protection, and their well-being have to outweigh research interests and society's interests is fundamental. The idea behind this principle is to secure respect for the fundamental freedoms of individuals and vulnerable groups, to protect

them against abuse of power and abuse of office, as well as to prevent physical, psychic, and social damages. The principle of the dignity of man in particular is emphasised (NOU 2005:1, p. 161, 176). A human being has a value of his/her own by the very reason of being a human. Respect for the human dignity of the research participants and for human rights implies that the right to decide regarding the use of personal data about oneself (ibid., p. 70) is fundamental. The principles of self-determination and voluntariness support the requirement for voluntary, informed, and explicit consent of those who are involved to the collection, use, and storage of health data (ibid., p. 70).

To secure the individual's integrity and dignity by observing the principles of self-determination and voluntariness in research is crucial, but by no means unproblematic. Since the use of humans for research purposes is indispensable for producing new knowledge, one cannot avoid being confronted with challenges and dilemmas that arise in the process of obtaining consent. In the following I shall problematise a number of issues that became relevant in the study.

Research and seduction

Dewalt & Dewalt (1998) hint at something crucial when they contend that we as researchers want the research participants, at least for a while, to forget that we are outsiders. We want them to become accustomed to us to such an extent that they would like to share insights and information only insiders have. We regard this as a strength of participant observation as a research method. Therefore participant observation inevitably is unethical "by virtue of being interactionally deceitful" and "… (it is) by its nature deceptive", as they point out (ibid., p. 273 with reference to Punch & Ditton). The fact that research contains elements of seduction makes the question of conducting research on other humans' lives relevant (Miller & Bell 2002): research issues that are assessed as ethically dubious can, at the same time, yield favourable conditions for good qualitative research. The purpose of participant observation and open qualitative interviews is to get under the participants' skin, in order to attain "rich, deep data" (Birch & Miller 2002). This is a contradiction inherent in my study. I have "exploited" (ibid.) patients and nurses in order to get important information.

Miller & Bell (2002) ask what research participants are actually saying yes to when they give their consent to participate in a study. This question is related to a point Bloch & Salzbergs (2003) make when they state that we have little empirical knowledge of informed consent.

Moreover, the qualitative research process is unpredictable, therefore the information we present at the beginning of a study can change during course of the project (Miller & Bell, 1992). This was what happened in the case of my study. It can also be that detailed information conceals more than it clarifies (Cieurzo & Keitel 1999), and detailed information can be envisaged as increasing insecurity and distrust among psychotic patients. Like Norvoll (2007), I remember many situations (from early in the project, when I used to ask each patient for consent) where it was expecting too much of the patients to present them with an information sheet and consent form. But, at the same time, these patients were willing to have contact and talk to me, although I had reminded them that I was a researcher visiting them.

Miller & Bell (ibid.) conclude that one must make a point of continuous assessment and "renegotiations" regarding consent. In the current study, by degrees I realised that it was unrealistic to consider this kind of practice. There was a rapid patient turnover on the ward. It would have caused uncertainty and embarrassment if patients, who were about to be discharged and who possibly had not even appreciated the stay very much, would have been addressed by a researcher with the request to re-negotiate consent. Since this practice would have been unethical, we must ask ourselves whether or not this kind of participant should be included. However, this takes us back to the point that, from a practical standpoint, it is difficult to conduct research on psychotic patients on an acute psychiatric ward. Society's interest in sociological and humanistic knowledge of this field collides with ethical considerations in research. Among other things, it is in this area that significant discussions should be conducted, in the future as well.

An important way of coping with the ethical challenges in research was to cooperate with the employees. I was in close contact with both the nurses, the doctors and with persons from other professional groups who knew the patients well. Part of the agreement established with the department before I started the fieldwork was that the senior doctor in cooperation with the nurse in charge, each time I was scheduled, should assess whether it was advisable to let me in. Therefore I made a habit of contacting the unit and asking whether my presence was advisable that very day (in all cases my presence was assessed as defensible). While I was present on the unit, I was continually assessing whether my presence could be justified or not. I often consulted with the employees in order to sort out the matter. In some cases, I personally made the decision to withdraw, although I had obtained consent, and I informed the nurse in charge. I also maintained constant contact with the nurse who was responsible for

the unit on any particular day. As a rule, she was also the person who clarified whether I could be present. Having this kind of continuous contact regarding my presence in the unit made me feel safe, and I am sure that if the employees had been in doubt about whether my presence could possibly upset the patients, they would have asked me to leave. Most of the time I was with the patients in the common room, or in the corridor, were, as a rule, some of the employees were also present. Their presence meant that also I was under surveillance by the nurses, which should have been a reassuring aspect. All these different procedures and modes of cooperation contributed to the situation where both partners maintained a kind of consciousness significant to the project. On the whole, my way of behaving in the field as a researcher in a convincing way illustrates that the ethical dilemmas that arose cannot be settled bureaucratically, because they often are of relational and processual nature (Mattingly 2005, Norvoll 2007). It cannot be denied that it is the researcher's critical appraisal, realised as being constantly aware of his/her conduct in the field, that is decisive for ethically acceptable research.

It should also be mentioned that I informed the supervisory commission about the projec (cf. appendix 11). I sent a copy of all relevant documents to the chairman of the board, including project description, information sheet, consent form, REK's (Regional Committee for Medical Research Ethics) letter of recommendation and the notification to NSD (Norwegian Social Science Data Services). In addition, the chief supervisor and I had a meeting with the medical director, the chief physician, the senior doctor and the nurse group leader where we discussed how problem situations should be handled. As appendix 10 shows, there was a strong desire in the department to continue the project.

NEM's position

During the last few years, NEM has been involved in discussions about research projects with ethical challenges similar to those I experienced. Against this background, NEM has expanded the Guidelines (2005) in health research for the inclusion of adult persons who have no or impaired ability to consent. NEM's point is that if vulnerable persons with no or reduced competence to consent are always excluded from research, this could easily add to the patients' vulnerability, because a possible increase in knowledge that facilitates better treatment does not reach them. Therefore, preventing research on these persons cannot be justified. NEM argues in favour of introducing special conditions, procedures, and protection measures in connection with the inclusion of these persons in research, in a way that makes

them feel safe (ibid.). NEM as a general principle suggests that persons not capable of giving informed consent should be included in research, if the research cannot be conducted on persons who are not capable of consent, and if it is likely that the research has direct and substantial advantages for the individual persons or groups the research is conducted on (ibid.). In our article (Hem, Heggen & Ruyter 2007) we address the problem where the competence to consent for a number of psychotic patients can be unsteady, and we describe some instances in the case of three patients. The reasons why they were included are threefold. Firstly, the consent was unstable; if they, over a period of time, had been consistent, both verbally and non-verbally, about declining my presence, I would have withdrawn and would not have included them (this is what I did in some other situations). On the contrary, most of the time they sought out contact with me. The question is whether the contact initiated by them was motivated by the wish to participate in research or the wish for contact with a person who had time and was prepared to pay attention and listen to them. Secondly, their instability in certain periods regarding their preferences and wishes is characteristic of many psychotic patients. Shedding light upon how this unsteadiness is demonstrated in contexts having to do with consent is significant for discussing questions of ethically acceptable research; in this way, the article promotes the psychotic patients' interests as a patient group. Third, care has been taken to anonymise patient data in a manner that excludes identification of individual patients. The problem of recording the data anonymously turned out to be equally complex. Due to my presence on the ward, I could not avoid uncovering confidential information about the patients. It was this information – anonymous and concerning people who did not explicitly refuse to be included – that I used for research purposes. My argument is that all the knowledge that is produced in the project is potentially important, even if it is not based on free will and explicit consent of all those who are concerned, and that there is little reason to assume that anyone was harmed through my presence on the ward. I mentioned earlier that being a nurse myself - as one side of my dual competence – was significant both with regard to field access and to the trusting cooperation with all the persons involved in the different stages of the project. At the same time, one could ask what it means that the researcher, also a nurse by profession, is already pledged to secrecy about confidential personal data, but that she, in her researcher role, is also obligated to make research issues public. My answer to this is that, although this conflict of roles is problematic, it nevertheless can be handled, among other things, through a sophisticated practice of making the data anonymous. The fourth and last point I would like to mention here relates to a frequent assertion, namely, that psychotic patients are extremely vulnerable. I have referred to this

fundamental insight at several points in the study, and it is important to maintain it. However, I agree with Norvoll (2007), when she emphasises that, although the vulnerability should be considered/taken care of, we nevertheless should not be so cautious that we become overprotective. Exaggerated carefulness can result in devaluation and stigmatisation.

Similar projects in Norway, Sweden, and the United Kingdom

In recent years, studies, pursuing purposes and following concepts very similar to those of my own study, have been carried out in Norway, Sweden, and the United Kingdom. Both Norvoll (2007) and Quirk (Quirk & Lelliott 2002, Quirk, Lelliott & Seale 2004, Quirk, Lelliott & Seale 2006, Lelliott & Quirk 2004) as well as Johansson (Johansson & Lundman 2002[34], Johansson, Skärsäter & Danielson 2006)[35] conducted field studies in acute psychiatric departments, and none of them asked all the patients staying on the ward, while the fieldwork was being conducted, for written informed consent for their presence on the ward. Norvoll's study includes two acute psychiatric hospital units, one in a larger city and the other one in a medium-sized town, Quirk's study includes three acute psychiatric departments in London and surroundings, whereas Johansson's study was conducted in an acute psychiatric department in Gothenburg. All three of them provided written and oral information about why they were present. Norvoll delivers detailed descriptions about how she used her judgement and sensitivity in each of the three dilemmas she was confronted with. She carefully assessed what type of information was appropriate in what situations, and her experience was that the patients were capable of refusing to be included in research. Norvoll states that she was especially observant towards the most confused patients, among other things, by maintaining a careful distance. She also points out that she often discussed these problems with the employees, in order to find the best way to cope with the situations. Quirk states that he, in situations where he had the impression that the patients did not want to have anything to do with him, withdrew from the patients on the spot. Indirectly he used verbal consent, i.e., the patients had to actively verbalise their consent to his presence. Johansson, for her part, writes that the patients could withdraw to their rooms if they did not want the researcher to be present. Moreover, Norvoll and Quirk conducted interviews with patients, and on these occasions, they obtained written informed consent from the participants, and I proceeded in

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[34] This article was written as part of her Master's degree thesis.
[35] My writing is based on information in their publications as well as on information I got through e-mail contact (26.02.2007 and 15.05.2007 with Quirk and 28.02.2007 and 18.05.2007 with Johansson); this material includes passages from Quirk's application to the local ethics committee concerning the question of consent. Both confirmed by mail (Quirk: 15.05.2007; Johansson: 18.05.2007) that they permit me to mention mail contact.

the same way. The studies of the three researchers mentioned above disclose how important the cooperation with the employees concerning assessments, procedures, and guidelines was. Quirk also strongly emphasises the significance of being sensitive and behaving tactfully and decently; it was especially important for him to realise when he needed to withdraw and leave the patients in peace. All three, Norvoll, Quirk, and Johansson, were given advice from the respective ethical committees, as I also did, but what actually caused problems was how to understand and handle situations with patients who did not want to have anything to do with the researcher. If we had used the method of written informed consent, we would have had to leave the ward every time a patient refused to sign. It is therefore doubtful that these studies could have been carried out.

4

Summary of results

4.1 Paper I: Is compassion essential to nursing practice?

Hem, M. H. & Heggen, K. M. (2004b). *Contemporary Nurse* **17**(1-2), 19-31.

The Norwegian Nurses' Association recently (2001) approved a new code of ethics that included compassion as one of the basic values in nursing care. This paper examines the idea of compassion in the context of the Bible story of the Good Samaritan using an analysis of qualitative data from nurses' clinical work with psychiatric patients. The aim is to show how the idea of compassion challenges nursing practice. Thereafter, the paper discusses the benefits of and premises for compassion in care work. The results show that nurses tend not to be guided by compassion in their work with patients. The organisation of the day-to-day work in the hospital ward, the division of labour between nurses and doctors, and the nurses' approach to nursing were identified as influencing this tendency. The study shows that compassion is a radical concept with a potential to promote greater respect for patients' dignity.

4.2 Paper II: Being professional and being human: one nurse's relationship with a psychiatric patient

Background. The theoretical foundations and professional ideals of psychiatric nursing contain inbuilt contradictions. One central ideal is that nurses should use themselves as therapeutic instruments. The expectation that nurses should have both a professional and a human function is examined in this study.

Purpose. The purpose of this study was to find out how nurses experience and interpret the contradictory demands of being both fellow human being and health professional in their work with patients.

Methods. An ethnographic research design including participant observation and narrative interviews with nurses working on an acute ward of a psychiatric hospital was used. The case of one nurse is analysed and discussed.

Findings. The study shows that when nurses themselves are 'therapeutic instruments', tensions are created. Contradictory demands produce difficult role conflicts. Nurses vary in the ways in which they interact with patients. The study shows how the nurse's own vulnerability can be a constructive element in patient care. It also shows that although the nurse is aware of this, she is also critical of her performance, feeling that it falls short of accepted professional standards. Her colleagues reinforce these standards.

Conclusion. The ideal that psychiatric nursing should be a balancing act between intimacy and distance, between human and professional ways of acting, appears to be too harmonious and narrow a one. The study suggests that there is potential for professional development if nurses are able to recognize their own vulnerability. Critical examination and discussion of conventionally accepted ideals can help develop our knowledge of the profession.

4.3 Paper III: Rejection – a neglected phenomenon in psychiatric nursing

The basically asymmetric character of the 'psychotic patient–psychiatric nurse' relationship constitutes an ethical challenge for the nurse. One aspect of this relationship is that nurses must constantly self-consciously control their behaviour towards the patient. There is some evidence that the patient sometimes feels offended because of his perception that the nurse rejects him. The purpose of this article is to examine the role rejection plays in the 'psychotic patient–psychiatric nurse' relationship and ethical implications this might have for the field of psychiatric nursing. This study is conducted using an ethnographic research design that includes participant observation and narrative interviews of nurses working on an acute ward of a psychiatric hospital. One case is analysed and discussed in depth through the philosophical insights (particularly 'the ethical demand') of the Danish moral philosopher K.E. Løgstrup. The psychotic patient, being vulnerable, dependent, and trusting, confronts the psychiatric nurse with a constant 'ethical demand' to take care of him. The patient's trust, and his fight to maintain his dignity, creates a risk of being rejected. The nurse, by resorting to the tactic of 'impersonal professional routine', which does not define the relationship as a personal encounter, creates boundaries between herself and the patient. The nurse's withdrawal from the patient's perception of reality is experienced by the patient as rejection and hence an offence of his dignity. The nurse's rejection of the patient has two causes: external factors – for example inadequate staffing – cause the nurse to be unable to live up to the professional ideal of 'welcoming' the patient; internal factors – for example the profession's understanding of itself – create an unclear understanding of the nurse's role and responsibilities. It is necessary to work with both the external and internal factors to improve psychiatric nursing.

4.4 Paper IV: "Only a manic depressive!" The zone of the untouchable and exceeding limits in acute psychiatric care

Hem, M. H., Nortvedt, P. & Heggen, K. M. *Research and Theory for Nursing Practice* **22**(1), 56-77.

The article addresses psychotic patients' fragile boundaries and need for professional help to restore their personal untouchable zone. We examine how nurses move into this inviolable zone and re-establish limits. The theoretical perspective stems from the Danish theologian and philosopher K. E. Løgstrup's concept of our "zone of the untouchable". Interpreted in the light of Løgstrup's thought, the empirical data are drawn from an acute psychiatric setting and focus on one patient in different situations and on her relationships with nurses. The material also contains data from the nurses' discussions and the researcher's experience. The analysis shows how and with which critical and constructive consequences the diagnosis-oriented understanding affects the relationship between patient and nurse, and concludes with clinical recommendations about the premises that should be used when nurses move into the patient's untouchable zone.

4.5 Paper V: Pervasive distrust. The hard work involved in creating trust in an acute psychiatric ward

Hem, M. H., Heggen, K. M. & Ruyter, K. *Nursing Ethics*; in press: revised version: "Creating trust in an acute psychiatric ward"

The ideal of trust pervades nursing. The article directs critical attention to this ideal and uses empirical material from acute psychiatry that reveals that it is distrust rather than trust that is prevalent in this field. In the first place our analyses of the data show how distrust is expressed in the therapeutic environment and in the relationship between nurse and patient. Secondly we point out how trust can nonetheless be created in an environment that is characterised by distrust; and thirdly both trust and distrust are exposed as "fragile" phenomena that can rapidly "tip over" towards their opposites. The article concludes that trust is not something that nurses possess or are given, but is rather something that they earn and have to work hard to achieve. Regarding oneself as a potential cause of distrust and an active

wielder of power rather than purely as a person who works with trust and to achieve trust can contribute to nurses developing a more realistic view of their practice of the profession. Assuming a realistic middle-way perspective can help them to manoeuvre appropriately between the extremities of excellence and resignation, which in turn can lead to processes that create trust between psychotic patients and nurses.

4.6 Paper VI:

Questionable requirement for consent in observational research in psychiatry

Hem, M. H., Heggen, K. M. & Ruyter, K. (2007). *Nursing Ethics* **14**(1), 41-53.

Informed consent represents a cornerstone of the endeavours to make healthcare research ethically acceptable. Based on experience of qualitative research on power dynamics in nursing care in acute psychiatry, we show that the requirement for informed consent may be practised in formalistic ways that legitimise the researcher's activities without taking the patient's changing perception of the situation sufficiently into account. The presentation of three patient cases illustrates a diversity of issues that the researcher must consider in each individual situation. The article argues for the necessity of researchers basing their judgement on a complex set of competencies. Consciousness of research ethics must be combined with knowledge of the challenges involved in research methodology in qualitative research and familiarity with the therapeutic arena where the research is being conducted. The article shows that the alternative solution is not simple but must emphasise the researcher's ability to doubt and be based on an awareness of the researcher's fallibility.

5

Discussion

5.1 Introduction

In the various projects that constitute this dissertation, my co-authors and I investigate what occurs in the relationship between nurses and psychotic patients on an acute psychiatric ward. Thematically we discuss various therapeutic approaches that collectively can be termed "therapeutic use of oneself". First, the balancing of what it means to be a fellow human being vs. a professional person, between proximity and distance, is discussed. Second, we investigate reality orientation and imposition of limits. At a more general level, we also discuss the purpose of these different approaches, which is to create trust within a field of distrust. We assume a generally critical attitude to the management of these professional ideals and the way in which these are expressed in the various therapeutic approaches. In one of the articles (Hem & Heggen 2004b), however, we argue explicitly in favour of an altruistic ideal like compassion as an appropriate professional paradigm in psychiatric nursing.[36] The

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[36] We have discussed thoroughly whether or not to include this article in the dissertation. The reason is that in this article we most explicitly address a basic ideal, compassion, in nursing. Compassion is an ideal that historically has been a constituting narrative or a guiding star for the profession, and this ideal has been reinstated in the ethical guidelines for nurses. We conclude that the ideal of compassion possesses a constructive and critical potential for nursing, but we have only hinted at this. What we obviously failed to notice was that compassion can be perceived differently, depending on what notion of care is assumed. However, through our investigations of action-oriented principles for the exercise of the profession, discussed in the other articles, we have been led to a criticism of this ideal which is better articulated and problematised than what we were able to achieve in article I. Nevertheless, in the article we underscore that in our opinion, we hold the personal qualities of the nurse to be important with regard to the treatment of the patient. Describing this in the form of idealistic imagery that fails to work in practice is the problematising focus in the dissertation. The dissertation can be perceived as a contribution to facilitating new ways of thinking which might be able to provide the ground for development of new "tools" for orientation and action in a complex professional situation. This being said, I would also like to emphasise that today we would have written article I in a different manner, for example by including various notions of care (cf. chapter 3.3.1).

therapeutic measures and interventions, which are at the core of psychiatric nursing, can at the same time be seen as framed within the more general description of what nursing ideally should be.

This is the point of departure for the discussion chapter. In this chapter I will go beyond the specific empirical and theoretical descriptions to a discussion of more fundamental issues. In this discussion, I will draw on several perspectives. By way of introduction I will discuss some of the problems that I hold to be associated with an altruistic conception of nursing care. I will address several issues, including: (1) the risk of concealing the "roughness" of the field (ch. 5.2.2); (2) the invitation to idealise the field (5.2.3); (3) concealment of power (5.2.4): 4) immunity against criticism (5.2.5). I have developed these points based on my practical, theoretical and research-based familiarity with the field. Further, I will discuss whether and how mature care might possibly provide an appropriate answer, or a fruitful corrective, to those inadequacies that are associated with the altruistic notion of nursing. In this discussion I will draw in Ruyter's (2005) point from classical moral philosophy on the middle ground and "the virtue of the middle", because I find several interesting commonalities between the ideas of Pettersen (2004) and Ruyter (2005). This approach implies that I attempt to contribute to a renewed debate on care and nursing, which might reveal that relationships of care in psychiatric nursing involve both the recipient and caregiver in complex and dynamic ways.

5.2 Challenges raised by the altruistic notion of care

5.2.1 Introductory notes

In chapter 2, I noted that at the heart of the various therapeutic approaches – and they also constitute professional ideals – lies a reasoning of what nursing "really" is about (cf. chapter 2.2). Fundamentally, nursing is care for the ailing person. Care is provided with empathy and sympathy for the suffering and dependence of the other person. The main purpose of care is to promote the well-being of the other person. Care is selfless, meaning that the helper basically expects nothing in return. The purpose is to provide help for the sake of the other person. This is the altruistic ideal of care (cf. chapter 2.4.1-2.4.2). To me, it appears as if the altruistic ideal of care has a strong position in the nursing profession, even in the field of acute psychiatry.

Not only is good nursing emphasised, but good nursing presupposes good nurses. This perspective points to both the nurses and nursing. This perspective is nevertheless fraught with some problematic aspects, and in the following I will elucidate some of these.

5.2.2 Concealing the "roughness" of the field

In article V (Hem, Heggen & Ruyter, in press), my co-authors and I describe acute psychiatry as a rough field. We particularly associate this roughness with the fact that the relationship between the patients and the nurses tends to be characterised by conflicts and struggle, that the patients toil with difficult and comprehensive problems that interfere deeply with their ability to function in everyday life, and that nurses have to resort to coercion, threats, persuasion, or in other words, more or less hidden forms of power. When one attempts to grasp and describe this roughness through concepts like wholeness, humanism, compassion and trust, a problematic mismatch – a disparity, a discrepancy – arises between the ideal situation and the actual realities. In acute psychiatry there is little (or at least it is not easy to observe any) softness, sensitivity, goodness and self-sacrifice that we usually associate with altruism. For this reason, I claim that the idealising interpretations conceal this explicit "roughness". In the preface of the dissertation I mention how as a nurse I was deeply touched by the suffering of the patients, and that I have great respect for the toil that characterises the lives of many psychotic patients. In one sense, my descriptions may evoke associations to idealisation, as it has a certain romantic tinge. I have chosen not to describe all the strains, all the times I was scared witless by threats and actual violence, all the times I was rejected and had abuse heaped on me, how difficult it was to attempt to mobilise some hope on behalf of patients who had lost all hope and faith, working with urine and faeces, sometimes even with infected blood, out of control. This shows that I have internalised some of the significant aspects of the culture of nursing. This does not mean that what I described in the preface is not true, but even I have contributed to concealing the fact that my narrative only constitutes part of the reality. Doubtlessly, working with people with this kind of ailment in this kind of situation brings one close to deeply existential phenomena. The idealising descriptions fit well into this form of understanding, because they call for sensitivity and reverence. When I continue to claim that it is problematic to describe this field without including its rough and tumble – and demanding – nature, it is because I believe that the care of psychotic patients can be improved if we succeed in creating concepts and notions – ways of understanding –

that to a larger extent include the various challenges and problematic aspects involved in practising nursing care within this field. In this harsh field, as a nurse I was expected to reconcile phenomena that appear to be irreconcilable. This dissertation demonstrates that the relationship between patients and nurses is complex and fraught with opposing phenomena. The situations between the patients and the nurses are unstable and fragile to extent where they may easily "switch", for example from trust to distrust, or in the opposite direction (Hem, Heggen & Ruyter, in press). Nurses are expected to be both distant and close, and to acknowledge the psychotic realities experienced by the patient, while at the same time seeking to correct them. They are expected to combine power and control with protective care and support. This kind of demanding complexity needs to be brought more clearly to the fore in reflections on clinical nursing as well as in clinical practice and in theorising work. It has been claimed that theoretical interpretations of nursing are "thin", meaning that they insufficiently describe and elucidate the facts of clinical practice. Our studies may be claimed to support such criticisms.

5.2.3 Invitation to idealisation

A further problem associated with the altruistic notion of care is related to the above point, and concerns its possible invitation to idealisation. The altruistic notion of care stresses that the provider of care should not expect something in return for his/her efforts. The unselfishness of care is a key point, and the matter is not whether we receive something in return; care exists solely for the benefit of the other person (cf. chapter 2.4.1-2.4.2). In this manner, care has been elevated to an attitude, a virtue. This has happened at the cost of a focus on actions in nursing practice (Olsvold 2000). An emphasis on nursing as an individual presupposition may lead to an idealisation, romantisation and mystification of nursing, and a consequent negligence of other key aspects, like the fact that nursing also is a practical activity that requires time, resources and appropriate organisational forms (ibid.). It removes the focus from actions and assessments of what is good and proper in the specific situations, with a specific patient (Hem 2000).

Another and related aspect of this discussion on idealisation concerns the importance of emotions in nursing. For example, criticism in the discussions of the nurses' ability to show empathy has emphasised that to an excessive extent focus has been placed on the subject, the

abilities and qualities of nurses, rather than on the recipient of care, the patient[37]. This criticism is related to Olsvold's (ibid.) objections: if the focus is placed too heavily on the ability of the nurse to show empathy, attention may shift from the heart of the matter, which is the situation of the patient.

In article I (Hem & Heggen 2004b), we describe a further aspect of idealisation. We ask whether the inclusion of compassion in the Code of ethics for nurses, as a description of what nursing should be, may give rise to problems, because this does not coincide with the patients' experiences. In chapter 2, I referred to many studies that point out how patients miss having nurses who can see, hear and understand the nature of their experiences. Patients may experience a description of nursing as compassion as distant from their actual situation. This may also be an affront to patients, as discussed by Heggen (2002) in her and Sætersdal's book on violations in treatment and nursing. The experience of being rejected may represent a violation. Heggen (ibid.) describes the outrage that the next of kin experience when they observe that their parents receive inadequate care. This outrage is met with a businesslike response that appears indifferent and distant in the encounter with the despair that the relatives seek to communicate. In the light of this and similar examples, coupling nursing with compassion may appear as an affront. One may ask whether this is an argument against having any ideals for nursing. Some will claim the opposite, but actions that are perceived as violations can hardly be reconciled with a compassionate ideal for those in question. In article I (Hem & Heggen 2004b) we demonstrate how Finn, the patient, is outraged over not being understood with regard to what is important for him in the situation, which is that he has been forcibly committed. He fails to see the point of it, he disagrees in the assessment on which the commitment was made, he does not understand what plans have been made for him, he does not understand what is happening, and he feels that he no longer has any authority over his own life. He is met by a nurse who listens attentively and lets him speak, but who cannot provide any answers to which he can relate there and then. The nurse says that the topic is not relevant to the situation; it is a personal matter that he must discuss with his physician. He feels that he is getting nowhere, what is important to him was just transferred to someone else. Using an expression from Sætersdal & Heggen (2002, p. 9), what is happening here can be called "small-scale malice" (my translation). This does not mean that the nurse is malicious, only that the nurse is part of the administration of a professional understanding and an

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[37] Personal communication with P. Nortvedt in June/July 2007.

institutionalised distrust that in the encounter with the patient may be perceived as an affront. Sætersdal & Heggen (ibid., p. 9) state that this "small-scale malice" is not life-threatening, but it "violates human dignity in everyday life, and gives people the impression of being insignificant and unworthy" (my translation). Even though the intentions may be good, the outcome may not be equally good for the person concerned. This kind of violation occurs every day, all the time. Vatne (2003) and Vatne & Fagermoen (2007, p. 45) link the observation that nurses withdraw from situations in which they feel uncomfortable to their "lack of relational skills such as dialoguing, and self-delimiting approaches". They argue in favour of including acknowledgement in nursing practice in a pronounced way and in this way compensating for the "lack of relational interventions" (ibid., p. 45). This represents a difficult problem for acute psychiatry, because the patients are particularly vulnerable. However, if we continue to think relationally about patients and nurses, should this question not entail a discussion of whether this important and difficult phenomenon also ought to include the manner in which the nurses understand and practise their profession? For example, this discussion would need to focus on "the care professions' everyday, undramatic and unobtrusive, but nevertheless important, use of power that is able to strengthen or undermine dignity" (Juritzen & Heggen 2006, p. 62 (my translation)). This perspective will shift the focus away from the visibility and articulation of power, and that the locus of power is always found in other people.

In this chapter I have discussed the problem that the altruistic ideal of care legitimates a gap between ideals and reality. A further difficult point related to the above is associated with the risk of concealing the fact that nursing care is enforced care, which I will discuss in the next chapter.

5.2.4 Camouflaging power

If we accept the premise that care and power are closely related,[38] having altruistic care as an ideal for nursing may conceal the reality that nurses also exercise power.[39] Ideals of altruism, humanism, compassion and care have been critically debated in the nursing profession for exactly this reason. For example, Juritzen & Heggen (2006, p. 62) state that: "The discomfort of power decreases when it is not mentioned specifically, but is concealed by the use of positively laden terms like total care, empathy and respect for the autonomy of the individual" (my translation).

Turning to article V (Hem, Heggen & Ruyter, in press), where we discuss what occurs between the patient called Joe and the nurses, we might ask how we can comprehend the distance and lack of involvement in the situation where Joe's vulnerability is so obvious. The asymmetry in the relationship between them is equally obvious; he is completely at the mercy of the nurses (Donovan 2000). In order to understand this, we need to see distrust and trust in relation to both vulnerability and power. Grimen (2001, 2004) has described this connection (cf. chapter 2.2). Grimen (2001, p. 3617) claims that analyses of trust that exclude power are naive, and analyses of power that exclude trust are shallow. Linking perspectives of power to analyses of trust provides a richer theoretical basis on which to understand the social conditions for establishment, development and erosion of relations of trust (ibid.). The perspective of power is fruitful, in particular because it reveals the fundamental asymmetry which is a characteristic of the patient-nurse relationship. The asymmetry of relations is crucial to how we assess distrust and trust in relationships. The absence of choice faced by many patients may force the patients to have trust, Grimen claims (ibid.). Asymmetry and

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[38] The article by Juritzen & Heggen (2006), *Omsorgsmakt. Relasjonsnære sonderinger mellom makt og avmakt* [Power dynamics in care. An exploration between power and powerlessness in the relationships between patients and nurses] constitutes, as far as I am aware, the first systematic attempt to associate care and power in practical care to an extent where it becomes obvious that they are each other's presuppositions, thereby the term "power in care relations". The idea behind parts of this dissertation, that power and care are tightly interwoven in a number of different and complex ways, is inspired by the article by Juritzen and Heggen, as well as the recurring debates on this challenging topic.

[39] I am currently (March 2007) grading examination papers for a bachelor's degree in nursing. One of the exam questions requests the students to explain the use of isolation and imposition of limits in psychiatric nursing. It evokes how several students explicitly state that it is important that the nurses should not use these methods on patients in a manner that implies the use of power. It is interesting to note that in situations where the nurses' interventions obviously lead the patient in a particular direction, the students stress that it is essential that this should be done in a manner that does not imply the exercise of power. This concurs with the observation made by Juritzen & Heggen (2006, p. 62) that power, both in the hospital and in research, appears to be displaced by "narratives about care, and is rendered invisible and unavailable for debate" (my translation).

vulnerability can be understood in the light of absence of choice. Psychotic patients who are forcibly committed can hardly be said to have much choice, but does this imply, as claimed by Grimen, that they are forced to have trust? Can psychotic patients who are forcibly committed to acute psychiatric wards be forced to have trust? In my opinion, the answer is both yes and no. If a patient who is insecure and frightened is committed against his/her will, the patient may perceive this as care (Cullberg 2006). It may considered comforting for someone else to take charge when he/she herself experiences loss of control (ibid.). He/she has no other choice but to have confidence that everything will be alright with him/her, to quote Grimen (2001). However, we could also envisage the opposite outcome: the patient perceives it as a violation, distrust is reinforced, and the conflicts between the patient and the nurses escalate (Koivisto, Janhonen & Väisänen 2004, Cullberg 2006). The decisive factor for whether the patient will develop trust and confidence in the nurses or remain insecure and suspicious is a complex matter. Aspects of the patient as well as of his/her surroundings, the relationship to the nurses and other staff all play a role (Lelliott & Quirk 2004). However, stable research findings (cf. chapter 2.3.2) that accord with the clinical experience of both ourselves and others indicate that the manner in which interaction takes place is decisive for earning the patients' trust (Rønnestad & von der Lippe 2002). The nurses' attention to the needs of patients and reassurance are essential to establish trust (Ryan & Bowers 2005, p. 701). In her study, Norvoll (2007, p. 312) concludes that there is a need to establish a more "active and recognising nursing practice", a "recognising responsiveness" (my translation) that reflects a desire to understand the experience and life-world of patients.

The above paragraph contains a key point or problem that concerns the following: Can proper care turn the use of power into something that can be accepted as use of power, or be perceived as acceptable by the patient? The relationship between power and trust also concerns this issue. The power exercised through the use of coercion may be both ethically and professionally legitimate, by ensuring what is in the best interest of the patient when he/she is unable to take care of him-/herself. How power is used could be decisive for the patient's perception of care, which could be important at a later stage with regard to the reestablishment of trust. This perspective claims that appropriate use of power represents proper care. This is an expression of the traditional perception of power in psychiatry: paternalistic power (possibly weak paternalism, cf. Martinsen 1990) is appropriate and necessary on the basis of this kind of traditional notions of care. The nurse must use power in the service of good. The question remains whether power in this perspective is understood in

a sufficiently broad manner with regard to all the relational processes that are at work between the patient and the nurse in acute psychiatry.

Løgstrup (1993) also associates the phenomena of trust, power and dependence closely with each other. He does this differently from Grimen (2001), because to Løgstrup these phenomena form part of his ontological interpretation. Pahuus (2006, p. 241) uses the expression "ethics of dependence" in describing Løgstrup's ethics, exactly because the latter's philosophical understanding is associated with human interdependence: "We are mutually dependent on each other, and this dependence is so deep that without it, our existence would not at all be human" (Løgstrup 1995, p. 115 (my translation)). On this basis, Pahuus (2006, p. 241) claims that Løgstrup's ethics can be called ethics of trust, and that this dependence is manifested in the meeting with others because we expose ourselves. I find this perspective fertile with regard to psychotic patients committed to acute psychiatric care. Both the fragility and the insecurity associated with the psychosis, and the fact that other people to a very decisive extent have intervened to take charge of their lives, makes the patients both very dependent and very exposed. This perspective may serve to more clearly reveal that there is a lot at stake for the patient. Even more interesting is Løgstrup's (1993, p. 143-144) association of our mutual dependence with – exactly – our mutual power over each other.

> Our dependence on each other means that we are exposed to the exercise of power, and that we ourselves also exercise power. We are never in a power vacuum. The self-realisation of one is simultaneously an exercise of power over others. Self-realisation and the exercise of power cannot be separated (my translation).

This perspective provided by Grimen (2001), who claims that power, trust and vulnerability should be considered in conjunction, and by Løgstrup (1993, 1995), who states that we are never in a power vacuum and that power and dependence are related, provides different ways of understanding the power that is at work in the relationship between patients and nurses when basing our views on the altruistic notion of care.[40] I will return to this topic on power in care relations in chapter 5.3.4. In the next chapter I will review a final problematic aspect of altruistic care.

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[40] In general, various perspectives and different concepts will capture various parts of reality, or various experiences. Because of the complexity of acute psychiatry, it is hard to imagine that only one perspective could be exhaustive. The altruistic notion captures some (key) aspects, but problems are created if this perspective is allowed to dominate alone.

5.2.5 Immunity to criticism

Professional ideals may also serve to protect against criticism. In this light, one may question whether anybody should take the liberty of criticising a professional practitioner who is doing his/her best, and who says that he/she would have liked to do more, but that this is impossible in the face of prevailing resource constraints. Claiming that the idea and purpose of nursing is to take a holistic approach, to engender trust, mutual respect, care and compassion, may run the risk of making oneself immune to criticism. Thorsen (2003, p. 128) formulates this position in the following manner: "Even care and good deeds for needy persons may imply an exercise of power, but this power is often invisible, concealed by the good intentions" (my translation). We may ask whether this declaration of professional ideals may act as an effective instrument of rhetorical power in discussions and negotiations with patients who express deficiencies in the nursing care on the ward. Articles I (Hem & Heggen 2004b), III (Hem & Heggen 2004a) and V (Hem, Heggen & Ruyter, in press) contain descriptions of patients (Finn, Ann and Joe) who direct their despair and frustration at the nurses. They receive a clear response, for example by being told that they will have to wait until the physician arrives or that they should bring up the topic in their next meeting with their physician. Ann receives clear feedback on her perception of reality: even though the nurse understands it, she does not share it. However, the main impression, as interpreted by my co-authors and myself, is that the patients are confronted with passivity. The nurses retreat, by not acknowledging the patients' message, by not acting actively and responsibly and not communicating clearly and in a forthcoming manner. However, comprehending what transpires between patients and nurses in these trivial everyday situations is not an easy task. Having the nurses act politely, talking to the patients, ensuring that routines are kept and that everybody is safe, ensuring that patients are fed, kept active and get enough sleep – does this not constitute defensible and proper psychiatric care, even though it may fall short of the professional ideal? What could possibly legitimate any kind of criticism against this manner of fulfilling professional responsibilities? I believe this legitimacy can be found in the complex character of this field and in the particular challenges associated with the efforts to ensure the dignity of the patients.

A further point is the circumstance wherein the outcome of the patient may not always concur with the wishes of a well-intentioned nurse. In acute psychiatric care this is a relevant point for the simple reason that "care is not always care", meaning that what is perceived as care by

one patient may be perceived differently by another patient, or even as a violation. In some instances, what is intended as care, and professionally well-founded as care, is perceived by the patients as degrading, both in the situation and in the long term. This means that the ideals in their most common formulation often lack the nuances to be able to capture all the challenges involved in practical work with patients.[41]

In this context it is relevant to point out an important aspect of responsibility. Pettersen (2004) compares Gilligan's and Goodin's[42] views on responsibility, and she claims that both authors imply that professional care and responsibility arise from the vulnerability of the patient. This contrasts with the idea that responsibility is the result of a contract. Thinking in terms of vulnerability vs. contracts could serve to elucidate the empirical findings discussed by my co-authors and myself in several articles. In the articles I (Hem & Heggen 2004b), III (Hem & Heggen 2004a) and V (Hem, Heggen & Ruyter, in press) we problematise how the professional responsibility perceived by nurses can be related to the professional and institutional contract, rather than to the vulnerability of the patient. Practices may appear impersonal and distant, an observation also noted by, for example, Müller & Poggenpoel (1996). In article III (Hem & Heggen 2004a, p. 55) we use the expression "impersonal professional routine" to describe how nurses act and demonstrate responsibility, but doing so in a way that leaves an impression of lack of involvement and positive attitudes. Practices turn into routine. Does this imply that the nurses' responsibility could be perceived as a fulfilment of institutional obligations, rather than as making a personal effort in ways that promote therapeutic processes?

5.2.6 Summary and topics for further discussion

A partly unarticulated – and problematic – premise for the altruistic notion of care is found in the perspective that care is only good when it focuses on the other person. However, when the theoretical focus is placed only on the needs of the recipient, one disregards that this is a relationship between a helper and a recipient. What goes on between them – and how – is of

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[41] This will undoubtedly be more complex when including the obvious point that it is not only the patients' experiences that determine the nature of appropriate care.
[42] Pettersen (2004) refers to a book by R. Goodin, published 1985: *Protecting the vulnerable. A reanalysis of our social responsibilities.* Chicago: The University of Chicago Press.

importance for the care provided.[43] This is problematic, because the theoretical assumptions do not coincide with a more thorough understanding of all the factors that are at work within a professional care relationship in psychiatric nursing.[44]

However, a problematic contradiction is also inherent in the very idea of altruistic care. Its ontological point of departure is the connectedness and interdependence of human beings (cf. chapter 2.4), but in discussing care, it appears as if the needy person is perceived atomistically. It is lost from view that the needy person and the provider of care are interwoven into social relationships and are – as human beings – vulnerable and dependent.[45] One may ask whether an understanding of care that takes both the giver and recipient into account – and which is based on a delimitation of self and an understanding of both self and the other, and which leaves space for the necessity of making conscious priorities between needs, as well as promoting rationality – would constitute a more constructive interpretation of care, just by reflecting its relational aspects.

In the following, I will discuss how the concept of mature care, combined with ideas of the middle ground taken from ethics of virtue and the "virtue of the middle" may encompass this type of question.

5.3 Mature care – a supplementary corrective?

5.3.1 Introductory notes

As I have shown in chapter 2, altruistic care and mature care emphasise different aspects of the care situation as well as of the human condition in general. In this chapter I will discuss whether the relational ontology which is at the heart of the notion of mature care can provide

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[43] Here I do not include the fact that theoretically as well there is a focus on the helper, but only in the form of ideals of wholeness, humanism, etc.

[44] A relevant point in this context is the observation made by Juritzen & Heggen (2006, p. 66) that within the welfare state research associated with the Study of Power and Democracy, the interest in investigating resistance is greater than in studying the power wielded by providers of care. Neither are the phenomena of power and resistance considered in this respect. On this basis the authors ask: "Should resistance be studied in relation to an external superior power, or could it be investigated in the relationship between a powerless (female) caregiver and a recipient of care?" (my translation). In so doing, they explicitly argue in favour of a relational understanding.

[45] Having this ontological understanding of human beings will naturally not imply a quest for equality of responsibilities and roles in the field of professional care. The nurse is responsible for providing professionally adequate care.

this approach to care with some qualities that could be appropriate when nurses interact with psychotic patients in the field of acute psychiatry. In addition to the concept of mature care, as presented in chapter 2, I will provide a supplementary perspective. This perspective is related to how Pettersen (2004) towards the conclusion of her dissertation discusses the relationship between classical Aristotelian ethics of virtue and modern ethics of care. She finds interesting parallels between a "thick" notion of care and virtue. After having focused on the virtue of friendship, she concludes that Gilligan's ethics of care belong in the category of ethics of virtue. In ethics of virtue, the idea of a middle ground and balancing of extremes is a key notion. Here, I will draw on the Norwegian theologian K. Ruyter (2005).

I will organise this discussion on the basis of the chapter headings in chapter 5.2.

5.3.2 A demanding practical field

Contrary to Gilligan (1982), Pettersen (2004) includes certain characteristics of professional care in her analyses of mature care. According to Pettersen (2004), Gilligan attempts to understand personal interactions, be it in a private or a professional setting. Therefore, Gilligan's notion of care lends itself to being used within professional ethics and professional care (ibid., p. 148). Pettersen (2004) interprets care in a non-dichotomous manner. She states that mature care does not distinguish in principle between professional and non-professional care (ibid.). In accordance with this interpretation, Pettersen's analyses can be employed within various professional contexts, as I have done with regard to nursing. The roughness that characterises acute psychiatry can to some extent be understood with reference to the lack of mutuality found in a number of situations that occur between patients and nurses. Being committed against one's will, while at the same time having a deficient grasp of reality, indicates that patients tend to have problems in entering into mutual relationships with nurses.[46]

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[46] The point regarding deficient mutuality is relevant when it comes to understanding the relational challenges inherent in acute psychiatry. However, using it remains problematic. A risk associated with stating that in general there is insufficient mutuality in the relationship between patients and nurses consists in overlooking the ontological basis of human interconnectedness. In my opinion, working with psychotic patients involves challenging relational tasks that are associated in particular with the communication problems faced by many patients. Therefore, I find the use of this concept appropriate.

With regard to care, Pettersen also refers to Goodin: care can be defined in degrees of intensity, as "concentric circles". According to Pettersen (ibid.), Goodin states that the vulnerability of others constitutes the moral foundation for our responsibility towards family, friends and patients. To protect the vulnerability of others is to protect them from harm. The more dependent the other person is, the more responsibly we need to act. Based on this notion of care, Pettersen here establishes a unified view of care that I maintain is essential. Professional care is not qualitatively different from care in general, but constitutes a part of the same concept. This approach may provide some interesting openings for our understanding of professional care. We may not need to think in dichotomous categories like we do when describing, for example, how using oneself therapeutically involves striking a balance between being a fellow human and being a professional. It could be meaningful to claim that being a professional is to be a fellow human in certain particular ways. The qualities of professional care are found in the outer circles rather than in the very core, or professional care may possess some of the qualities that are also found in the core. However, these qualities are composed differently from what is found in private care, because we are also moving outward through the circles. Furthermore, it is meaningful to claim that professional care, as well as private care, does not constitute a certain magnitude with particular characteristics. On the contrary, professional care may assume many forms and be articulated differently depending on various contextual factors, such as the type of affliction and the setting for the treatment. Similarly, private care should be interpreted broadly: there is a difference between caring for your own sick child and helping a disabled neighbour with the shopping. The main focus of this dissertation, psychotic patients committed to acute psychiatric wards, typically constitutes a highly vulnerable group of patients, and hence requires professional nursing care characterised by qualities taken from many places within the concentric circle. In article IV we describe the patient Maria (Hem, Nortvedt & Heggen 2008), who needed considerable care from the nurses. She struggled with her own limits, she was very angry, she was scared and anxious, and she often felt disregarded and misunderstood. She needed nurses who could show a lot of warmth and sympathy and who could take responsibility for her to make her feel secure. On the other hand, she also needed the nurses to be firm and impose limits on what was acceptable on her part. Her situation called for qualities of care taken from various places in the concentric circles.

5.3.3 Counteracting idealisation

A risk inherent in arguing in favour of mature care, in the sense of finding a middle ground between extremes, is to provide arguments in favour of a mechanical administration of interests (Pettersen 2004, p. 212). With reference to Aristotle, Pettersen (ibid.) claims that learning how to handle emotions is essential, and she has a point. Mature care is a demanding "project". For example, it requires the involvement of each individual in efforts to raise awareness in relation to him-/herself as exercising power in the context of care. First and foremost, this implies transcending ordinary notions of power and care. The ability to strike a balance between interests is a key notion of mature care. This implies that it is legitimate to take one's own interests into account, a point also emphasised by Aristotle in his anti-dichotomous interpretation of human nature as preoccupied with both self-concern and other-concern (Pettersen 2004, pp. 211-212). This point of view may appear trivial, but I believe that the concept of mature care may provide opportunities for an elucidation of the various interests that are at stake in a given situation. This elucidation may serve to provide the required clarity with regard to the nature of the people involved and what kind of legitimate interests they have. Whose needs and interests should be given priority, and in what manner? How should the patients' need for self-determination be reconciled with the nurses' need for control and order? I believe that awareness-raising among nurses may serve to make them more aware of their field of responsibility, and more prepared to administer this responsibility in an explicit manner. It may be necessary to reassess, for example, whether the physician must have given his assent before a patient is allowed to make a phone call to a friend, as discussed by my co-authors and myself in article V (Hem, Heggen & Ruyter, in press).

An interesting parallel can be found between Pettersen's point concerning how to use and learn how to handle one's own emotions and the emphasis on what is important when it entails using oneself therapeutically (cf. chapter 2.2). Taking a critical view of oneself implies learning how to use personal emotions and reactions in a manner that distinguishes one's own self from the patient's. A structured and analytical approach to one's own personal reactions and intuition may provide a better understanding of what is at stake for the patient. This must be done in a rational manner to prevent personal reactions from turning into sentimentality. Administered in a mature manner, this may form an "ideal" which has been insufficiently

promoted. Maybe it has disappeared in nursing routines that are more concerned with administration of the patient than with interaction with him/her?

A further and interesting aspect of mature care is its openness to the fact that caring may fail, or as formulated by Pettersen (2004, p. 230): "Harm may result when only good was intended". To be a professional provider of care who is "good enough"[47] implies following what is felt to be the best and most responsible course in any situation. I believe that this point taken from mature care may constitute a fertile approach to nursing, and could serve as an efficient antidote to idealisation. As I have demonstrated, when nursing psychotic patients in particular we are exposed to a number of difficult and at times insolvable dilemmas. We have possibly become resigned to the fact that theory and practice are different matters, which is a problem. In chapter 5.3.5 I will discuss this issue in the context of Ruyter's (2005, p. 112) arguments in favour of upgrading "the virtue of the middle".

5.3.4 Power in care relationships

Care and power represent perspectives and positions that are usually kept separate. However, in nursing the two appear to be closely related in various ways. Here, I will therefore attempt to link power and care, care and power, more closely together. In this context, perspectives on care as a form of exercise of power are relevant. In the following, I will therefore investigate whether the notion of mature care has the ability to encompass this particular perspective. In other words, I will discuss whether these perspectives on care as a form of power provide an opportunity to link care with power in a manner which is able to elucidate how these two condition each other in practical nursing work. Pettersen (2004, p. 228 ff) discusses problems of "asymmetric thick care", mentioning factors like imbalance of power, unequal influence and difference in resources. With reference to paternalism and self-sacrifice she states that: "Paternalism represents the failure to attend to the interests of the person under care, and self-sacrifice represents the failure to take the interests of the carer into account" (ibid., p. 235). This is a precise formulation of key problems associated with paternalism and self-sacrifice. On the other hand, this perspective fails to capture how care and power interlink, how they

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[47] This expression is inspired by the American psychoanalyst and researcher D. Winnicott (1965, in Shapiro & Applegate, 2000, p. 14), who uses the term "good enough mothering" to describe features of the relationship between infants and the persons who care for them, in the light of its contribution to a child's healthy development.

constitute mutual opposites or mutual preconditions depending on the various contexts, situations and actors involved. In the next sections I will discuss this issue.

In one of his most famous quotations, Løgstrup uses "the hand" as a metaphor to emphasise the point that we have the responsibility of caring for each other (Løgstrup 1997a, p. 16).[48] However, the hand metaphor has an ambivalence which is interesting to investigate in the context of nursing. Two intriguing questions can be raised: In what way are the words and deeds of nurses an expression of care in the sense of *holding the patient's life in their hand*? Or are they in charge of the patients to the extent that they have the patients *in the palm of their hand*? This interpretation of the ambivalence of the hand is inspired by Hansen (1998). The hand metaphor reflects the opportunities to achieve both good and harm when caring for others. However, this ambivalence in the care relationship presupposes that there is a distinction, that power and care are opposites. This understanding of care is incomplete. On the contrary, care and power are interrelated in complex ways. The ambivalence of care refers to the fact that care means to provide help, offer something, do what is best. This also constitutes power, the power to do both good *and* evil. The care provided by nurses consists in using the power that they wield. The power held by nurses consists in providing certain forms of care (for example, reality orientation and imposition of limits). In this perspective it becomes more obvious that care is power and power is care.[49] The two condition each other. How can this power do both harm and good in a care relationship? The nurses' administration of the "power dynamics in care relations" is not always for the good of the patient (not in the patient's best interest). This power undoubtedly also causes unnecessary harm, as shown by this study and others. There is no problem when this power actually helps the patient. If we want this power to do more good, what needs to be changed? However, according to an idea of mature care, the possibility of this power causing some harm is unavoidable, for example when the will of the patient clashes with the will of the nurse. The patient's suffering is sometimes unavoidable. Causing pain in the moment may be necessary in order to achieve improvements in the long term.

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[48] The phrase equivalent to "holding some of this person's life in one's hands" in the Norwegian translation (Løgstrup 2000, p. 37) has in the English translation been turned into: "... having some degree of control over him or her" (Løgstrup 1997a, pp. 15-16). However, in a later edition of the English translation the word "hand" is included: "... of his placing something of his own life into the hands of the other person" (ibid, p. 16).

[49] This point of view obviously does not imply that I claim that power always constitutes care. It would be more accurate to say that power may constitute care.

If we for a moment turn away from the asymmetrical nature of the nurse-patient relationship and the view that the patient is vulnerable, dependent and needy, and look at the relationship between the patient and the nurse as fragile and unstable, we establish a more complex image. We arrive at a point worth mentioning in this context, related to the fact that patients themselves are also capable of acting, not only nurses. The patient also possesses the power to shape the situation. For example, the patient may forcefully outmanoeuvre and sideline the nurse. The nurse, on the other hand, is also vulnerable, as we have discussed in article II (Hem & Heggen 2003). Article VI (Hem, Heggen & Ruyter 2007) clarifies how the nurse and patient negotiate; their mutual relationship is not static and one-sided, consisting of a powerful and invulnerable nurse and a powerless and vulnerable patient. In article V (Hem, Heggen & Ruyter, in press) we demonstrate the strong potential for the situation to escalate, for example into the use of physical violence by both the patient and the nurse. Juritzen & Heggen (2006) note how patients sometimes ridicule the staff in ways that offend the nurses and give the patients a feeling of having the upper hand, or how patients can use resistance to create frustration, discouragement and feelings of powerlessness among the helpers: "The competent health worker may at a moment's notice be caught off-guard by encountering powerful resistance from a party assumed to be powerless, and is overcome by powerlessness in this new situation" (ibid., p. 76 (my translation)). Asymmetry is therefore not "a stable structure for ordering superiority/inferiority" (ibid. (my translation)), and both care and power are ambivalent phenomena.[50]

5.3.5 Critical reflection

In the following discussion I will focus in particular on mature care as a form of middle ground between extremes. According to this idea of the middle ground, the mature moral

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[50] For example, the interest in elucidating the ambivalence of care can be found in Ruyter & Vetlesen (2001). Their aim in the book *Omsorgens tvetydighet – egenart, historie og praksis* [*The ambivalence of care – characteristics, history and practice*] is to occupy a space in between Foucault's only implicitly normative analyses of power in historical practice on the one hand, and the in-principle and abstract perspectives of the ethics of care on the other. In this position, I perceive a criticism of the purely moral-philosophical perspective, which lacks a proximity to those "practices, experiences and impressions for which principles and norms are provided" (ibid., p. 16 (my translation)). The authors wish to demonstrate exactly this ambivalence of care, both historically and in the present time. Their undertaking is to raise awareness, to recognise the ambivalence which is inherent in all forms of care, and to understand the moral aspects of the flipside of care. This contains a broad discussion of the ambivalence of care. The book fails to discuss these issues on the basis of empirical findings taken from the everyday situations encountered in professional care practice. Neither does it discuss aspects of care and power as phenomena that are inextricably linked. This dissertation can be seen to supplement the book with regard to these two issues.

actor takes the interests of the other as well as his/her own interests into account. A concept of mature care may serve to reveal that both parties to a relationship must be taken into account, i.e. both the patient and the nurse. Making a balanced assessment between oneself and others – balancing opposites – requires qualities and skills in the form of delimitation and understanding of self and others, ability to define priorities, and rationality (cf. chapter 5.3.3).

Ruyter (2005, p. 112) argues in favour of upgrading the "virtue of the middle". This term refers to the situation where "the morality to be sought for is found at the midway point between the extremes" (my translation). This means that this morality of the middle ground avoids the extremes found at either end of the scale, both moral superiority and resigned hopelessness. Of particular interest in this context is Ruyter's (ibid) "warning" against the excesses that may result when professional practitioners uphold high moral standards and ideals. He (ibid.) claims that ideals in combination with high professional competence may induce the professional to develop a notion of moral superiority. The outcome may result in a smugness and arrogance which is not attentive, patient and respectful towards those who are in need of help.

Ruyter here focuses on the professional as an individual. In my opinion, his example is undoubtedly a well-known fact in nursing in the field of (acute) psychiatry. The idea that nurses – who have a mandate to administer ideals of compassion, altruism, respect and care (cf. chapter 2.2), and who at the same time are most likely to view the patient as ailing (in the form of symptoms like paranoia and hallucinosis, for example) – may risk ending in one of the extremes described by Ruyter. The nurse knows best what the patient needs, and he/she knows that he/she is capable of contributing what is needed for the patient to be healed. Having this professionalism and morality, the nurse is quite likely to focus on the implementation of his/her own measures rather than listening to the patient's (psychotic) utterances.

Ruyter (ibid., p. 113) also highlights the fact that the professional may go to the other extreme, and become "disillusioned, because the higher goal cannot be achieved". One may wonder whether this resignation is at the core of an observation made in a number of studies, namely that the patients perceive the nurses as friendly, but distant (cf. chapter 2.3.2). This kind of attitude as a "friendly professional" (Jackson & Stevenson 2000, p. 378) might well be an expression of the resignation pointed out by Ruyter. Ruyter (2005, p. 113) claims that the

professions "need to strike a balance between excellence and resignation" (my translation). His plain, but demanding, suggestion is that helpers should never "let go of the fact that the morally decisive issue always remains *how* the individual performs his/her job and *how* they relate to the persons they are serving" (ibid., p. 113). As I interpret Ruyter's position, he explicitly argues that provision of care is a quality, and not just a skill (cf. also Wyller 2005). In so doing he concurs with ideas from ethics of virtue that regard virtues as essential preconditions for "actions that aim to do good deeds for others, and thereby qualify as care" (Vetlesen 2001b, p. 282 (my translation)). Virtues in the shape of qualities are developed by the individual through the performance of active care in relation to others. Virtues develop into characteristics of the individual only through actual practice (Vetlesen 2001b, Nortvedt 2001).[51]

An additional and relevant point concerns delimitations. Within a "modern notion of care" it is essential that care should not be without limits. Where these limits are drawn, however, varies with the circumstances, and the competent professional must assess this issue (Pettersen 2004). In practice, it is a challenging task to determine the necessary amount of care in specific situations. Professional care has an inherent risk of self-sacrifice, which benefits neither the caregiver, nor the recipient (ibid., p. 230). Therefore, care comprises considerable aspects of power. Discussing whether we, by assuming a new ideal, can escape the oppositions between ideals and reality, is important. The necessity of limits to care is both theoretically and practically inherent in the idea of mature care.

Interesting, and overlapping, perspectives can be found in the concept of mature care and in the idea of "the virtue of the middle", respectively. The challenges that exist are formulated differently by Pettersen and Ruyter, but I believe that their perspectives are complementary. Pettersen (ibid.) notes the dangers as consisting in self-sacrifice on the one hand and paternalism on the other. Ruyter (2005) claims that the challenge consists in balancing self-righteousness and resignation. Having a description of what in this manner constitutes underachievement on the one hand and overachievement on the other, seen in the light of ethics of virtue, can motivate a search for what is found between these extremes, the middle ground.

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[51] We can therefore see that the focus on the caregiver as a person is emphasised in parallel, but different, ways in ideas of psychiatric nursing (cf. chapter 2.2), in notions of mature care and in "the virtue of the middle".

5.3.6 Concluding remarks

An interesting and critical question that can be posed in conclusion to this discussion of mature care is how much further we are able to proceed in our understanding of what goes on in the relationships between psychotic patients and nurses in the field of acute psychiatry. Am I running the risk of "kicking in open doors" in my critical review of the legacy from Christian and altruistic notions of care (cf. chapter 2.4.2)? The question is whether this search for a "middle ground" may also be regarded as equally idealistic as the quest for a therapeutic balance. Am I still reflecting a tendency within the nursing profession to strive for less ambivalence? Aren't we living in a world that vacillates between extremes? In other words, could it be that mature care and the idea of a middle ground also constitute a form of idealisation? Is "striking a balance" possible and useful in practice? Or does this constitute the reestablishment of an ideal, this time in the form of the "virtue of the middle"? Does this discussion only serve to lower the ideals? If so, how useful could it be with regard to clinical applications?[52]

Or could it possibly be that mature care and the "virtue of the middle" provide a number of new opportunities that can be used when addressing this complex practical field? I ask myself whether the concept of mature care is more specific and constitutes a "thicker" theory which is more contextually sensitive than the altruistic notion, which is more abstract and thereby "thinner". In this context I identify a further problem, which is related to the parable of the Good Samaritan. The parable is often portrayed as a core narrative about unselfish and limitless care for the person in need. Yes, the Samaritan caters to the wounded and needy stranger, but he proceeds to his own duties after having found someone to look after the wounded man. He is not self-effacing. Cannot this manner of handling the responsibility to others be seen as reflecting a mature notion of care? This question may constitute an interesting topic for further discussion.

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[52] These critical questions were inspired by discussions in a seminar at the Institute of Nursing and Health Sciences at the University of Oslo on 27 March 2007 where I was a participant along with some fellow students.

5.4 Summary

I believe that professional nursing may benefit from a fresh approach to its practical aspects. More emphasis should be placed on stimulating and developing the nurses' level of reflection with regard to the difficult and nearly intractable dilemmas they need to relate to as professionals. The following questions may be asked: What kind of power do I exercise? How do I behave when exercising that power? What are my thoughts with regard to trust and distrust? Seeing oneself as a wielder of power and potential creator of distrust, and not only as a promoter of trust, could induce the nurses to develop a more realistic view of their own practices. This may subsequently pave the way for a more constructive conception of how care practices also comprise aspects of power. Ruyter's (2005) arguments in favour of the middle ground are valid in this context; we should strive for a virtue of the middle, the middle ground, because this helps us steer clear of the extremes of excellence (that may conceal moral superiority and arrogance) and resignation. The tension between "care" and "control" represents a challenge (Bowers et al. 2002), and should be included in this discussion. A further point that may be important in this context is that throughout history, care has been perceived both as a burden and a blessing (Pettersen 2004, cf. chapter 2.4.3). This kind of ambivalent interpretation of care could open the way for a more multi-faceted understanding of care. One challenge raised by this position could be to develop ways of comprehending care that could strike a balance between these extremes. This understanding should consider both the recipient of care and the caregiver.

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Summary and outlook

6.1 Summary

"Without you there is no me". This ambiguous quotation by Geijer (1856, quoted in Cullberg 2006, p. 3) points directly to what has inspired this dissertation: the interest in understanding what transpires in the meeting between (two) persons. One of these persons is in need of help, having experienced something that makes him lose control of his/her life; the other is the professional who is responsible for providing this help. The thematic centre of this dissertation has been to elucidate and understand the interaction between psychotic patients and psychiatric nurses on an acute psychiatric ward. The premise for this dissertation is that the things that occur between the needy person and the helper within this field is essential for the needy person's experience of being helped. According to Martinsen (1989), care is a practical, relational and moral activity. In this chapter I will summarise the perspectives outlined in the dissertation. I will also expand the perspectives by pointing out areas and problems that in my opinion ought to receive further attention in research and professional development of psychiatric nursing in the years to come.

In five of the six articles that comprise the dissertation I analyse and discuss various therapeutic principles and professional ideals. On the basis of the analysis, comprehensive empirical material has been collected through participant observation and interviews with patients and nurses in two units. Because I encountered particular challenges with regard to how the vulnerability of the psychotic patients could be understood and addressed with a view to the ability to provide informed consent, it was also natural to add an article on this topic.

In the introductory and synthesising discussion I have placed the findings from the partial projects in context by discussing them in the light of an altruistic notion of care. The main result is that the altruistic notion of care is being challenged in the practical field by realities characterised by disharmony, chaos and lack of control. Accordingly, the dissertation has a generally critical and inquisitive assessment of the professional ideals and the way in which these are expressed in various therapeutic strategies. I ask whether the altruistic notion of care may serve to conceal the roughness of acute psychiatry as a field. I further point out other risks of the altruistic notion of care, namely that it may serve to encourage idealisation, conceal the exercise of power and provide immunity to criticism. In this manner, it is fair to say that I have debated the ideals of an altruistic attitude to care, which are internal to nursing, but I have also discussed the psychiatric ideals of using oneself in a therapeutic manner.

Consequently, the study argues in favour of challenging and discussing established manners of thinking concerning therapeutic ideals and notions of care. In accordance with this critical approach, the study argues in favour of mature notions of care as a possible and constructive alternative. Here I leave the fields of nursing and psychiatry to obtain ideas that possibly could enrich my field of study.

Particularism is a strong point in the perspective of mature care.[53] The particularistic relationships, the relationships between patients and nurses, are at the heart of this study. The importance of investigating what transpires in relationships, and how we can understand these relationships, are basic points in this dissertation. Various theoretical positions and perspectives may serve to deepen this understanding. I therefore find it meaningful to discuss whether the idea of mature care has the potential to elucidate more exhaustively the relational challenges nurses face in acute psychiatry. For example, I indicate the necessity of incorporating aspects of power as inescapable: care and power interlink, they are each other's opposites and each other's preconditions, depending on the various contexts, situations and actors involved. Subsequently I discuss the significance of the concept of mature care with regard to providing space for critical reflection, which can be said to represent a response to possible tendencies towards idealisation of nursing.

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[53] The particularism inherent in this perspective in other contexts could represent a weakness. The theory fails to assume a position of how a request for care that emerges from general and/or specific anonymous others should be met, and this could be problematic in situations involving, for example, ethical dilemmas related to setting priorities.

The idea of mature care provides other opportunities, in particular associated with its non-dichotomous approach.[54] For example, mature care incorporates the perspective that people are concerned both with others and with themselves. Using the ideas of mature care, we are, therefore, in a more systematic manner able to include in our reflections the nurse who provides care. This perspective considers that both parties to the relationship contribute to what transpires, and the focus should accordingly be placed on both the recipient and the giver in order to gain an adequate impression of what is at stake, in what ways and for whom in what situations. This dissertation thereby challenges existing notions and practices in psychiatric nursing. A shift from altruistic care to mature care as a fundamental idea in and about nursing will entail consequences for practices and training as well as research. Because the idea of mature care invites the caregiver (the nurse) to appear as a human being, just like the needy person, he/she will emerge as more distinct and well-defined.[55] Having a clearer view of their humanity – and professionalism – could serve to establish a stronger awareness of responsibility and responsible behaviour. In the continuation of this ambiguous perspective I find it interesting that recent research has found that nurses have a dual motivation for choosing this profession. An orientation towards others as well as an orientation towards themselves and their own interests interact when young people choose to become nurses (Jensen & Tveit 2005). They are self-defining and oriented towards others at the same time. They develop their identities through the relationships to the patients, and the encounter with the patients is a confrontation with themselves. The perspective on the dialectic connection between self and others has a parallel in classical ethics of virtue: one develops as a person through the practice of virtue. Developing relationally is only possible in the company of others (Pettersen 2006b). Accordingly, being trained as a nurse provides a particular

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[54] Ideas of mature care thereby also represent a meta-criticism of traditional theories. Mature care takes into account that phenomena might be ambiguous. Ambivalence is a recurring theme in Pettersen's (2004) dissertation. Traditional theories of morality are at a loss because of the tendency to dichotomisation: the assumption of a perspective of either/or regarding human phenomena, in this context care. In other words, mature care involves thinking beyond dichotomies.

[55] In this context I refer to my previous discussions of the vulnerability of nurses in article II (Hem & Heggen 2003, cf. chapter 5.3.4). It is interesting to note that Vetlesen (2001a) writes about the physician's role in a similar vein, of being in a tense situation between successfulness and vulnerability. On the basis of a discussion of how the physician may appear as both personal and professional at the same time, he claims that the role of the physician leaves a pronounced impression of successfulness. He argues in favour of challenging this image, and claims that "... the importance of vulnerability, conceived as a deeply founded and non-chosen basic aspect of being human, with a view to how the physician should conceive of him-/herself and should be conceived by society – namely as just as vulnerable as everybody else. Correctly understood, the vulnerability of the physician is a precondition for him or her to gain access to the situation of the patient and be involved in the patient's ailment" (ibid., p. 1118 (my translation)).

opportunity to develop relational skills. Confronting the distress of others represents an opportunity to learn something about human vulnerability and strength. Using these opportunities inherent in learning about the human condition provides an opportunity to mature as a person, which in turn will provide positive feedback on one's own behaviour as a caregiver, both personally and professionally.

6.2 Outlook

A large number of possible research problems could be appropriate to mention by way of outlook in conclusion to a dissertation that thematises care relations in acute psychiatry. In sketching the topics that might be natural to follow up, I will remain close to the themes that form the core content of the dissertation. I wish to address three themes. These are, respectively, the perspective of power as an aspect of care relations, how we can comprehend relational skills, and finally the question of what constitutes the specific character of psychiatric nursing.

First, the dissertation encourages pursuit of a perspective that incorporates the linkage between *power* and *care*, as I have done in the context of the concept of mature care. As I see it, my attempt to link power and care, care and power – power as an aspect of care relations – could be developed further. My interpretation represents only a first step towards establishing an intriguing perspective that could have an impact on reflections on nursing care in a broader sense. In one sense it is sensational – but nevertheless typical – that I have not included any gender perspectives in the dissertation. Care is a gendered phenomenon and ideal. My argument for not including gender perspectives is associated with the need for delimitation. Gender is a comprehensive theoretical field, and deserves a more thorough exposition than what could be encompassed in this dissertation, given the perspectives chosen. However, gender and power are similar in one respect, by remaining partly non-topicalised, an unconscious perspective in spite of their pervasive presence in the communication between patients and nurses in acute psychiatry. In the future, we can expect the profession to be enriched by good and insightful analyses of care, power and gender.[56]

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[56] It is possible that the perspective of power as an aspect of care, as well as the analysis itself, could have benefited from incorporation of gender as an analytical category in addition to power and care.

Another point that in my opinion the dissertation encourages to discuss further is the question of how we should comprehend relational skills, in acute psychiatry in particular and in nursing care in general. For example, an issue that lends itself to further investigation is whether a mature caregiver – who knows him-/herself well, who can make an extra effort to provide help, but knows his/her own limits – could be better suited to interact with the patient and cater to the patient's needs than a caregiver who – stated bluntly – in a more unreflected manner believes him-/herself to be there exclusively for the sake of the other. A topic only implicitly included in this dissertation is that mental disorders are fraught with guilt and shame. Skårderud (2001) points out that the shame of patients may affect the caregivers in their dignity and belief in themselves as good helpers. This will in turn engender powerlessness. This feeling of powerlessness comprises a potential for unreflected exercise of power. Thereby, this latter point is linked to the former: power and care should be conceived of in conjunction with, and not as separate issues in, nursing care. The issue of relational skills in nursing care should also incorporate the use of oneself in a therapeutic manner, and I have described this issue in the dissertation. In my opinion, the profession possesses potentials – both theoretically and practically – for the use of personal qualities in a therapeutic setting. I ask myself whether it could be possible to investigate such interaction through empirical studies that analyse the content and practice of such communication between patients and nurses in various practical fields. In addition, I believe that insights can be gained by including perspectives from psychotherapy to a larger extent, in which there is a comprehensive practical competence and body of theoretical literature on the implications of using one's own person(ality) in a therapeutic manner. Schibbye's (2002) ideas on the dialectical understanding of relations represent an example of a contribution by psychology that in a beneficial manner could be incorporated into psychiatric nursing (Jordal 2006). There are two points related to limits and the understanding of relationships that I find worth investigating further. One point is to ask myself whether it might be an intriguing paradox that a person who knows him-/herself well, and is aware of his/her personal qualities, knows his/her own limits and is able to enforce them, might possess the relational skills required in order to approach the neediness of the other person, and thereby create an experience in the other person of being understood. The suffering of the other is recognised, and this experience is often emphasised as meaningful in relationships associated with care (cf. chapter 2.4). The other point is that using oneself, offering patients an emotional involvement beyond what is normally called for, implies associating the relational experiences made by nurses in the contact with patients with an experience that is also rewarding for nurses. It could be

interesting to further develop knowledge of whether this could serve to confirm the identities of nurses, in the sense of confirming who they are and who they want to be. In accordance with this line of thought, it might appear as if self-sacrifice to the benefit of the patient might also be seen as a rewarding act for the nurses. This view reflects a relational understanding, in that the parties to a relationship cannot be understood independently of each other, and that the parties to a relationship continually recreate each other's preconditions.

The third issue concerns the characteristics of the profession. In the dissertation I have maintained a conscious focus on psychiatric nurses. This is because my own experiences are derived from this field, and because I contend that it is important to maintain a strict focus on a group of health workers who, to a large extent, contribute to shaping current psychiatric practices and thereby the kind of help provided to patients. For this reason, I believe that studies that investigate the characteristics of psychiatric nursing are important. I am well aware of the exhausting ideological and organisational battles that have characterised the psychiatric field with regard to professional qualities, the drawing of boundaries around fields of responsibility, the focus on interdisciplinarity and multi-disciplinary cooperation. Nurses have rightly been accused of being isolationist, narrow-minded and behaving as though they possess a monopoly on psychiatric care. My idea is that these protectionist strategies are based on a professional insecurity. In one sense, the dissertation has also centred on this issue. I assume that to a larger extent a secure professional group would have had the curiosity to encourage cooperation with others, or engage in cooperation with others. For psychiatric nurses as a profession to develop a greater confidence in the distinctive character of their own profession, I believe that a possible course is to investigate the professional activities as they are experienced in relation to the patients, as well as in relation to professionals in other fields.

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Appendices

The study on unit 1:

No. 1: Recommendation from the Regional Committee for Medical Research Ethics (Health Region 1)

No. 2: Response from Norwegian Social Science Data Services

No. 3: Information to be posted on the ward

No. 4: Information to nurses about the project

No. 5: Declaration of Consent

The study on unit 2:

No. 6: Recommendation from the Regional Committee for Medical Research Ethics, Southern Norway (REK South)

No. 7: Receipt from the Norwegian Social Science Data Services for delivery of mandatory Report

No. 8: Response from the Directorate for Health and Social Affairs

No. 9: Letter from the Faculty of Medicine, University of Oslo, by Nina Vøllestad, Head of Institute

No. 10: Letter from Hospital NN, acute psychiatric ward

No. 11: Letter to the hospital's monitoring commission

No. 12: Request for participation sent to patients and nurses

No. 13: Information to be posted on the ward

No. 14: Declaration of Consent

Gaustadalléen 21, 0349 Oslo. Telefon 22 95 87 98

Oslo, 1. juni 1999

1.amanuensis Jan K. Hummelvoll
Høgskolen i Hedmark, avd. sykepl.utd.
P.b. 43
2400 Elverum

Vår ref.: 221/99-99067

Psykotiske pasienter og sykepleie. En studie av klinisk
kommunikasjon og kunnskapsgrunnlag i sykepleie

Vi viser til brev av 11.05.99 fra Marit Hem med vedlagt
omarbeidete informasjonsskriv.

Komiteen tar brevet og vedleggene til orientering, men vil
bemerke:

Informasjonsskrivet til pasientene bør ha en overskrift, som
også angir at det dreier seg om en studie.

Opplysninger om at det er frivillig å delta og at pasientene
når som helst kan trekke seg skal stå i selve informasjonen og
ikke i samtykkeerklæringen. Det gjelder også opplysninger om
at lydbånd vil bli benyttet, at alle data vil bli anonymisert,
og at lydbåndopptakene vil bli makulert når studien er
avsluttet.

Komiteen mener for øvrig at informasjonen bør innledes med en
presentasjon av prosjektet og ikke av sykepleieren.

Vennlig hilsen

Sten Sander
professor dr.med.
formann (sign.)

Ida Nyquist
sekretær

Kopi: Marit H. Hem

Norsk samfunnsvitenskapelig datatjeneste
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

NSD

Marit Helene Hem
Brisingaveien 4
1655 SELLEBAKK

Dato: 24.08.1999   Vår ref: 9900768/LT/RH   Deres dato: 23.04.1999   Deres ref:

VURDERING AV KONSESJONSPLIKTIG STUDENTPROSJEKT

Vi viser til mottatt meldeskjema 23. april d.å. for konsesjonspliktig forskningsprosjekt. Videre vises til øvrig korrespondanse, senest e-mail fra prosjektleder 27. juli d.å.

Etter gjennomgang av de opplysninger som er gitt i meldeskjemaet med vedlegg, finner vi at prosjektet ikke medfører opprettelse av personregister etter personregisterlovens § 1 og dermed følgelig heller ikke utløser konsesjonsplikt etter personregisterlovens § 9.

Hvor vurdering er gjort på bakgrunn av følgende:
- Prosjektet omfatter observasjon og intervjue med sykepleiere som er ansatt i en akuttpsykiatrisk avdeling.
- Det samles ikke inn og registreres opplysninger som direkte eller indirekte kan identifisere enkeltpersoner.
- Det er innhentes tillatelse fra oversykepleier og avdelingssykepleier ved den aktuelle avdelingen.
- Prosjektet er forelagt Etisk komité, helseregion I.

Dersom noen av de ovennevnte punkter ikke er korrekte, ber vi om at du tar kontakt med oss. Hvis prosjektet endres på noen av de ovennevnte punkter, kan det utløse konsesjonsplikt. Vi ber derfor om at eventuelle endringer meldes til oss for ny vurdering.

Kontaktperson: Lis Tenold tlf. 55 58 33 77/ 55 58 21 17

Vennlig hilsen
Datafaglig sekretariat
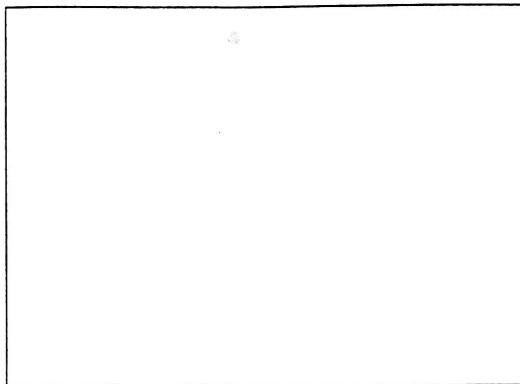
Vigdis Kvalheim

Lis Tenold

TIL PASIENTENE

INFORMASJON OM PROSJEKT

Jeg er psykiatrisk sykepleier og har lang arbeidserfaring fra psykiatrien. I dag arbeider jeg som lærer for sykepleiestudenter. Dessuten studerer jeg hovedfag i helsefag ved Universitetet i Oslo. En viktig del av studiet er å utarbeide en forskningsoppgave. Den skal handle om hvordan sykepleiere og pasienter kan etablere kontakt og tillit.

For å få informasjon om dette skal jeg være til stede i avdelingen for å se hvordan sykepleier-ne jobber. At vi som sykepleiere utvikler kunnskap om dette temaet tror jeg er viktig for at pasienter skal få best mulig hjelp fra oss.

Jeg kommer til å være i avdelingen noen dager hver uke i september og enkelte dager utover høsten. All informasjon jeg får vil jeg behandle konfidensielt. Hvis du ikke ønsker at jeg er til stede, vil dette bli respektert, og det får selvsagt ingen konsekvenser for den behandlingen du mottar.

September 1999

Marit Helene Hem

Marit Helene Hem
Brisingaveien 4
1655 SELLEBAKK
Tlf. priv.: 69 34 51 68
    arb.: 69 30 30 81

Sykepleiere ved   Sykehus
Akutt   , Avdeling

Fredrikstad, 3. mai 1999

INFORMASJON VEDRØRENDE UNDERSØKELSE

Jeg er student ved Universitetet i Oslo, Det medisinske fakultet ved Seksjon for helsefag, Studieretning omsorg og rehabilitering. I forbindelse med hovedfagsstudiet skal det utarbeides en hovedfagsoppgave. Dette er et selvstendig forskningsarbeid utført under veiledning av en erfaren forsker. Min hovedveileder er førsteamanuensis Jan Kåre Hummelvoll ved Høgskolen i Hedmark. Biveileder er førsteamanuensis Kristin Heggen ved Universitetet i Oslo.

Temaet for min hovedfagsoppgave er psykiatrisk sykepleie. Arbeidstittelen er: *"Psykotiske pasienter og sykepleie. En studie av klinisk kommunikasjon og kunnskapsgrunnlaget i psykiatrisk sykepleie"*. Fokus er på sykepleieres samhandling med psykotiske pasienter i en akuttpsykiatrisk avdeling. Min interesse for en forskningsmessig belysning av dette temaet er relatert til egen sykepleieerfaring gjennom 10 år ved en akuttpsykiatrisk avdeling.

Hensikten med studien er å utvikle innsikt om psykiatriske sykepleieres kliniske kompetanse. Hva slags kompetanse nyttiggjør sykepleiere seg for å etablere og vedlikeholde konstruktiv klinisk kommunikasjon med pasientene?

Som en del av studien vil jeg oppholde meg i miljøet i avdelingen, og ønsker å følge sykepleiere gjennom en del av de arbeidsoppgavene de utfører med og for pasientene (feltstudium). Jeg vil dessuten ønske å intervjue sykepleierne om deres opplevelser og tanker i relasjon til arbeidet med pasientene. Jeg anser det hensiktsmessig å være til stede i avdelingen bortimot daglig i noen uker og deretter ca en dag pr uke. Totalt kan det dreie seg om en tre måneders periode. Når det gjelder intervjuene, vil jeg gjerne ta disse opp på bånd. Dette for å unngå forstyrrelser som bruk av blokk og blyant kan medføre, samt at jeg sikrer meg å få med alle data fra sykepleierne.

Ved tilstedeværelse i avdelingen vil jeg komme tett inn på både pasienter og sykepleiere. Dette fordrer høy grad av etisk aktsomhet og sensitivitet fra min side. Jeg vil kontinuerlig vurdere, i samråd med sykepleierne, hvilke situasjoner som egner seg for mitt nærvær og hvilke som ikke gjør det. Pasienthensyn går foran hensynet til data.

Lydbånd og notater og tekster i forbindelse med feltobservasjonene vil bli oppbevart utilgjengelig for uvedkommende. Alle data og opplysninger jeg får vil bli behandlet konfidensielt. Lydbåndene slettes når oppgaven er utarbeidet.

Deltakelse i studien er frivillig, og det er anledning til å trekke seg fra deltakelse når som helst uten at dette får noen form for konsekvenser.

Dersom hovedoppgaven blir godkjent, vil den bli tilgjengelig for lesing i avdelingen. Den kan bli publisert.

Vennlig hilsen

Marit Helene Hem
Marit Helene Hem

SAMTYKKEERKLÆRING

Jeg,_____

samtykker i å delta i feltstudier og intervjuer med Marit Helene Hem i forbindelse med hennes studie knyttet til utarbeidelse av hovedfagsoppgave ved Hovedfag helsefag, Studieretning omsorg og rehabilitering ved Universitetet i Oslo.

Det er gitt skriftlig og muntlig informasjon om prosjektets hensikt og gjennomføring.

Jeg er inneforstått med at deltakelse er frivillig, og at jeg, når som helst og uten å måtte begrunne det, kan trekke meg fra deltakelse uten at det får noen konsekvenser for meg.

Jeg er gjort kjent med at alle data, lydbåndopptak inkludert, vil bli anonymisert og behandlet konfidensielt, og at lydbåndopptakene makuleres når studien er avsluttet.

Jeg er informert om at studien kan bli publisert.

_____   _____
Sted / dato   Signatur

Regional komite for medisinsk forskningsetikk
Sør-Norge (REK Sør)

Førsteamanuensis, dr.polit. Kristin Heggen,
Seksjon for helsefag
Universitetet i Oslo
Pb.1153 Blindern

Deres ref.:   Vår ref.: S-03143   Dato: 01.07.03

Verdighet og krenkelse. 'Hverdagsdramaer' i akuttpsykiatrien
Prosjektleder:

Komiteen behandlet prosjektet i sitt møte torsdag 19. juni 2003.

Komiteen har ingen generelle kommentarer til selve søknaden.

Komiteen har følgende kommentarer til pasientinformasjonen:

1. Informasjonsskrivene bør starte med "Forespørsel om å delta i forskningsprosjektet: *navn på prosjektet*".
2. Det bør fastsettes en bestemt dato for når evt. lydbåndopptak vil være slettet (f.eks senest ...).
3. Når det gjelder taushetsplikt, må det presiseres at det gjelder pasientopplysninger. Mellom kolleger vil det være en selvpålagt taushetsplikt.
4. Det bør opplyses at det ikke vil bli gitt opplysninger fra prosjektet til avdelingen eller sykehusets ledelse.
5. Avsnitt 2 i oppslaget til pasientene må presiseres i retning av at det vil bli respektert hvis man ikke ønsker at prosjektleder følger med til den enkelte pasient.

<u>Vedtak:</u>
"Under forutsetning av at prosjektleder tar hensyn til merknadene ovenfor, tilrår komiteen at prosjektet gjennomføres."

Vi ønsker lykke til med prosjektet.

Med vennlig hilsen

Sigurd Nitter-Hauge (sign)
Professor dr.med.
Leder

Ola P. Hole
Avdelingsleder
Sekretær

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Marit Helene Hem
Seksjon for helsefag
Universitetet i Oslo
Postboks 1153 Blindern
0316 Oslo

Dato: 08.10.2003   Vår ref: 200300525 GHA/RH   Deres dato: Deres ref:

KVITTERING FRA PERSONVERNOMBUDET

Vi viser til endring i melding om behandling av personopplysninger, mottatt 18.09.2003. All nødvendig informasjon om prosjektet forelå i sin helhet 07.10.2003. Meldingen gjelder prosjektet:

10111: Verdighet og krenkelse. "Hverdagsdramaer" i akuttpsykiatrien

Norsk samfunnsvitenskapelig datatjeneste AS er utpekt som personvernombud av Norges teknisk-naturvitenskapelige universitet, jf. personopplysningsforskriften § 7-12. Ordningen innebærer at meldeplikten til Datatilsynet er erstattet av meldeplikt til personvernombudet.

Personvernombudets vurdering

Etter gjennomgang av meldeskjema og dokumentasjon finner personvernombudet at behandlingen av personopplysningene fortsatt vil være regulert av § 7-25 i personopplysningsforskriften. Dette betyr at behandlingen av personopplysningene vil være unntatt fra konsesjonsplikt etter personopplysningsloven § 33 første ledd, men underlagt meldeplikt etter personopplysningsloven § 31 første ledd, jf. personopplysningsforskriften § 7-20.

Unntak fra konsesjonsplikten etter § 7-25 gjelder bare dersom vilkårene i punktene a) – e) alle er oppfylt:

a)   førstegangskontakt opprettes på grunnlag av offentlig tilgjengelige registre eller gjennom en faglig ansvarlig person ved virksomheten der respondenten er registrert,
b)   respondenten, eller dennes verge dersom vedkommende er umyndig, har samtykket i alle deler av undersøkelsen,
c)   prosjektet skal avsluttes på et tidspunkt som er fastsatt før prosjektet settes i gang,
d)   det innsamlede materialet anonymiseres eller slettes ved prosjektavslutning,
e)   prosjektet ikke gjør bruk av elektronisk sammenstilling av personregistre.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres slik det er beskrevet i vedlegget.

Behandlingen av personopplysninger kan settes i gang.

Ny melding

Det skal gis ny melding dersom behandlingen endres i forhold til de punktene som ligger til grunn for personvernombudets vurdering.

Selv om det ikke skjer endringer i behandlingsopplegget, skal det gis ny melding tre år etter at forrige melding ble gitt dersom prosjektet fortsatt pågår.

Ny melding skal skje skriftlig til personvernombudet.
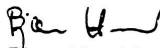
Offentlig register

Personvernombudet har lagt ut meldingen i et offentlig register, www.nsd.uib.no/personvern/-register/

Ny kontakt

Personvernombudet vil ved prosjektets avslutning, 20.04.2004, rette en henvendelse angående status for prosjektet.

Vennlig hilsen

Bjørn Henrichsen

Grethe Halvorsen

Kontaktperson: Grethe Halvorsen tlf.: 55 58 35 42

Vedlegg: Prosjektbeskrivelse

Ψ∫ Sosial- og helsedirektoratet

Førsteamanuensis, Dr. Polit Kristin Heggen
Seskjon for helsefag
Medisinsk fakultet, Univ. i Oslo
Postboks 1153, Blindern
0316 OSLO

Saksbehandler:	L.R. Haga
Vår ref (oppgis ved henv.):	03/3889 T/TS LRH
Arkivkode:	511
Dato:	08.09.2003

SØKNAD OM DISPENSASJON FRA TAUSHETSPLIKT

Vi viser til Deres søknad av 11.08.03 om dispensasjon fra taushetsplikt ifbm. forskningsprosjektet "Verdighet og krenkelse. Hverdagsdramaer i akuttpsykiatrien", og tidligere kontakt med Deres prosjektmedarbeider Marit Helen Hem.

Forskningsprosjektet ønsker å studere samhandlingen mellom psykotiske pasienter og sykepleiere i en psykiatrisk institusjon, og har som formål å skaffe kunnskap om hva som fremmer verdighet- og virker krenkende for psykotiske pasienter. Undersøkelsen er tenkt gjennomført i perioden september 2003 – april 2004, og opplysninger er tenkt innhentet ved bruk av deltagende observasjon og kvalitative intervjuer med et utvalg av sykepleiere og pasienter. Undersøkelsen består i første rekke av å følge arbeidet til 10 sykepleiere og observerer deres kontakt med pasientene, men vil etter hvert også omfatte kvalitative intervjuer med disse sykepleierne og et tilsvarende antall pasienter. Både sykepleierne og pasientene som vil bli intervjuet, forutsettes å samtykke til deltagelse i prosjektet, men det vil ikke bli innhentet samtykke fra de øvrige pasientene som er til stede ved avdelingen. Norsk samfunnsvitenskapelige datatjeneste as (NSD) synes derfor å ha ansett det som nødvendig at det ifbm. prosjektet søkes om dispensasjon fra taushetsplikt for disse pasientene.

Sosial- og helsedirektoratets vurdering:

Det rettslige utgangspunkt er jf. helsepersonelloven (hlspl) 21 og forvaltningsloven (fvl) § 13 at helsepersonell og enhver som utfører tjeneste eller arbeid for forvaltningen, skal hindre at uvedkommende får adgang til taushetbelagte personopplysninger de får kjennskap til i forbindelse med sitt arbeid. Tilgang til taushetsbelagte opplysninger vil derfor bare kunne gis dersom de personer som er beskyttet av taushetsplikten, jf. hlspl. § 22 og fvl. 13a har samtykket til dette, eller det f.eks. blir innvilget dispensasjon fra taushetsplikten etter hlspl. § 29 og fvl. § 13d.

<ins>Intervjuer med ansatte/sykepleiere:</ins>
Gjennomføring av intervjuene med de aktuelle sykepleierne synes ifbm. med det foreslåtte prosjektet å ta utgangspunkt i at det innhentes samtykke fra de aktuelle sykepleierne, men helsepersonell kan naturligvis ikke samtykke til brudd på den taushetsplikt de har etter helsepersonelloven (hpl) § 22. Da det ifbm. søknaden ikke er skissert hvilke typer spørsmål som er tenkt stilt, men lagt opp til at intervjudelen vil være en blanding av halvstrukturert og åpent intervju som blir tatt opp på bånd, legger vi til grunn at intervjuet også vil kunne omfatte formidling av taushetsbelagte opplysninger om pasientene. En forutsetning for å kunne gjennomføre slike intervjuer med pleiepersonalet, vil være at det enten foreligger gyldig samtykke fra berørte pasienter, jf. hlspl. § 22, eller at det foreligger dispensasjon fra taushetsplikt jf. hlspl. § 29.

Dispensasjonsadgangen etter fvl. § 13 d og hlspl. § 29 er ikke begrenset til å gjelde skriftlige eller nedtegnede opplysninger, men vil også kunne gjelde andre typer taushetsbelagte opplysinger og vurderinger som helsepersonell besitter, og som gis av helsepersonell ifbm. en intervjusituasjon. Pasientene som inngår i denne studien utgjør en meget sårbar og liten pasientgruppe, og det er i tilknytning til dette prosjektet derfor lagt opp til at det blir innhentet samtykke fra pasientene. Sosial- og helsedirektoratet er enige i at det i dette tilfelle vil være riktig å bygge på pasientenes samtykke, men stiller spørsmål ved om det er tilstrekkelig at det bare innhentes samtykke fra de pasientene som aktivt er tenkt å skulle medvirke ved intervjudelen i prosjektet. Dette fordi den åpne intervjusituasjonen som det legges opp til, lett vil kunne innebære at det også utveksles personopplysninger vedrørende de øvrige pasientene, som prosjektgruppen har stiftet bekjentskap med ved sitt oppholdet ved avdelingen.

Innhenting av samtykke og intervjuer med pasienter som har samtykket til deltagelse i prosjektet:
Det kan ikke forutsettes at pasienter aktivt skal delta ifbm. studien, uten at de på forhånd har samtykket til en slik deltagelse, og denne delen av forskningsprosjektet bygger derfor at det vil bli innhentet samtykke. Sosial- og helsedirektoratet finner imidlertid grunn til å minne om at krav til samtykke fra psykiatriske pasienter ikke er helt uproblematisk. For at samtykke skal være gyldig, forutsettes det at vedkommende har fått informasjon om hvilke opplysninger det gjelder, hvordan disse skal anvendes, hvem som er mottaker av opplysningene og eventuelle konsekvenser av dette, og ut fra situasjonen evner å forstå hva dette innebærer. Dvs. at det stilles krav til at samtykke skal være informert, og at pasienten innehar nødvendig samtykkekompetanse. For myndige personer som jf. hlspl. § 22 tredje ledd jf. pasientrettighetsloven (pas) § 3-3 andre ledd ikke kan ivareta sine interesser på grunn av psykiske forstyrrelser, må det innhentes krav om samtykke fra nærmeste pårørende.

Pårørende som trer inn for å representere pasientens interesser, har etter vår oppfatning heller ikke en selvstendig og ubetinget kompetanse til å oppheve taushetsplikten på vegne av pasienten. Et representert samtykke forutsetter at oppphevelse av taushetsplikten anses å være i pasientens interesse, og i tråd med det pasienten selv ville ha ønsket. På grunn av at det i dette tilfellet er snakk om en svært sårbar pasientgruppe, blir det derfor særlig viktig å ivareta den enkelte pasients integritet og verdighet. For pasienter som ikke har nærmeste pårørende eller er umyndiggjort, gjelder nærmere bestemmelser i pasientrettighetsloven kap. 4.

Observasjon av sykepleiernes kontakt med pasientene:
Slik vi også tidligere har gitt uttrykk for, ved henvendelse fra prosjektmedarbeider Marit Helene Hem i uke 32, vil hlspl. § 29 ikke gi hjemmel for å tillate observasjon av kontakten mellom pasienter og helsepersonell. Dette spørsmålet har også vær vurdert ifbm. en tilsvarende dispensasjonssak som tidligere i år ble påklaget til Helsedepartementet. Fra Departementets vedtak siteres:

> "Etter departementets vurdering er ikke helsepersonellovens unntaksregler om taushetsplikt anvendelige når en skal ta stiling til om en skal tillate innhenting av opplysinger ved observasjon i forskningsøyemed. Etter departementets vurdering er det ikke hjemmel i helsepesonelloven § 29 til å kunne bestemme at observasjon av en helsepersonell – pasientkontakt kan skje i forskningsøyemed uten samtykke fra pasienten. Annet relevant regelverk og retningslinjer, blant annet personopplysningsloven / helseregisterloven og etiske prinsipper nedfelt i Helsinkideklarasjonen, peker i samme retning. Det klare utgangspunkt etter personopplysningsloven er at sensitive personopplysninger bare kan innhentes og behandles etter samtykke fra den registrerte" og "Departementet har ingen lovhjemmel til å gjøre unntak fra disse reglene".

Etter det vi kan se vil observasjonsdelen av undersøkelsen på ingen måte være begrenset til studier av kontakt mellom helsepersonell – og navngitte pasienter i nærmere angitte situasjoner. Vi viser her til den informasjon som er gitt i henvendelse til NSD og vedlagte prosjektbeskrivelse fra NSD, der det bl.a. er gitt følgende opplysninger:

> "..Alle observasjonsarenaer vil bli benyttet, både de 'offentlige arenaer' på posten og pasientenes rom...". "Prosjektleder skal være tilstede og delta i postens daglige aktiviteter i flere måneder, og

observere utvalget av sykepleierens samhandling med psykotiske pasienter. Det å snakke med pleierne og pasientene vil være en del av den deltagende observasjonen. Hensikten er å få så mange inntrykk fra så mange ulike situasjoner som mulig. "

Sosial- og helsedirektoratet finner både på grunnlag av en samlet vurdering av prosjektet som helhet, og med utgangspunkt i at hlspl. § 29 ikke gir grunnlag for å tillate observasjon, at det ikke kan innvilges dispensasjon til gjennomføring av dette prosjektet. En ev. gjennomføring av prosjektet vil etter direktoratets vurdering måtte baseres på samtykke fra samtlige pasienter tilknyttet den aktuelle sykehusposten.

Vi anbefaler at en skisse til gjennomføring av prosjektet, hvor det tas utgangspunkt i samtykke fra pasientene, blir forelagt Regional Etisk komite for ny vurdering og godkjenning, før ev. iverksettelse av dette prosjektet.

Vi forutsetter også at en endret skisse til gjennomføring av prosjektet blir forelagt NSD/Datatilsynet for ny vurdering. Som ovenfor nevnt finner vi også grunn til å stille spørsmål ved om det ifbm. intervju av sykepleierne også kan fremkomme taushetsbelagte personopplysninger om pasienter som ikke deltar aktiv i undersøkelsen. Unntak fra konsesjonsplikt i personopplysningsloven §33, etter personopplysningsforskriftens § 7-25, synes samtidig å forutsette at respondenter eller verge, har samtykket til alle deler av undersøkelsen.
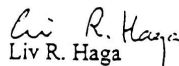
Klageadgang:
Sosial- og helsedirektoratets vedtak er å anse som et forvaltningsvedtak i henhold til forvaltningsloven (fvl) § 2b.

Vedtak om dispensasjon fra taushetsplikten kan påklages og klagefristen er 3 uker fra De mottar dette brevet, jf. Fvl. §§ 28 og 29. Klageinstans er Helsedepartementet, men en eventuell klage skal rettes til Sosial – og helsedirektoratet. Det følger av Fvl. §18 at en part har rett til å gjøre seg kjent med sakens dokumenter, med mindre annet følger av de unntak loven oppstiller i §§ 18 og 19.

Med vennlig hilsen

Hans Petter Aarseth e.f.
avdelingsdirektør

Liv R. Haga
rådgiver

Kopi   - Regional etisk komite, Postboks 1130, Blindern, 0318 Oslo
              - NSD, Holmboes gt. 22 – 5007 Bergen
              - Datatilsynet, Postboks 8177 Dep, 0034 OSLO

UNIVERSITETET I OSLO
DET MEDISINSKE FAKULTET

KOPI

Førsteamanuensis Kristin Heggen
Førsteamanuensis Per Nortvedt

Seksjon for sykepleievitenskap og
helsefag
Postboks 1153 Blindern
0318 Oslo
Besøksadresse:
Gydas vei 8, Majorstua
Telefon: 22 85 84 10

Telefaks: 22 85 84 11

Dato: 21.04.2004

Deres ref.:
Vår ref.:   03/4518

Vedr prosjektet "Verdighet og krenkelse. 'Hverdagsdramaer' i akuttpsykiatri" ved stipendiat Marit Helene Hem

Det vises til brev fra dere ang. erfaringer med gjennomføringen av prosjektet, der det fremgår at dere har måttet fravike noen av de krav som er stilt fra Sosial- og helsedirektoratet. Det er beklagelig at dere ikke har fått svar fra direktoratet på deres henvendelse til dem om problemene. Jeg setter pris på at dere i stedet for å la dette stoppe dere helt, har søkt råd hos sekretariatsleder Knut W. Ruyter ved Den nasjonale forskningsetiske komité for medisin, og har tatt saken opp med de ansvarlige på sykehuset der undersøkelsen foregår.

Jeg har forståelse for at det måtte gjøres endringer. Ut fra deres redegjørelse og den dokumentasjon som er fremlagt, synes det for meg som om dere har løst dette på en akseptabel måte som er klart etisk forsvarlig. Dersom det oppstår ytterligere problemer i forhold til dette, ber jeg om å umiddelbart bli kontaktet, slik at instituttet kan gi dere den bistand dere har behov for.

Jeg ønsker dere lykke til med den videre prosessen.

Med vennlig hilsen

Nina K. Vøllestad
instituttleder, professor

Kopi til: Doktorgradsstipendiat Marit H. Hem

Sykehus

26.04.04

Universitetet i Oslo
Det medisinske fakultet
Seksjon for sykepleievitenskap og helsefag
v. instituttleder, professor Nina K. Vøllestad

Angående prosjektet "Verdighet og krenkelse. "Hverdagsdramaer" i akuttpsykiatri"
ved stipendiat Marit Helene Hem

Vi bekrefter at vi kjenner forskningsprosjektet som Marit Helene Hem har fått tillatelse til å
gjennomføre ved Psykiatrisk Akuttavdeling, ▉▉▉▉
Dette prosjektet er ønsket fra vår side i den forstand at vi ønsker å legge forholdene til rette
for at prosjektet lar seg gjennomføre, og sykepleiere på post ▉ vil gjerne være informanter.
Dette innebærer at Marit Helene Hem er gitt tillatelse til å være deltagende observatør i
posten, og at hun vil intervjue noen av våre spesialsykepleiere/ sykepleiere og pasienter som
samtykker til det.

Marit Helene Hem vil særlig ha fokus på personalets samhandling med pasientene og hva som
kan gi en opplevelse av verdighet versus krenkelse. Vi ser det som helt nødvendig i den type
virksomhet vi driver at personalet utviser varhet i sin kommunikasjon med pasientene i
forhold til hva som kan gi en opplevelse av verdighet vs. krenkelse. Deltakelsen i prosjektet
bidrar i seg selv til et økt fokus på dette viktige temaet. Det gir mulighet til økt kunnskap og
mer bevissthet i forhold til holdninger. Vi ser det derfor som svært nyttig for avdelingen å
delta i prosjektet.
Våre erfaringer med prosjektet så langt bekrefter at de etiske forpliktelser en forsker har
overfor pasienter og ansatte i arbeidet med å samle inn data overholdes på en høyst
tilfredsstillende måte.

Vi er kjent med de føringer som er lagt fra Sosial- og helsedirektoratet når det gjelder
innhenting av skriftlig informert samtykke til Hems tilstedeværelse i posten fra alle pasienter
som til enhver tid er innlagt.
Vi mener det er en svært lite hensiktsmessig framgangsmåte overfor denne pasientgruppen,
særlig når det dreier seg om samtykke fra pasienter som *ikke* er informanter i studien.
Vi er inneforstått med at Hem følger forskningsetiske retningslinjer når det gjelder de
pasienter som er informanter i studien.
Vi vet at Regional Komité for medisinsk forskningsetikk (REK) har godkjent prosjektet.

Våre erfaringer så langt er at prosjektet og Hems tilstedeværelse ikke har medført problemer
eller vært til ulempe for posten.
"Verdighet og krenkelse" er viktige temaer i behandling av mennesker med alvorlige psykiske
lidelser, og det er behov for mer kunnskap om dette. Avdelingen er glad for å kunne bidra i
kunnskapsutviklingen om slike spørsmål.

For Psykiatrisk Akuttavdeling

Marit Helene Hem
Seksjon for helsefag
Det medisinske fakultet
Universitetet i Oslo
Postboks 1153 Blindern
0316 Oslo

Kontrollkommisjonen ved … Sykehus
v/ NN
…
…

Oslo, 22. oktober 2003

Informasjon om forskningsprosjekt ved … Sykehus, Psykiatrisk avdeling, post …

Jeg er doktorgradsstipendiat ved Seksjon for helsefag / Etikkprogrammet ved Universitetet i Oslo. I den forbindelse skal jeg gjennomføre et forskningsprosjekt med tittel: "Verdighet og krenkelse. 'Hverdagsdramer' i akuttpsykiatri". Jeg har fått tillatelse til å gjennomføre den empiriske del av studien ved … Sykehus, Psykiatrisk avdeling, post … Planlagt oppstart er den 29. oktober d.å. Vedlagt følger dokumentasjon om prosjektet til informasjon for Kontrollkommisjonen.

Hvis noe er uklart, kan jeg kontaktes via telefon: 22 85 84 20 eller 950 86664, eventuelt e-post: m.h.hem@helsefag.uio.no

Vennlig hilsen

Marit Helene Hem
Doktorgradsstipendiat

Vedlegg:
1. Prosjektbeskrivelse og sammendrag av prosjektbeskrivelse
2. Korrespondanse med … Sykehus
3. Korrespondanse med Regional komité for medisinsk forskningsetikk
4. Korrespondanse med Norsk Samfunnsvitenskapelig Datatjeneste
5. Korrespondanse med Sosial- og helsedirektoratet
6. Diverse informasjon mm. i forbindelse med praktisk gjennomføring av prosjektet

Kopi: Overlege …, Psykiatrisk avdeling, … Sykehus

FORESPØRSEL OM Å DELTA I FORSKNINGSPROSJEKTET:
"VERDIGHET OG KRENKELSE.
'HVERDAGSDRAMAER' I AKUTTPSYKIATRIEN"

… SYKEHUS
PSYKIATRISK AVDELING, POST …

Til pasienter og sykepleiere

Jeg arbeider med et doktorgradsprosjekt med tittel "Verdighet og krenkelse. 'Hverdagsdramaer' i akuttpsykiatrien" der fokus skal rettes mot samhandling mellom psykotiske pasienter og sykepleiere i en psykiatrisk akuttavdeling. Undersøkelsen tar sikte på å skape kunnskap om hva som fremmer verdighet og hva som virker krenkende for psykotiske pasienter. Økt kunnskap om dette temaet kan bidra til bedre behandling, og jeg ønsker å komme i kontakt med pasienter og sykepleiere på post … som kan tenke seg å delta i undersøkelsen. Undersøkelsen vil foregå i perioden september 2003-april 2004.

For å skape kunnskap om dette temaet ønsker jeg å være til stede på post …. For at situasjonene skal bli så naturlige som mulig, og for at jeg skal få mest mulig informasjon, ønsker jeg å delta i postens dagligdagse aktiviteter. Jeg skal selv ikke være sykepleier. Jeg ønsker å "følge" inntil 10 sykepleiere, og de pasienter sykepleierne har ansvar for. Jeg vil ha fokus på hvordan sykepleiere og pasienter samhandler, og jeg vil være opptatt av både det som fremmer verdighet og det som virker krenkende for pasienten. Dette betyr at jeg har fokus på **pasienters verdighet og mulige krenkelse av deres verdighet**. Jeg vil være interessert i å få vite om både pasienters og sykepleieres opplevelser av og erfaringer med gode og mindre gode samhandlingssituasjoner. Jeg vil selvsagt vise respekt hvis pasienter ikke ønsker at jeg følger med sykepleierne til den enkelte pasient. I tillegg ønsker jeg å foreta intervjuer med inntil 10 pasienter og de samme 10 sykepleiere som jeg "følger" i avdelingen for å høre hver enkelt sine erfaringer med temaet. I intervjuene vil pasienter uttale seg om forhold til sykepleiere og sykepleiere vil gi uttrykk for erfaringer med pasienter. Intervjuet vil foregå når vi har blitt kjent med hverandre, og vil vare 1-2 timer. Jeg vil gjerne få benytte lydbånd for å ta opp intervjuene fordi det gir mer verdifull informasjon enn om jeg kun tar notater.

Deltakelse er frivillig, og du kan, når som helst og uten å måtte begrunne det, **trekke deg**. All informasjon om deg vil da bli **slettet**. Hvis du velger å trekke deg, får det ingen konsekvenser for deg og ditt forhold til avdelingen og sykehuset.

Alle data, lydbåndopptak inkludert, behandles **konfidensielt**. Taushetsplikten gjelder pasientopplysninger. I forhold til sykepleierne gjelder selvpålagt taushetsplikt. Lydbåndopptak blir makulert når studien er avsluttet, senest 1. desember 2007. Det er kun mine veiledere og jeg som vil ha tilgang til opplysninger jeg får. Det vil ikke bli gitt opplysninger fra prosjektet til avdelingens eller sykehusets ledelse.

Studien vil bli publisert på engelsk i form av artikler i internasjonale vitenskapelige tidsskrifter. Det vil ikke være mulig å gjenkjenne enkeltpersoner i disse publikasjonene.

Jeg har selv arbeidet ved denne posten som psykiatrisk sykepleier i cirka 10 år. Det innebærer at jeg kjenner posten og postens pasientgruppe godt. Jeg har også undervist sykepleiestudenter i psykisk helsearbeid. I forbindelse med mitt hovedfagsprosjekt i 1999-2000, som handlet om dilemmaer i relasjoner mellom psykotiske pasienter og sykepleiere, gjorde jeg en tilsvarende undersøkelse på en liknende avdeling. Dette betyr at jeg har

kunnskaper om psykiske lidelser og erfaring i å møte pasienter med psykiske lidelser, samt erfaring med samme type forskningsopplegg som jeg ønsker å bruke i denne studien.

Veiledere for prosjektet er førsteamanuensis Kristin Heggen ved Seksjon for helsefag og førsteamanuensis Per Nortvedt ved Senter for medisinsk etikk, begge ved Universitetet i Oslo. Etikkprogrammet ved Universitetet i Oslo finansierer prosjektet, som planlegges avsluttet våren 2006, eventuelt våren 2007. Prosjektet er tilrådd gjennomført av Regional komité for medisinsk forskningsetikk, og prosjektet er meldt til Personvernombudet for forskning, Norsk Samfunnsvitenskapelig Datatjeneste AS.

Du kan naturligvis tenke deg om noen dager før du gir tilbakemelding på om du ønsker å delta i undersøkelsen eller ikke. Hvis du ønsker ytterligere opplysninger om prosjektet, kan du få prosjektbeskrivelsen og / eller sammendrag av prosjektbeskrivelsen. Dette vil være tilgjengelig på post … og / eller ved direkte henvendelse til meg i posten. Jeg kan også kontaktes via e-post: m.h.hem@helsefag.uio.no eller telefon: 950 86664 / 22 85 84 20

Vennlig hilsen
Marit Helene Hem

TIL PASIENTENE

INFORMASJON OM FORSKNINGSPROSJEKTET:
"VERDIGHET OG KRENKELSE.
'HVERDAGSDRAMAER' I AKUTTPSYKIATRIEN"

I forbindelse med doktorgradsprosjektet, "Verdighet og krenkelse. 'Hverdagsdramaer' i akuttpsykiatrien", kommer jeg, Marit Helene Hem, til å oppholde meg på post … fra og med september/oktober 2003 til cirka juni 2004. Jeg skal være til stede i posten noen dager pr. uke. Jeg kommer til å studere hvordan pasienter og sykepleiere samhandler, og fokus vil være rettet mot hva som fremmer verdighet hos og hva som virker krenkende for pasienter. Økt kunnskap om dette temaet kan bidra til bedre behandling.

All informasjon jeg får vil jeg behandle konfidensielt. Jeg kommer ikke til å skrive ned opplysninger som kan identifisere enkeltpersoner. Som en del av prosjektet skal jeg også intervjue inntil 10 sykepleiere og inntil 10 pasienter. De pasienter som jeg ønsker å intervjue vil få egen forespørsel om det. All informasjon som skrives ned fra intervjuene (som tas opp på bånd) blir anonymisert.

Siden jeg selv har arbeidet på denne posten som psykiatrisk sykepleier i perioden 1986-1996 kjenner jeg posten og pasientgruppen godt. Jeg har også god kjennskap til og erfaring med forskningsmetodene gjennom et liknende forskningsprosjekt.

Nærmere informasjon om prosjektet fås ved henvendelse til meg eller de ansatte på post …

September 2003

Bilde
Marit Helene Hem

SAMTYKKEERKLÆRING

Jeg,_____

samtykker i å delta i feltstudier og intervjuer med Marit Helene Hem i forbindelse med hennes doktorgradsprosjekt, "Verdighet og krenkelse. 'Hverdagsdramaer' i akuttpsykiatrien", ved Det medisinske fakultet, Seksjon for helsefag og Etikkprogrammet ved Universitetet i Oslo.

Jeg har fått skriftlig og muntlig informasjon om prosjektets hensikt og gjennomføring.

Dato / sted:_____

Underskrift:_____

Original papers

List of papers

Paper I-VI

I.   Hem, M. H. & Heggen, K. M. (2004b). Is compassion essential to nursing practice? *Contemporary Nurse* **17**(1-2), 19-31.

II.   Hem, M. H. & Heggen, K. M. (2003). Being professional and being human: one nurse's relationship with a psychiatric patient. *Journal of Advanced Nursing* **43**(1), 101-108.

III. Hem, M. H. & Heggen, K. M. (2004a). Rejection - a neglected phenomenon in psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing* **11**(1), 55-63.

IV.   Hem, M. H., Nortvedt, P. & Heggen, K. M. (2008) "Only a manic depressive!" The zone of the untouchable and exceeding limits in acute psychiatric care. *Research and Theory for Nursing Practice* **22**(1), 56-77.

V.   Hem, M. H., Heggen, K. M. & Ruyter, K. Pervasive distrust. The hard work involved in creating trust in an acute psychiatric ward. *Nursing Ethics.* In press.

VI.   Hem, M. H., Heggen, K. M. & Ruyter, K. (2007). Questionable requirement for consent in observational research in psychiatry. *Nursing Ethics* **14**(1), 41-53.

Is compassion essential to nursing practice?

ABSTRACT

The Norwegian Nurses' Association recently (2001) approved a new code of ethics that included compassion as one of the basic values in nursing care. This paper examines the idea of compassion in the context of the Bible story of the Good Samaritan using an analysis of qualitative data from nurses' clinical work with psychiatric patients. The aim is to show how the idea of compassion challenges nursing practice. Thereafter, the paper discusses the benefits of and premises for compassion in care work. The results show that nurses tend not to be guided by compassion in their work with patients. The organisation of the day-to-day work in the hospital ward, the division of labour between nurses and doctors, and the nurses' approach to nursing were identified as influencing this tendency. The study shows that compassion is a radical concept with a potential to promote greater respect for patients' dignity.

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INTRODUCTION

Nursing has always been supposed to be founded on compassion, care and respect for those who are weak and suffering. Patients' vulnerability and their dependency on health professionals imposes on nurses a moral obligation to take care of them, an obligation that is very clearly summed up by the word "compassion". This might sound obvious and unproblematic. But in nursing circles in Scandinavia a debate is currently taking place on whether compassion and care should occupy a central place in nursing and if so, to what extent. The compilers of the most recent version of the Norwegian code of ethics for nurses (2001) have chosen to include the word "compassion".

The question at issue, however, is whether a professional approach based on compassion might lead to a quasi-religious, idealised view of nursing as a vocation, which in turn might lead to a low-paid profession becoming romanticised. Compassion alludes to the individual nurse's character and manner in a fairly explicit way, and this can reinforce feelings of guilt and inadequacy in nurses who do not feel they are living up to their professional ideals. Another issue in the debate is whether a focus on compassion might obscure the objectivity that must be expected of a professional nurse.

PURPOSE

The present article is intended to be a contribution to the debate based on the analysis of empirical material from nursing practice. A case drawn from an acute psychiatric ward is examined in relation to the idea of compassion. The aim is to examine specific nursing practices in the context of compassion, and to show how the content of this concept challenges such practices. We then discuss whether the idea of compassion has general relevance for the practice of nursing.

THEORETICAL CONTEXT

The idea of compassion has played an important role in nursing as well as medicine, and it has been a cornerstone of western hospital tradition since 400 CE. The ideal expresses the duty to love and care for the weak and the sick regardless of their social rank or status (Nortvedt, 2002). In theoretical medicine it has been argued and regretted that compassion has weakened it's position in favour of the prevailing view of medicine as applied biology. Pellegrino (1979), Pellegrino and Thomasma (1981), Toombs (2001), Kleinman (1988) and Zaner (1993) are among the significant medical theorists who explore medicine as moral enterprise. Kleinman (ibid., p. 54), for instance, argues that the moral core in medicine is an existential commitment to be with the sick person. Like-

wise, compassion has been a central concept when discussing how nursing is to be understood. Is nursing applied science or first and foremost a healing relationship and a form of dialogue with the sick person (Nortvedt 1998)? A lot of clinicians and researchers in nursing seem to agree on the importance of establishing a nurse–patient relationship in which nurses use themselves as therapeutic tools. Influential researchers and textbook authors as Travelbee (1971), Mereness & Taylor (1982), Stuart & Sundeen (1991), Peplau (1992), Porter (1992), Forchuk (1995), Gijbels (1995) and Cleary & Edwards (1999) have all focused the importance of interpersonal processes and therapeutic interaction in psychiatric nursing. In other words nursing theorists focus on the importance of the encounter or "meeting" with patients. Nursing might, in other words, be described as an interpretive meeting, which takes place between the nurse and the patient with the aim of understanding the one who is ill and seeks care. Gallop et al. (1990) underline that the concrete aims of the nurse–patient relationship are to explore and become familiar with the patient's own understanding of his/her present situation and the past, and to contribute to the patient's well-being and personal growth (Peplau, 1992; Müller & Poggenpoel, 1996). Furthermore, a functioning nurse–patient relationship is considered a necessary condition for providing care, which is looked upon as the very essence of nursing (Schafer, 1997, p. 206). The literature on psychiatric nursing is very considered with nursing as a practice, and consequently focuses the abilities and qualities one should expect from a psychiatric nurse. Emrich (1989), Hellzén et al. (1995) and Lindström (1997) underline acceptance, affirmation, and generosity as dominant professional qualities. Other authors emphasise the nurse's ability to show empathy and to recognise the patient's problems (e.g. Hellzén et al. 1995). In other words, the role of the psychiatric nurse has been discussed in terms of relationships, under-

standing, attitudes, as well as feelings (Mereness & Taylor, 1982, p. 10) and caring (Martinsen 1989; 1993; 1996). Explicit and often implicit compassion seems to be an important concept when focussing on nursing in general and specifically on psychiatric nursing. The paper intends to "re-examine" the concept of compassion and use this concept while analysing a meeting between a patient and a psychiatric nurse. This necessitates a closer look at the origin of compassion as an idea.

The Bible story of the Good Samaritan is often used to illustrate and examine the idea of compassion. In short, the story tells of a man who is travelling from Jerusalem to Jericho and who is set about by thieves, who beat him and leave him half dead by the wayside. A priest comes by, and when he sees the wounded man he passes by on the other side. A Levite comes by and does the same. But then a Samaritan comes by, and when he sees the man lying there, he is "moved to pity", he empathises with the sufferer. He goes up to the man, bandages his wounds and takes him to an inn. The next morning the Samaritan gives the innkeeper two silver pieces, and says, "Look after him; and if you spend any more, I will repay you on my way back." (Luke 10, 31–35). This story has had a considerable influence as a nursing ideal, and it illustrates two aspects of compassion: compassion as an idea, and compassion in practice (Hansen, 2001).

COMPASSION – IDEA AND PRACTICE

In the Bible story both the priest and the Levite *see* the man by the wayside. The following is the whole point of the story: "For in the act of seeing, two people are confronted with each other and from this confrontation springs the ethical appeal for care" (Hansen, 2001:20). But the priest and the Levite ignore the man's distress. The Samaritan also sees him, but in contrast to the other two he feels *pity* for the man. He is moved by the man's situation, he responds to

the appeal that the suffering man emits. In the story the wounded man is anonymous: he is not described in terms of age, social class or where he lives. Hansen (2001:19) claims that the anonymity is being used deliberately to indicate "a universal humanity". A nurse's mandate is to care for the sick stranger (Nortvedt, 2000), and in this light the story expresses the ideal of helping everyone who is in need, purely because of their need.

The nurse's *moral responsibility* to care for the sick is determined by "the individual's helplessness, vulnerability and suffering" (Nortvedt, 2002:31). The basis for every kind of help is the acknowledgement of the fundamental features of human existence: vulnerability, dependency, fragility and mortality (Henriksen & Vetlesen, 1997). Dependency and vulnerability are what make a person human, and care is directed towards these fundamental aspects of the human condition, about which we have no choice. Thus relating to the patient as a dependent, vulnerable person is to be within a moral sphere of activity. In other words: nursing is moral praxis (Martinsen, 1989, 1993, 1996), in the sense that the patient's *is* is the nurse's *should* (Martinsen, 1996).

However, the story of the Good Samaritan does not only point to which attitudes and which kind of personality matter in relations between people. On the basis of pity for a man's suffering a tie is formed between two strangers, the wounded man and the Samaritan, and the Samaritan carries out a series of care actions (Hansen, 2001). The help given by the Samaritan is described in very specific detail, which implies the emphasis on good deeds.

The Good Samaritan's actions are not the result of calculation. On the contrary, they are spontaneous, a natural response to a specific situation. The Samaritan acts, not after due reflection or according to a programme, but from pity for the suffering man because of his suffering. The Samaritan asks for no return from the sufferer for his kindness (Hansen, 2001), which

emphasises the unselfish nature of compassionate acts. A compassionate person acts without thought of reward. Practical care means acting in response to the patient's appeal for help and without expecting any return from the person being cared for. Martinsen (1989, 1993, 1996) points out the importance of clinical discernment for a correct understanding of the situation, and she emphasises the intrinsic value of such practical acts.

The question of what it means for a nurse to be morally responsible in relations with psychiatric patients needs to be discussed in an empirical context, and we therefore present a case history as an illustration. First we present the study's design.

THE STUDY

Material and methods

The data were compiled at a medium-sized Norwegian psychiatric hospital in autumn 1999 (Hem, 2000; Hem & Heggen, 2003; Hem & Heggen 2004) as part of a larger study of communication between psychotic patients and psychiatric nurses. The first author (MHH) spent 65 hours (over a period of two and a half months) on a locked ward that had five patients. Most patients stayed on the ward for about one week. The majority of the patients were psychotic, but to which degree they were psychotic could wary. Most of them were involuntarily committed. The researcher observed six nurses carrying out tasks with and for patients. She paid particular attention to the interaction between the nurses and the patients and to what the nurses thought and said about what they were doing. In addition the researcher participated in the daily life of the ward. These observational data, in the form of field notes (divided into 'observational notes', 'theory notes', 'methodology notes' and 'personal notes') (Hammersley & Atkinson, 1996; Henriksson & Månsson, 1996; Wadel, 1991; Hansen, 1995; Savage, 1995; Dahlgren, 1996;

Heggen & Fjell, 1998), were filled out, supplemented and validated (Kvale, 1995; Holstein, 1995; Svensson, 1996) by data obtained from narrative interviews (Ramhøj, 1993) with the same six nurses. The narrative interviews lasted 20–60 minutes; they were recorded on tape and transcribed verbatim. Some 80 pages of field notes and interview transcriptions were made. The field notes describe what nurses did in their interaction with patients, while the interviews record nurses' personal understanding of their work (Hem & Heggen 2003; 2004).

Data analysis

A number of cases that were typical examples of the variety of problems arising in clinical communication between nurses and psychotic patients were selected. The case descriptions illustrated the nurses' experiences in situations in which they took responsibility for patients or ignored patients, as well as situations in which they showed understanding and sympathy or took no notice of and disregarded the patients. Each case was analysed in depth and classified according to categories that reflected the tensions, nuances, discrepancies and contradictions in the material. One of these cases was chosen for the present study because it provided a good opportunity to analyse the concept of compassion in the context of nursing practice.

Ethical considerations

In accordance with the ethical guidelines for medical and health research (Kvale, 1995; Hammersley & Atkinson, 1996; Henriksson & Månsson, 1996; Solbakk, 1998), consent was obtained from the hospital management, the department in question and each individual patient and nurse.

CASE: THE MORNING MEETING

What follows is an abridged version of our field notes. The field notes describe a morning meeting between patients and staff members in the

locked ward. The names and other information have been changed to ensure anonymity.

Four patients and three staff members take their places round the coffee table in the ward common room. This is where the morning meeting regularly takes place. The day's newspapers are lying on the table. The television has been turned off. Most of the participants have brought a cup of coffee with them from breakfast, which they have just finished eating. The autumn sun is shining through the windows. The room looks cosy and the atmosphere is pleasant and peaceful. Christoffer (a nurse) is chairing the meeting. He is sitting in the middle of the sofa with patients and nurses on each side. He has a piece of paper in front of him, which he occasionally refers to. He tells the patients which nurse is their contact person for the day, and what appointments they have with physicians, psychologists, physiotherapists, etc.

He then says to Finn (a patient), "We are trying to organise a visit home for you today. We may not manage it, because there are so few of us at work. If we don't manage it today, we'll try and organise it for tomorrow." This sparks off a long interchange between the two of them. Finn leans forward on his upright chair; his face is red with emotion. He seems excited. Finn is upset because he has been involuntarily committed and feels he is in a hopeless situation, that the staff make all the decisions and not him, that as a patient he has no rights. "I'm just kept hanging about here day after day and nothing happens. It's absolutely dreadful." Hanne, a fragile little woman very nicely dressed in an attractive sweater and trousers with a matching scarf, says she agrees. "I have exactly the same feeling." She interrupts Finn's sentences with her own views and feelings. She is preoccupied with the feeling that patients lose their dignity in a ward like this. She says she thinks the whole situation is so awful that sometimes she "blows right up in the air". Finn asks Olga, who is leaning back in a comfortable chair with her feet up on a footstool and a rug tucked around her, what she

thinks is most important: listening to the patients or to the staff. "Listening to the staff," she replies. A couple of times during the meeting Olga breaks in with questions like, "D'you know where my husband is?" or "D'you think I need to wash my hair today?". She is not interested in the same things as Finn and Hanne. Pelle, who last time he was admitted was in opposition to the entire system, sits quietly and registers what goes on. He makes supportive remarks to both patients and staff. For example, "This is the best ward in the whole hospital."

Finn keeps on and on. He and Christoffer get caught in a dialogue, just the two of them; none of the other nurses says anything. Christoffer sits quietly; he watches Finn and lets him talk before he himself says anything. He says he understands that Finn finds the situation difficult. He says Finn should take up these personal issues with his doctor. Finn says he has done this, but that it doesn't help. "I get absolutely nowhere there, he doesn't listen to me!" He says he is completely healthy, but has been told he is mentally ill. "How can they be allowed to lock up a healthy person for weeks at a time? I think a lot about kindness. I think it's important for people to care for each other, have real contact, listen to what other people have to say. People nowadays don't listen, they aren't interested in other people and what's happening to them. People are only interested in themselves." He looks at the other nurses, but no one says anything. Christoffer repeats again and again that this is a personal problem, Finn must talk to his doctor about it. The morning meeting is not the place for personal problems. "This is an information meeting," he says. Finn replies, "Yes it's a meeting for information from you to us. What about our need to be heard?" Christoffer says, "I hear what you're saying. The staff don't have any influence on decisions that have already been made. We're just a mouthpiece. But you can rely on us to do everything we can to make your stay here as good as possible." Finally he says, "I think we'll end this dis-

cussion now," and goes on to assign practical tasks for the day. After a short time both Finn and Hanne leave.

A little later Finn stops Barbro, a nurse, in the corridor. He asks, referring to the meeting, "Did I go too far?" Barbro says no. He says he is "fully equal to everyone else as regards human dignity and human rights". He has tears in his eyes. He says, "I give up, I'm going to bed."

INTERPRETATION AND DISCUSSION

Rejecting the patient's appeal

This case will be discussed as a test of compassion in a situation that many psychiatric nurses will recognise. The framework is the regular morning meeting between nurses and patients. All the patients on the ward are present, but it is Finn who plays the most active role. A nurse, Christoffer, chairs the meeting. When, after giving out a good deal of practical information, Christoffer addresses a specific message to Finn, this seems to trigger a great many thoughts and feelings in Finn about his situation as a whole and the problems he experiences being in hospital. The "administrative input" from the nurse is not met by a simple "administrative response" from the patient.

Finn is upset. This is visible in his physical posture; he sits leaning forward in his chair, he is red in the face and his whole aspect expresses his disturbed and distressed state of mind. Throughout the meeting he shows his *vulnerability*, *dependency* and *suffering* (Henriksen & Vetlesen, 1997; Nortvedt, 2002). He expresses himself strongly. He thinks the whole situation is "hopeless", he feels he has no rights, he feels he is not allowed to make decisions and is not listened to. His experience of involuntary commitment and of not being able to make decisions is "absolutely dreadful". It is obvious that for Finn this is vitally important, and he explicitly confronts the nurses with this. In this way he gives the nurses an opportunity to respond to or

ignore his appeal. But there does not appear to be any response to his appeal (i.e. compassion as a value), nor does the appeal lead to understanding and pity and by extension to specific action by the nurse to help him deal with his difficulties (i.e. compassion in practice). In this case the patient's distress was expressed very clearly, as it was in the story of the Good Samaritan. The priest and the Levite guard themselves against the wounded man's suffering and appeal in a passive way, by not acting, and Christoffer guards himself more actively by telling Finn that he cannot help him. Christoffer *ignores the appeal* by establishing a framework of "administrative logic" for the meeting and by keeping within it. The fact that nurses ignore patients' appeal is also supported by the international research in the field. Empirical studies have investigated how and to what degree psychiatric nurses establish a therapeutic relationship with their patients (Delaney et al., 1995; Gijbels, 1995; Clarke, 1996; Ryrie et al., 1998; Cleary & Edwards, 1999). Several studies have, for instance, focused on how patients have experienced psychiatric nursing (Beech & Norman, 1995; Pejlert et al., 1995; Müller & Poggenpoel, 1996; Lepola & Vanhanen, 1997; Lindström, 1997; Cleary & Edwards 1999). Patients have reported that their psychiatric nurses have been friendly, but that the patients understood this friendliness more as an impersonal social attitude than as a sign of personal commitment related to the therapeutic relationship (Müller & Poggenpoel, 1996). Patients feel offended because of the nurses' abuse of power, use of constraint, and lack of support. Patients often have the impression that nurses are vague, distant, and neither physically nor emotionally available when they need them (ibid.; Hem & Heggen 2003; 2004).

Ignoring the patient's distress

The morning meeting is unpleasant for both Finn and Christoffer and also for the other patients and nurses. One possible reason for

this is that Finn and Christoffer have different expectations of the meeting and ideas of what it is supposed to be for. Christoffer's approach is practical; he gives out information on appointments and specific tasks. Finn wants to talk about his problems, or more specifically about his feelings about being committed against his will to an acute psychiatric ward. The nurse gives the impression of understanding the patient but insists on maintaining an *administrative framework* around the meeting – a framework that ignores the patient's distress.

Finn tries to include other patients in the discussion of his distress at being involuntarily committed. He is only partly successful: Pelle makes some generally supportive remarks. Finn's distress seems to be aggravated by the fact that the other patients respond so little to his unambiguous appeal to them to understand his distress. Nor does Christoffer seem to be able to respond to Finn's invitation to the other patients to really see his distress. Two of the patients leave before the end of the meeting. Finn may well interpret this as being his fault: that by voicing his distress he has "ruined" the meeting. But it can also be interpreted as a signal of support to Finn: that these two patients do not accept the fact that the nurse is "administering" Finn's distress. This also has a parallel in the story of the Good Samaritan: the fact that the priest and the Levite pass by without alleviating the man's suffering may be because his appeal for help upsets their plans. Christoffer also passes by: he has a *programme* for the meeting that he wants to follow, and he does not allow Finn to upset his plans. Ignoring the patient's distress, like Christoffer does, might lead to loneliness for the patient, which, in fact, studies have pointed at. For instance, Lepola & Vanhanen (1997) and Lindström (1997) found that patients tend to feel lonely in the ward. Pejlert et al. (1995) report that patients tend to develop the feeling of not belonging to the community in the ward. Accordingly, patients are appreciative of nurses who are available,

who listen, who are friendly, tolerant, and who show respect (Beech & Norman, 1995).

Shifting the responsibility

Finn expresses his despair at not getting anywhere with "the system", and he reacts to being involuntarily committed. Christoffer responds by saying that he understands that Finn feels his situation is difficult. Christoffer *sees* Finn and demonstrates what might at first sight seem like a compassionate attitude and actions. But in fact the term "compassion" is not an accurate description of the situation because what Christoffer actually does is to *reject* Finn. He re-assigns what is distressing Finn to the *doctor's sphere of responsibility*. When Finn says that he has tried to talk to the doctor about "personal things", but that the doctor doesn't listen, Christoffer replies, "I hear what you're saying. The staff don't have any influence on decisions that have already been made. We're just a mouthpiece." And then he adds, "But you can rely on us to do everything we can to make your stay here as good as possible." Christoffer's message to Finn is ambiguous.

Christoffer explicitly says he understands that Finn feels he is in a difficult situation, but at the same time he shifts responsibility for the problem over to the doctor. He indirectly becomes part of the doctor's decision and allies himself with the system by assuring the patient that the staff will "do everything we can to make your stay here as good as possible." The model of the Good Samaritan requires the nurse to commit himself and to act in order to demonstrate his compassion. Christoffer does not commit himself; he takes refuge in the institutional rules about division of responsibility in order to guard himself against Finn's appeal. In this context one could say that the institution and the practice of its rules prevents the exercise of compassion. Christoffer also ignores Finn's appeal by insisting that the meeting follows an administrative logic in which personal distress like Finn's has no place. Christoffer's

actions are underlined by a feigned compassion, which further paralyses Finn. When Christoffer says, "we'll do everything we can to make your stay here as good as possible," this does not allow Finn much room for protest. It is difficult for a patient to criticise a nurse who assures him that he wants what's best for him. The attitude described can be understood as a kind of professional distance. This professional distance (Hem & Heggen, 2003; Hem & Heggen 2004) has been debated from a variety of perspectives. Foucault (1965/1988), for instance, has shown how modern society has created a distance between being normal and insane. The power knowledge relationship, creating a distance between those who suffer from mental illness and the experts, is also illuminated by influential researchers as Latour (1987). The concept of professional distance in nursing was also discussed as early as in the 1960's. Based on an empirical study of the nursing service of a general hospital, Menzies (1960) showed how nurses developed techniques to help them to separate the relationship between nurses and patients and to allow them to distance themselves from the suffering patients.

Reflections

The morning meeting made an impression both on the nurses and on Finn. Both parties needed to talk afterwards about what had happened. Christoffer took it up with his colleagues in the duty room. In their conclusion they attribute the situation to Finn's qualities: he can be very difficult, "that's the way he is", and he "has little insight into his illness". The nurses do not try to imagine how distressed Finn is or how he feels at losing his freedom, autonomy and power to make decisions by having been involuntarily committed. Not do they think about the morning meeting as an interactive situation where what happens, especially between Finn and Christoffer, is the result of a two-way process. The categorisation employed by the nurses is very far from the idea of compassion. If they

had drawn on compassion it would in fact have made them aware of Finn's distress. Instead their attitudes to the meeting show that they had immunised themselves against Finn's suffering. The immunity might be interpreted as an effort to protect oneself. Bray (1999) found that psychiatric nurses who work in acute wards experience difficulties in working closely with patients suffering from psychological disorders. This work is emotionally demanding and they employ various strategies to create a space between themselves and patients. For example, they might physically distance themselves from patients (ibid.; Menzies, 1960).

Finn, for his part, expressed his need to talk about what had happened by addressing one of the other nurses. This shows that, in spite of the nurses' categorisation of him as difficult and lacking in insight, he was in fact thinking about what happened at the meeting in general, and his own part in it in particular, and evaluating it. He even expressed a fear that he had gone too far. It is possible that he was afraid he had created a difficult and unpleasant situation for the other patients, for Christoffer and for the other nurses.

CONCLUDING REMARKS

The aim of the present article was to examine specific nursing practices in the context of compassion, and to show how the content of this concept challenges such practices. We also wished to examine whether the idea of compassion was relevant and what effect it might have on nursing practices. We arrived at the following findings.

Absence of compassion

It seems quite clear from the above that in the case analysed here the nurses' interaction with the patients does not reflect compassion. One of the nurses (Christoffer) seems to be aware to some extent of the patient's suffering, but is inhibited from going further by, among other things, his own administrative logic and the

division of responsibility and labour between the physicians and the nurses; he also deals with the situation without using words that would make the patient's own understanding of his distress more visible. The above analysis clearly shows what good results might be achieved by the active use of compassion. We can see that Christoffer could have met the patient's distress in a more committed way and could have paid more attention to human dignity by establishing a different framework for the situation. It is worth noticing that Benedetti (1974) claims that patients appreciate professional helpers who try to understand them and who make an effort to find out what is the matter with them. What is essential for patients is that the professional helpers demonstrate that they are willing to and make every effort to commit themselves. In fact, just by demonstrating the will and effort to commit themselves, nurses can make a deep impression on patients (ibid.).

Although compassion is explicitly mentioned in the Norwegian code of ethics for nurses, it is in fact often not practised. Thus we cannot draw the conclusion that including a new idea in a set of guidelines is sufficient to alter practices. Moving from idea to theory to practice is never a simple linear process. Thus the inclusion of the idea of compassion in the code does not immediately improve nursing practice in the sense of making it more compassionate. And a romanticised description of a nurse's practice that does not correspond to the actual interaction between nurse and patient can aggravate the situation. It can mean that nurses' actions are put into words in a new way, and that nurses have an idealised idea of themselves and their practice that does not correspond to their patients' experience (Heggen, 2000). A romanticised idea of nursing practice can result in worse patient care, not better, and thereby violate patients' human dignity (Heggen, 2002). Hummelvoll and Røsset (1999) found a similar phenomenon in their study of psychiatric nurses, who claimed to have a humanistic approach while in fact their actions showed a disease-oriented, diagnosis-based focus, which appeared to be in conflict with their stated ideals. There is no point in having "a good attitude" and a humanistic approach to patients if this is not translated into practice.

Collective approach to nursing practice

The nurses' conversation in the duty room showed that compassion had little effect on their collective interpretation of the situation. In their comments they blamed the patient for his lack of insight into his illness and classified him as difficult. They made no attempt to explore the potential in this situation, which consisted in allowing the patient's *suffering and distress* to come to the fore.

An interesting point in this connection is what happened when one of the nurses met Finn in the corridor. In this situation she seemed to depart from the collective way of thinking in the duty room, and to ally herself more closely with the patient. But her attempt at compassion seemed to reinforce Finn's distress. His impression that when things were difficult he was alone against the world was confirmed. Even though he was given to understand that one of the nurses understood his distress, it also became clear that there were no adequate, articulate advocates to plead his cause. The nurse's response aggravated his feeling of being alone in an impossible situation. This shows that it is not enough that one nurse is aware and supportive of a patient in distress. It has to be a *collective response*.

The critical potential in the idea of compassion

We have pointed out the traces of compassion to be found in the situation we have analysed and considered what opportunities are open to those whose actions are based on compassion. We have also shown that there are many limitations attached to using compassion as a basis for

nursing practice. These depend to some extent on the individual nurse. We wish to point out, however, that if the potential inherent in compassion is to be fully utilised, it requires a collective ability and willingness to put the idea of compassion into practice and also the possibility of doing so.

This analysis makes it clear that compassion is a *radical idea*, with a *critical potential*. It also shows that compassion is demanding and difficult in practice and as an ideal. Acknowledging the necessity of compassion in the ethical guidelines for a profession, as has now been done in Norway, is a necessary but by no means sufficient condition for the radical step of taking a patient's distress seriously.

Acknowledgement

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II

Being professional and being human: one nurse's relationship with a psychiatric patient

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Being professional and being human: one nurse's relationship with a psychiatric patient

Background. The theoretical foundations and professional ideals of psychiatric nursing contain inbuilt contradictions. One central ideal is that nurses should use themselves as therapeutic instruments. The expectation that nurses should have both a professional and a human function is examined in this study.

Purpose. The purpose of this study was to find out how nurses experience and interpret the contradictory demands of being both fellow human being and health professional in their work with patients.

Methods. An ethnographic research design including participant observation and narrative interviews with nurses working on an acute ward of a psychiatric hospital was used. The case of one nurse is analysed and discussed.

Findings. The study shows that when nurses themselves are 'therapeutic instruments', tensions are created. Contradictory demands produce difficult role conflicts. Nurses vary in the ways in which they interact with patients. The study shows how the nurse's own vulnerability can be a constructive element in patient care. It also shows that although the nurse is aware of this, she is also critical of her performance, feeling that it falls short of accepted professional standards. Her colleagues reinforce these standards.

Conclusion. The ideal that psychiatric nursing should be a balancing act between intimacy and distance, between human and professional ways of acting, appears to be too harmonious and narrow a one. The study suggests that there is potential for professional development if nurses are able to recognize their own vulnerability. Critical examination and discussion of conventionally accepted ideals can help develop our knowledge of the profession.

Keywords: psychiatric nursing, psychiatric patient, professionalism, health professional, participant observation, narrative interviews

Introduction

The theory and practice of psychiatric nursing has two aspects. For patients, nurses are both health professionals and fellow human beings. In their therapeutic work, nurses must employ their diagnostic insights and precise knowledge of illness. At the same time, they must also be able to encounter patients as unique individuals. The profession bears the

traditions of both biomedical knowledge and humanistic psychology. It is expected that nurses have both a professionally objective, scientific stance and sensitivity to patients and their suffering. In short, inflexible schematic thinking must be combined with empathy. The ability to quantify must go together with the ability to be present as a fellow human being.

In this article we examine one of the ideals of nurse–patient interaction, namely the expectation that a nurse should combine the role of health professional with that of fellow human being. Our discussion is based on a study of one nurse's experiences on an acute psychiatric ward.

Theoretical context

A fundamental premise of psychiatric nursing is that nurses use themselves as therapeutic instruments. This means that their work has a markedly personal character. These personal and therapeutic processes have been examined by a number of researchers and textbook authors (e.g. Lützén 1990, Peplau 1992, Porter 1992, Forchuk 1995, Gijbels 1995, Cleary & Edwards 1999). The reason for this strong emphasis on the 'therapeutic relationship' is the fact that psychiatric patients have problems in communicating and forming relationships (Peplau 1992). It is for this reason that Porter (1992, p. 453) argues that we should see 'therapeutic interaction…as the essence of psychiatric nursing'. Stuart & Sundeen (1991, p. 981) employ the concept of 'interpersonal process', while Mereness & Taylor (1982, p. 10) stress that a psychiatric nurse's therapeutic role is not simply a matter of 'routines and procedures…it also must be discussed in terms of attitudes, feelings, relationships, and understandings'.

Clearly, many researchers and textbook authors in the field agree on the importance of psychiatric nurses being personally at patients' disposal. This includes nurses' readiness to become close to patients. However, if this personal relationship is to have a therapeutic function, they must also be professionally distant, and must be able to balance between human closeness and professional distance (Strand 1990, Hummelvoll 1997).

Our own clinical experience of psychiatric nursing supports the view that it is necessary to balance intimacy and distance. The notion of an optimal balance is a professional ideal. However, does this ideal have an inbuilt potential for conflict?

There are a number of obvious problems connected to such an ideal. One of them is that there may be too great a nurse–patient distance. A body of research indicates that, when there are low personnel resources and fast and effective treatment of very ill patients is needed, nurses experience an unpredictable work situation (Delaney *et al.* 1995, Ryrie

et al. 1998, Cleary & Edwards 1999). Under such conditions, they experience feelings of powerlessness (Thomas *et al.* 1999a, 1999b) and appear watchful and controlling (Gijbels 1995). Co-ordination, administration and management dominate their practice, at the expense of planned patient-focussed activities (Ryrie *et al.* 1998). However, research also shows that nurses might be custodial and task-oriented, irrespective of resources (Clarke 1996). Such conditions create distance between patients and nurses.

On the other hand, a nurse can be too close to a patient. For various reasons, this phenomenon has received less attention. Bray (1999) found that psychiatric nurses who work in acute wards experience difficulties in working closely with patients suffering from psychological disorders. This work is emotionally demanding and they employ various strategies to create a space between themselves and patients. For example, they might physically distance themselves from patients.

It is a problem if nurses become too intimate or too distanced from patients. However, there is a third and much more fundamental problem. This arises from the very ideal that a nurse should at all times have a clear notion of the therapeutically correct degree of intimacy, and be responsible for regulating the relationship. We can ask if there is a danger of such regulation becoming too simplistic or too technical and instrumental. In fact, it is often claimed that nurses themselves are 'instruments' in caring for patients. Does the use of this word imply that nurses should not behave like real individuals who are vulnerable and have real shortcomings (Fog 1998)? Are relationships understood as concrete and unique ones, in which nurses and patients mutually and meaningfully interact, or does the 'instrument' metaphor suggest a well-controlled and somewhat cold professionalism? How do nurses experience the difficulty of being both intimate and distanced, in being a fellow human and a health professional? Such questions informed our empirical study.

The study

Purpose

The purpose of this study was to find out how nurses experience and interpret the contradictory demands of being both fellow human being and health professional in their work with patients.

Background and methods

In this article we draw on a larger empirical study of a medium-sized Norwegian psychiatric hospital in the autumn

of 1999 (Hem 2000). One of the authors (MHH) spent two and a half months on a locked ward that had five patients. She followed six nurses, and watched them carrying out their work. Special emphasis was laid on how the nurses interacted with patients. In addition, the researcher participated in the daily life of the ward. Field notes, recorded at the end of each day she had been present in the ward, were divided into 'observation notes', 'theory notes', 'methodology notes' and 'personal notes'.

The data created through participant observation (Wadel 1991, Hansen 1995, Olsen 1995, Savage 1995, Dahlgren 1996, Hammersley & Atkinson 1996, Henriksson & Månsson 1996, Solberg 1996, Heggen & Fjell 1998) were deepened, supplemented and validated (Holstein 1995, Kvale 1995, Fog 1996, Svensson 1996, Holm 1998) by data from narrative interviews (Ramhøj 1993, Knizek 1998) with the six nurses. The narrative interviews lasted 20–60 minutes, the majority taking 40–45 minutes, and were audiotaped (except one) and transcribed (verbatim). Some 80 pages of field notes and interview transcriptions were made. The field notes described what nurses actually did in their interactions with patients, while the interviews record nurses' personal understandings of their work.

Data analysis

Field notes and narrative interviews were used to create a number of exemplary case descriptions illustrating the nurses' experiences in situations in which they took responsibility for psychotic patients, in situations in which they acted as fellow human beings as well as in those in which they acted as professionals, or in situations in which they tried to persuade patients to act and decide on their own responsibility. On the whole, the data were intended to give an idea of the whole range of what the nurses had experienced in their interactions with the patients.

Each case was carefully analysed according to one of the major questions guiding the research, namely how do nurses handle the contradictory demands of being both fellow human beings and health professionals in their work with the patients. Each case was examined in detail and classified into categories reflecting the tensions, fine distinctions and contradictions inherent in the data. One of the dilemmas is presented and discussed in this article.

Ethical considerations

In accordance with the accepted ethical rules for medical and health research (Kvale 1995, Hammersley & Atkinson 1996, Henriksson & Månsson 1996, Engelstad *et al.* 1998, Solbakk 1998) we received permission from the hospital administration, the relevant ward and all nurses and patients.

Case study: a difficult nurse–patient relationship

What follows is an abridged version of one of our narrative interviews. The interviewee was talking about a young male patient.

It seemed to be more and more difficult for me to be myself when I was with him…my communication with him became more and more difficult. He was psychotic and anxious…he painted everything black. I managed to calm him and give him a sense of security…He was always studying me closely – my movements, my facial expressions, what I said, my intonations. It was as if all of me was being closely observed, he was trying to find out who I was…and he yelled at me day after day…'Shut your mouth, you fucking cow'. I was intensely rejected for days on end. Every day all of this negativity directed towards me…comments and negative remarks all the time…He constantly demeaned me, and that was hard to take. I suppose he used me as a shock absorber. I tried not to let it get to me. I tried to just put up with it and act normally. I was determined that I wasn't going to let it get on top of me. I said to myself, 'Breathe deeply, be yourself, but draw the line. Show that you deserve respect.'…It would have been easy for me to just trade insults with him. I felt I was being affected, I became insecure because I was continually provoked. My communication with him became unclear and incongruent. I felt that I was becoming more and more unclear…I felt that I was sidelined, and that I lost my grip over him and others. I experienced something of an identity crisis – I was being torn into two, split…this was intensely unpleasant…it was difficult to be both friend and professional carer, I found myself playing the role of friend or mother…yes, it was a very tough period.

But sometimes we communicated very well. He could dare to be honest with me. We told each other stories, and we made up stories together…there was something we had that was very good.

And I saw something in him, that he was a vulnerable boy who was carrying a lot of pain. I don't think that his parents ever really saw him. I don't think he could bear to sit alone with all of that suffering. I told him this. We agreed that he was very sensitive, but he also said, 'We mustn't talk about it', 'I don't want to be looked at in that way while I'm here', 'Don't dig too deeply – I can't handle it'. He simply couldn't tolerate that we tried to pierce his defences. I said that this was alright, that it was enough that we were aware of it. So there was understanding and contact between us – I felt that I showed him understanding. I also told him that I thought he was very direct and honest, and he took this in. We could talk about such things when we were alone…

Interpretation of the data

What immediately struck us was the nurse's feelings and involvement when she talked about herself and her patient. She was emotionally involved in the narrative – she commented that situations came alive for her when she talked about them. Uncomfortable physical responses returned. She experienced neck ache and body heat. She reported that she allows herself to get very involved with patients. This personal involvement is shown in her reflections. Her narrative is open and honest, and not at all coldly professional. She clearly wishes to be natural and authentic in her interaction with the patient. She points out that it was the fact that she could not wholly be herself – that she was 'uncertain', 'unclear' and 'split' – that was difficult. She has a typically relational way of talking about what happened. The experience she chose to talk about and dwell upon was that of a problematic nurse–patient relationship.

Being sidelined

The nurse's statement that she was 'sidelined' is worth examining. It seems as if she believes that her performance fell short of professional standards. She says she felt that 'it was difficult to be both friend and professional carer' and that she played the unsuitable and unprofessional roles of 'friend' and 'mother'. It seems that she is aware of how demanding the textbook ideal of an optimal balance between the roles of 'fellow human being' and 'professional' is. She accepts the notion that professionalism implies that one is 'on top of things', that one has control and an overall perspective on oneself and the patient. Being 'sidelined' can mean that one is professionally inadequate.

She is pressurized by the patient, towards whom she reacts strongly, and is provoked and confused by the manner in which he 'sidelines' her. She clearly expresses the pain of being marginalized when he calls her 'a fucking cow', and this episode is a critical turning point in her narrative. This 'breaking point' is of interest because it strongly challenges the ideals we hold about professional nursing. There is, however, a paradox in that, in spite of the fact that she feels she almost vanishes and becomes 'more and more unclear', she also retains affection for the patient. She does not lose her empathy for him – the ability to understand him on his own terms. She is 'sidelined', but continually manages to get back 'on top of things'.

An interesting feature is that she both sees and fails to see the possibilities of the situation. She describes the way in which she sees the dignity of the patient and gains fresh insights into his problems, but at the same time regrets the fact that she is being unprofessional. She seems unaware of this paradox. Traditionally accepted notions of professional distance and balance are the ideals she refers to when she reflects upon her own experience.

Stubborn empathy

One is struck by the extent to which the nurse retains empathy for her patient. In spite of being subjected to fierce personal attacks she retains the ability and will to understand his situation. It would have been unsurprising if she had responded by rejecting him or had fought back by using her own power strategies. She says herself that 'It would have been easy for me to just trade insults with him'. It may be the case that the patient invited rejection and punishment because he felt he did not deserve better treatment, and the nurse perhaps touches on this interpretation when she uses the expression 'shock absorber' to describe the function she thinks she had for the patient. She is more explicit when she states that 'I don't think he could bear to sit alone with all of that suffering'. She continually attempts to 'elevate' matters by trying to grasp the essence of the patient's situation, namely that he suffered from difficult feelings and thoughts which he transferred to her. Her ability to retain understanding and empathy could have depended on such an interpretation of his behaviour. It is also possible that it was essential for the patient to experience that she resisted his attempts to sideline her. This was unpleasant for him – 'I don't want to be looked at in that way while I'm here', 'Don't dig too deeply – I can't handle it'. However, the fact that she did not give in may be the reason why he remained so focussed on her.

One should also consider whether her lack of cold, distanced professionalism makes her more 'human'. Her lack of control and perspective may have facilitated contact with the patient. The nurse says in the interview that she had told him something about herself. Amongst other things, she had said that she was vulnerable and cried easily. We do not know what the patient made of this. However, it may well be that such a confession was a human touch that gave him the strength and security to cope better with his own feelings of inadequacy and smallness. That he calls her a 'fucking cow' could indicate that he has confidence in her and believes she can handle such an outburst. The data also suggest that he is provoked and disappointed because he wants a nurse who can free him from his pain and misery. There are also indications that he takes a degree of responsibility for the insecurity he makes others experience.

Importance of context

An important feature of the nurse–patient relationship was context. The patient demeaned the nurse in situations where others were present. When they were alone, however, other processes were in operation – 'there was something we had that was very good'. The two of them regularly created something together: they had good periods of close contact where 'we told each other stories, and we made up stories together'. She felt she 'showed him understanding'.

However, she became 'sidelined'. She started to be insecure and withdrew from both patients and colleagues, and describes how other nurses gradually became involved: 'Others took over, to some extent…I became more anonymous'. She was not informed about what came up in conversations with the psychologist (nurses were present at these sessions), and felt that secrets were being kept from her. She said that 'since he reacted so strongly towards me, I should have been involved in all stages of his treatment'. She thought she should have been one of the team that worked closely with the psychologist. Such a wish shows that she saw the potential of the difficult relationship, and had ideas about how it might have been positively exploited. She also describes a degree of rivalry between nurses as to who should work with him – 'it was as if everyone wanted to be involved with him'. She finds it hard to accept that 'sometimes it seemed that I was the nurse he didn't like'. She says that she became 'uncertain and a bit awkward – almost stupid'. The patient's verbal aggression had made her feel insecure, and she felt that she had lost the respect of her colleagues. While outsiders might have seen the therapeutic possibilities of the difficult relationship, it seemed that both the nurse and her colleagues only saw professional inadequacy.

It was not only her relationship with he colleagues that was affected. She described how the whole situation had consequences for how she related to the student nurses who were on the ward, and how unpleasant it was that they could hear how the patient spoke to her. She wondered what they thought and felt that they must have a low opinion of her, became even more insecure and followed a strategy of retreat: 'I drew back and made myself less visible'. However, she felt that this strategy was not in the patient's interests. If she moved into the background, he might feel rejected. He would either have had his feelings of worthlessness confirmed or he would have felt that his insults were more than she could cope with.

Being professional and being human

There are three features we would like to discuss. Firstly, there is the nurse's own description of the relationship with the patient. She shows empathy, loyalty, goodwill, frustration, anger and vulnerability. It is the limitations and possibilities of her vulnerability that we wish to examine further. Secondly, there is the fact that she feels she has failed to live up to her professional ideals. Thirdly, there are the signals she receives from her co-workers as to what constitutes appropriate professional behaviour.

The nurse's description: vulnerability

In her interaction with the patient, the nurse experiences and shows her own vulnerability. She has an ambivalent attitude towards her own behaviour. On the one hand, she expresses how her own vulnerability helped her in 'seeing' the patient and enabled him to show other sides of himself. Her openness was one of the premises for their interaction. However, she devalues her vulnerability when she relates it to her notions of professionalism, and this negative evaluation is encouraged by the other nurses on the ward.

There is a clear danger of romanticising the importance of nurses' accepting their own vulnerability and using it for the benefit of patients. We do not advocate that it should be an ideal for nurses always to 'be themselves'. Neither do we dispute that patients often need nurses who clearly demonstrate that they are in control of the situation (Strand 1990). However, it seems something of a paradox that, while patients' vulnerability is recognized, there is little acceptance that nurses may be vulnerable too.

Studies of patients' expectations of nurses show that it is human qualities that are important. Patients want nurses to be friendly, available and receptive, and they want to be understood and listened to (Beech & Norman 1995, Pejlert *et al.* 1995, Cleary & Edwards 1999). 'Vulnerability' is not explicitly mentioned in these studies, but it is personal qualities rather than specific therapeutic skills that patients are most aware of (Porter 1992, Wifstad 1997). It seems that there may be a lack of congruity between nurses' notions of professionalism and what patients really want from them.

As far as the notion of vulnerability is concerned, the literature that we have found is not based on what predominant philosophers in Scandinavia have come to realize. Nortvedt (2002), for example, emphasizes that a nurse's responsibility for looking after a patient is established by 'a single person's helplessness, vulnerability and suffering' (p. 31). To acknowledge vulnerability, dependency, fragility and mortality as essential human qualities must be regarded as fundamental to every kind of help or care (Henriksen & Vetlesen 1997, Løgstrup 1956, 1997). It is dependency and vulnerability, fragility and mortality that

make a human being a human being. If one expects nurses to act as moral persons, this requires that they are aware of patients' vulnerability and dependency and, moreover, that they admit that they are vulnerable and dependent themselves, accepting vulnerability and dependency as essential human qualities. Only if nurses are able to realize their own vulnerability and dependency are they able to identify with patients' needs and feelings (Henriksen & Vetlesen 1997, Vetlesen 2001).

The nurse in our study cannot accept that vulnerability can be a professional asset, but instead, equates 'professionalism' with 'control'. Perhaps we need to debate whether our professional ideals are too instrumental.

Professional ideals

Professional ideals are complex phenomena. Deeper discussion demands a thorough analysis of how ideals are theoretically formulated and communicated in textbooks. We also need to analyse how they are understood by individuals and groups of nurses in different situations. A thorough and meaningful analysis should also locate these ideals in the theoretical contexts of health science. Our empirical findings raise a number of critical questions about the notion of 'professionalism'. It may well be that our ideal of the 'friendly professional' (Jackson & Stevenson 2000, p. 378) who balances between intimacy and distance (Strand 1990, Hummelvoll 1997) is too harmonic a concept. It may be that there is too little room to articulate the difficulty of expecting individuals to be both intimate and distanced, 'human' and professional. Paradoxical or impossible expectations are put forward, expectations which nurses must find ways of tackling in their work. Such role conflict does not receive enough attention, probably because nurses primarily focus on what is best for patients. An increased awareness of the contradictory and disharmonic aspects of the ideals of 'professionalism' might perhaps lead to greater tolerance for vulnerable nurses who feel they are near breaking point.

Signals from colleagues

The third aspect we focus on is the importance of colleagues for the nurse's self-image. Nothing in the interview or observation data indicates that her colleagues saw the strength or positive aspects of her vulnerability. They seemed to think that professionals should be strong and well-controlled. However, such an attitude creates a problem. It suggests to us that it is not merely the stress caused by external demands for effectiveness and high patient

turnover that explain why this particular nurse was unable to express her own humanity and vulnerability. We must also critically consider the behaviour of her co-workers. A number of interesting questions present themselves. Can it be the case that attitudes to patient care that encourage patients to 'be positive' and 'look ahead', and that discourage introspection, might be transferred to relations between nurses? Does such an ethos discourage a focus on dynamic processes, and the possibilities and insights that this can bring about? Do we here touch upon what Cleary and Edwards (1999, p. 477) suggest, namely that the belief that 'something always comes up' is one that makes nurses less sensitive towards relational processes? Is it the case that nurses are uncertain about the essential nature of their own professional competence (Gijbels 1995)? Is this why the nurse in our example does not receive the support and understanding of colleagues, who feel incapable of offering any specific professional advice?

We were somewhat surprised by what the nurse told us because in our own experience informal conversations between nurses recognize and stress the importance of vulnerability. Is it the case that there is an inconsistency between what nurses say about their professional practice in 'closed' counselling sessions and what happens in their actual clinical practice? If there is such an inconsistency, it should be thoroughly researched and analysed.

Conclusion and practical implications

In this article we have examined how nurses experience and handle the art of balancing between being 'professional' and being 'human', and we have chosen to focus upon an example that challenges perceptions of this ideal. We would like to conclude by pointing to some possible practical consequences.

It is vital that nurses recognize their own vulnerability if they are to survive and develop professionally. Our study does *not* give grounds for recommending that vulnerability should be cultivated or elevated to a new ideal. However, there are grounds for suggesting that there may be potential for accepting and recognizing that nurses show they are vulnerable human beings.

A precondition for the constructive use of vulnerability is that colleagues develop a tolerance and positive awareness of this quality. This will give them support and make it possible for them to see their own vulnerability as something more than a professional lapse. The nurse in our study is probably not unique. We know that many psychiatric nurses experience 'being sidelined'. Our study suggests that professional ideals which emphasize 'balance' and 'harmony' make it difficult to consider constructively how 'vulnerability' can become a

What is already known about this topic

- One central ideal in psychiatric nursing is that nurses should use themselves as therapeutic instruments, which means that nurses should have both a professional and a human function.
- The ideal of being professional and human has an inbuilt potential for conflict because of the contradictory demands of creating an optimal balance between closeness and distance.

What this paper adds

- It argues that when nurses themselves are 'therapeutic instruments', tensions are created because of contradictory demands deriving from role conflicts.
- It asserts that the ideal of psychiatric nursing being a balancing act between intimacy and distance, between human and professional ways of acting, appears to be too harmonious and too narrow.
- It argues that a nurse's own vulnerability can be a constructive element in patient care and that there is potential for professional development if nurses are able to recognize their own vulnerability.

strength. We need a discussion of professional ideals and we need to look critically at how collegial relationships may contribute to narrow understandings of these ideals.

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III

Rejection – a neglected phenomenon in psychiatric nursing

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Rejection – a neglected phenomenon in psychiatric nursing

The basically asymmetric character of the 'psychotic patient–psychiatric nurse' relationship constitutes an ethical challenge for the nurse. One aspect of this relationship is that nurses must constantly self-consciously control their behaviour towards the patient. There is some evidence that the patient sometimes feels offended because of his perception that the nurse rejects him. The purpose of this article is to examine the role rejection plays in the 'psychotic patient–psychiatric nurse' relationship and ethical implications this might have for the field of psychiatric nursing. This study is conducted using an ethnographic research design that includes participant observation and narrative interviews of nurses working on an acute ward of a psychiatric hospital. One case is analysed and discussed in depth through the philosophical insights (particularly 'the ethical demand') of the Danish moral philosopher K.E. Løgstrup. The psychotic patient, being vulnerable, dependent, and trusting, confronts the psychiatric nurse with a constant 'ethical demand' to take care of him. The patient's trust, and his fight to maintain his dignity, creates a risk of being rejected. The nurse, by resorting to the tactic of 'impersonal professional routine', which does not define the relationship as a personal encounter, creates boundaries between herself and the patient. The nurse's withdrawal from the patient's perception of reality is experienced by the patient as rejection and hence an offence of his dignity. The nurse's rejection of the patient has two causes: external factors – for example inadequate staffing – cause the nurse to be unable to live up to the professional ideal of 'welcoming' the patient; internal factors – for example the profession's understanding of itself – create an unclear understanding of the nurse's role and responsibilities. It is necessary to work with both the external and internal factors to improve psychiatric nursing.

Keywords: asymmetric relationships, causing offence, dignity, ethical demand, rejection, the psychotic patient–psychiatric nurse relationship

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Introduction

Psychiatric nursing and ethics – introductory remarks

The chief aim of psychiatric nursing is to provide care for psychiatric patients, and the therapeutic nurse–patient relationship provides such a setting. Like all other relationships of care, however, the psychiatric nurse–patient relationship is basically asymmetric. The patient needs care and the nurse is expected to provide it. The fundamentally asymmetric character of the relationship constitutes an ethical challenge the nurse has to cope with. Part of this relationship is that nurses must constantly self-consciously control their behaviour towards the patients from a moral point of view: what is good and right, and what is not?

Focus and background of the article

In this article we are going to present a case illustrating a situation in which the phenomenon of a patient suffering from psychosis is rejected by the nurse. The case is intended as the starting point of a discussion of rejection as an ethically relevant phenomenon in psychiatric nursing.

To be psychotic means to more or less lose the ground under one's feet. Patients suffering from psychosis perceive a bottomless pit before them. This leads to mistrust towards their surroundings (Haugsgjerd 1990, Monsen 1990, Vetlesen 2001). Accordingly, it is quite a challenge for patients suffering from psychosis to trust nurses and the patients are especially sensitive to signs of rejection. There is evidence (Müller & Poggenpoel 1996, Hem 2000) that patients might be offended because they feel rejected by the nurses during their stay in a psychiatric ward. This means that psychiatric nurses need to be made aware of the implications of this to one of their main professional assets – the use of one's own person as a therapeutic tool. Nurses must carefully consider how they can achieve this and in order to avoid patients feeling rejected. How should they behave? What should they say and what not?

This article attempts to shed light upon the complex phenomenon of rejection in the nurse–patient relationship, mainly using insights from the Danish moral philosopher Løgstrup. He contends that to care for others is the primary ethical demand in human life. Løgstrup's concept of 'the ethical demand' (Løgstrup 1956/1997) will be employed both in order to render a general introduction into the role rejection plays in the field of psychiatric nursing and in order to analyse and discuss the case presented.

Literature review

Nurse–patient relationship – a central idea in psychiatric nursing

Many clinicians and researchers emphasize the importance of establishing a nurse–patient relationship in which nurses use themselves as therapeutic tools. Influential researchers as Mereness & Taylor (1982), Peplau (1992), Porter (1992) and Stuart & Sundeen (1991) have all focused the importance of interpersonal processes and therapeutic interaction in psychiatric nursing. The concrete aims of the nurse–patient relationship are, as Gallop et al. (1990) point out, to explore and become familiar with the patient's own understanding of her/his present situation and the past, and to contribute to the patient's well-being and personal growth (Peplau 1992, Müller & Poggenpoel 1996). Furthermore, a functioning nurse–patient relationship is considered a necessary condition for providing care, which is

looked upon as the very essence of nursing (Schafer 1997, p. 206).

The literature on psychiatric nursing is very concerned, as well, with the abilities and qualities one should expect from a psychiatric nurse. Emrich (1989), Hellzén et al. (1995) and Lindström (1997) underline acceptance, affirmation, and generosity as dominant professional qualities. Other authors emphasize the nurse's ability to show empathy and to recognize the patient's problems (e.g. Hellzén et al. 1995). In other words: the role of the psychiatric nurse has been discussed in terms of relationships, understanding, attitudes, as well as feelings. What do we know about the relationship from the patient's perspective?

Nurse–patient relationship from the point of view of the patient

Many empirical studies have investigated how and to what degree psychiatric nurses attain the normative principles and professional ideals like those mentioned above. For instance, several studies have focussed on how patients have experienced psychiatric nursing. Patients have reported that their psychiatric nurses have been friendly, but that the patients understood this friendliness more as an impersonal social attitude than as a sign of personal commitment related to the therapeutic relationship (Müller & Poggenpoel 1996). Patients feel offended because of the nurses' abuse of power, use of constraint, and lack of support. Patients often have the impression that nurses are vague, distant, and neither physically nor emotionally available when they need them (ibid.). Patients tend to feel lonely in the ward (Lepola & Vanhanen 1997, Lindström 1997) and to develop the feeling of not belonging to the community in the ward (Pejlert et al. 1995). Accordingly, patients are appreciative of nurses who are available, who listen, who are friendly, tolerant, and who show respect (Beech & Norman 1995). Others mention the nurse's capacity to show empathy (Cleary & Edwards 1999) and willingness to understand the patient (Hellzén et al. 1995).

To sum up this brief review of literature dealing with psychiatric nursing, one of the characteristic traits of the field appears to be the discrepancy between ideals and normative concepts on the one hand – which obviously also guide the nurses' orientations and conception of themselves – and the actual practice of nursing on the other hand – which is far from living up to these ideals.

Trust is considered as an essential condition in the care for psychotic patients. However, patients experience mistrust and rejection. The empirical material will be presented by a case study exemplifying the phenomenon of rejection. The case study will demonstrate trust as a basic precondition of human relationship and explain conse-

quences of abused trust. Firstly, we will explain the theoretical underpinnings for the analysis of the case.

Løgstrup's 'ethical demand' and the role of trust in human relationships

Løgstrup's idea in moral philosophy was to work out an alternative form of ethics that does not build on 'the misconception of the human being as sovereign' (Fink & MacIntyre 1997, p. xxiv) as the predominant ethical theories do. In other words, a form of ethics that does not view the individual as autonomous and independent (Løgstrup 1956/1997). Like many other moral philosophers, Løgstrup develops his ethical theory from everyday experience. Through a careful phenomenological approach he tries to create 'a more elaborate presentation of an alternative understanding of interpersonal life' (Fink & MacIntyre 1997, p. xxiii). One of his major analytical concerns is to find out how basic human principles like, for example, trust appear and function in actual life (Fink & MacIntyre 1997, Christoffersen 1999). In fact it is trust which plays a central role in his argumentation.

'It is a characteristic of human life that we normally encounter one another with natural trust', Løgstrup says (Løgstrup 1956/1997, p. 8). Moreover, he contends that all human interaction involves or presupposes basic trust. 'To trust means to expose oneself and thus to run the risk of being rejected' (Løgstrup 1956/1997, p. 17). Abused trust causes mistrust. These notions lead us deeper into Løgstrup's idea of what the basic character of trust is supposed to be and how it functions in human relationships: in every personal encounter we are confronted with an unspoken demand to take care of what is given to us:

> A person never has something to do with another person without also having some degree of control over him or her. It may be a very small matter, involving only a passing mood, a dampening or quickening of spirit, a deepening or removal of some dislike. But it may also be a matter of tremendous scope, such as can determine if the life of the other flourishes or not. (Løgstrup 1956/1997, pp. 15–16)

A bit further on, Løgstrup makes even clearer what he means by 'having some degree of control':

> By our very attitude to one another we help to shape one another's world. By our attitude to the other person we help to determine the scope and hue of his or her world; we make it large or small, bright or drab, rich or dull, threatening or secure. (Løgstrup 1956/1997, p. 18)

In other words: This is how power and control come to play an important role in human relationships. It is 'the ethical demand' originating from the principle of basic trust that leads Løgstrup to the assumption that in some ways the individual is not autonomous and independent.

Løgstrup does not define the substance of the demand. As the demand is silent or unspoken, the individual to whom the demand is directed must 'in each concrete relationship decide what the content of the demand is' (Løgstrup 1956/1997, p. 22). Løgstrup does not say anything about how caring is to be accomplished; everybody has to find out by using his or her imagination, insight, and knowledge (*ibid*., p. 22, 44).

Sample and methodology

Below we will draw on a larger empirical study of a medium-sized Norwegian psychiatric hospital in the autumn of 1999 (Hem 2000). In accordance with the accepted ethical rules for medical and health research (Kvale 1995, Hammersley & Atkinson 1996, Henriksson & Månsson 1996, Engelstad *et al.* 1998, Solbakk 1998) we received permission from the hospital administration, the relevant ward and all nurses and patients. We accompanied six nurses, observing many of the tasks they carried out. We focused especially on how they interacted with the patients. The data created through participant observation (Wadel 1991, Hansen 1995, Olsen 1995, Savage 1995, Dahlgren 1996, Hammersley & Atkinson 1996, Henriksson & Månsson 1996, Solberg 1996, Heggen & Fjell 1998) were supplemented and validated and given added depth (Holstein 1995, Kvale 1995, Fog 1996, Svensson 1996, Holm 1998) by data from narrative interviews (Ramhøj 1993, Knizek 1998) with the six nurses. The narrative interviews were audiotaped and transcribed (verbatim). The field notes describe what nurses actually did in their interaction with patients, while the interviews record the nurses' personal understanding of their work.

Field notes and narrative interviews were used to create a number of case descriptions illustrating the nurses' experiences from situations in which they took responsibility for psychotic patients, from situations in which they established and maintained contact with the patients, or from situations in which they had to tackle rejection. Each case was examined in detail and classified in categories reflecting the tensions, fine distinctions, and the contradictions inherent in the material. One particular case was of special interest because we believe it has great potential for deepening our understanding of rejection.

The case – 'I'm a human being'

Ann is sitting on the sofa in the common-room of the ward. She laughs all the time. All of a sudden she starts to howl. Elisabeth, the nurse in charge, suggests that the two of

them retire to Ann's room. Elisabeth sits on Ann's bed, while Ann chooses a chair. They are seated exactly opposite each other at about half a meter apart. Ann at once starts to talk about her family, especially her two sisters, with whom she has some contact. She complains about her sisters always stigmatizing her as a psychiatric case. 'But I'm a human being', she adds and goes on criticizing her sisters for never coming to her when they are in trouble. 'It's always me having to ask them for help. I'm so fed-up with all this!' She goes on to repeat the story about a video recorder being implanted in her brain. The camera records her thoughts, which are broadcast in a way that enables her fellow patients and the personnel in the ward to watch them. This is why everybody knows everything about her. 'I get lost in myself', she cries out, adding that she feels exposed and naked: 'I don't trust anyone! I don't trust anyone of you working here! You guys know everything about me. You have exposed me!' Elisabeth answers: 'It looks as if you are very desperate'.

They go on talking about a meeting later the same day, which Ann, her sisters, her psychologist, and Elisabeth are supposed to attend. Ann asks Elisabeth about the reason this meeting was arranged. 'We need information about you. We don't think we know enough', Elisabeth replies. Ann doesn't want to attend the meeting. 'I'm so influenced by everything and from everywhere', she says swinging her arms. 'Everything is so chaotic! It's chaos inside me! I get lost! I might as well die! Shoot me!' Elisabeth answers that she is very much aware that these experiences are real for Ann, 'but we don't experience things this way'. She assures Ann that 'You are not going to die!' She suggests that Ann make a note of important things she wants dealt with during the meeting. Elisabeth also says that she understands that Ann is in a very difficult situation, and that 'our aim is to help you, and we are sure we can help you'. She asks: 'What can we do for you now?' Ann turns away slightly, looks down and replies: 'I don't know. I have no idea how you can help me'.

Analysis of the case

We are now going to interpret the case presented above as an example of how nurses can reject patients. We will employ Løgstrup's concepts and categories while doing this.

Vulnerable and confident

The starting point is a common situation between nurses and patients without a shared interactive focus or purpose. At first Ann sits in the sofa laughing. She then disrupts the situation by howling. The disruption may be unintended, the laughter, and then the howling being a spontaneous

expression of mental torment and suffering. An alternative interpretation is that Ann wants to attract the nurse's attention by laughing. If not successful she starts howling, and this is the first deliberate step towards changing the setting.

The nurse in charge intervenes. She uses her institutional power to tackle the disturbance by creating a new setting, Ann's room, with only Ann and Elisabeth present. It is an intimate situation which encourages and even invites a personal encounter and confidentiality, irrespective of who brought it about – the patient or the nurse or both of them.

Ann perceives the situation as a private one and at once starts to expose herself, revealing her inner thoughts and feelings in quite direct way: 'I get lost in myself', 'I'm so fed up with all this', 'Everything is so chaotic', 'I'm so influenced by everything and from everywhere'. She is suffering from utter despair, chaos, and vulnerability. In fact, her situation is extremely dramatic, chaotic and vulnerable: As her thoughts are broadcast (cf. the video recorder implanted in her brain), they do not belong to her any longer but to everybody in the ward. The result is dramatic for Ann: 'I'm so chaotic!', 'I get lost!', 'I can as well die! Shoot me!'. To put what happens between patient and nurse in Løgstrup's terms: Ann more or less hands herself over to Elisabeth. She shares her inner drama with the nurse thus establishing 'basic trust' as part of their relationship. Through this she is 'confronting her with the unspoken demand to take care of what is given to her'. Her manner of exposing herself put her, according to Løgstrup, at risk of being rejected.

Fighting for dignity

Ann's remark 'I'm a human being' is worth considering a bit closer. The statement is, in fact, ambivalent.

On the one hand, it can be understood as an act of self-assertion, with which she tries to maintain her dignity. She finds it unfair always being dependent on her sisters. She does not seem to be at ease with this unstable relationship because she gets the feeling of being degraded. She is not treated as an independent sovereign person. Quite the contrary, she is reduced to being a psychiatric case, which makes her feel offended. From this point of view, it is easy to understand her comment: 'I'm a human being'. That means: I am not a psychiatric case.

On the other hand, the statement mirrors Ann's hopeless struggle against chaos and the feeling of being lost. As such, it is directed towards the nurse as a desperate appeal for help. With regard to her existence being threatened, Ann gives the impression that she is working hard to tell Elisabeth that she is a person worthy of respect. The fact that she does not stop communicating, although she is convinced that everybody knows everything about her, might

be a sign that she does not feel completely 'lost'. She is, in fact, quite confident, because she finds it worthwhile to talk about herself. The fact that she reveals so much of her inner state of mind is not only a sign of trust, but also a way of expressing hope that Elisabeth can help her.

Rejection of the patient

Elisabeth is obviously prepared to spend some time with Ann, which she demonstrates by sitting down in Ann's room. Elisabeth is calm, she listens, and she looks at Ann. This contributes to a nice and friendly atmosphere. Her reply to the patient's outburst, 'It looks as if you are very desperate', might at first sight be understood as an expression of empathy and understanding. After all, she does not only take the patient's feelings seriously, but she also acknowledges them by interpreting the message and categorizing Ann's state of mind as desperation. In actual fact, however, she is merely proceeding according to an impersonal professional routine, although the patient might not be aware of this at once.

That Elisabeth is acting as a representative of the institution all the time and by no means defines the situation as a personal or private encounter between Ann and herself, becomes apparent – even to Ann – when they start to talk about the meeting, which is going to take place the same day: Elisabeth explains that the meeting was arranged because of the staff's need for more information about Ann. 'We don't think we know enough'. What is behind this reasoning? Doesn't the patient talk about herself all the time? A paradoxical situation has arisen – at least for the patient. Ann has offered very intimate information about herself: 'I'm so chaotic! I get lost! I get lost in myself!', and the response she receives is that the staff does not know enough about her. Seen from Elisabeth's point of view, the kind of information Ann produced is obviously not the kind of information she and the rest of the staff need. The message to Ann, however, is that she is not competent to produce necessary information about herself. The whole episode – rendered in Løgstrup's terms – can be understood as an incidence of rejected trust.

Elisabeth uses 'we' and 'our' instead of 'I' and 'my' to refer to herself signalling by this that the relationship between her and the patient is not a personal one: 'but we don't experience things this way'. By this statement she creates a boundary between herself and the patient. The message is more or less that 'This is your reality; our reality is different'. She withdraws from the patient's way of experiencing the world and in doing so implies negative conclusions about the patient's reality and avoids going more deeply into it. She behaves as an agent of the institution, acting solely on behalf of the 'patient treatment plan' of the ward. She does not take into account Ann's specific needs and problems. She does not 'take care of what is given to her'.

In the end when Elisabeth asks 'What can we do for you now?' Ann's answer is 'I have no idea in what way you can help me'. This can be interpreted as the result of the process going on between them. Ann's answer is an obvious sign of resignation, a kind of verbal withdrawal. Showing resignation is her way of expressing the experience of abused or rejected trust. Ann supplements her verbal withdrawal with body language, slightly turning away and looking down. We take this as a sign of shame accompanying her resignation. When revealing how she feels Ann makes herself vulnerable. She is ashamed when realizing that her feelings are not taken seriously. It might as well be that she is ashamed by the fact that she understands herself as a person who is impossible to help. Realizing that she is rejected, the feeling of shame is even worse.

Discussion

We know that the situation described is a typical incident in nurse–patient relationships. What at first sight seems to be a friendly encounter between nurse and patient, or a friendly approach to the patient, turns out to be an incidence of rejection when one looks more closely.

In the discussion we will take a closer look at the therapeutic 'misuse' of oneself as a nurse and the factors hindering the nurse in using herself as a tool in constructive manner.

The psychiatric nurse and 'the patient in her hands'

Elisabeth is invited to join Ann in her world and to share her experiences. Elisabeth, however, does not seem to be able to understand Ann's behaviour as an invitation. According to Løgstrup (1956/1997) she is not able to decide what the content of the demand is. In order to understand the patient's message, the nurse should have used her imagination, insight, and knowledge (ibid.). In the case of this patient the nurse gets much information about the patient's feelings and thoughts. If she had acknowledged the importance of Løgstrup's 'ethical demand', she would have had to inquire into the patient's underlying needs and motives and – in order to accomplish this – she would have had to use her imagination, insight, and knowledge. Furthermore, in order to create trust, the nurse must be able to show empathy, compassion, understanding, acknowledgement and affirmation. To accomplish this Elisabeth would have had to go beyond an attitude of 'friendly distance' (Müller & Poggenpoel 1996). The ability transcend this attitude is, in our view, exactly what is meant by the notion of 'the therapeutic use of oneself' (Mereness &

Taylor 1982, Stuart & Sundeen 1991, Peplau 1992, Porter 1992). There are, in fact, some striking parallels between Løgstrup's concept of 'the ethical demand' and the concept of 'the therapeutic use of oneself'.

Benedetti (1974) claims that patients appreciate professional helpers who try to understand them and who make an effort to find out what is the matter with them. Perhaps nurses do not always live up to these expectations. Nevertheless they should, as Benedetti (ibid.) stresses, demonstrate that they are willing to and to make every effort to commit themselves. In fact, just by demonstrating the will and effort to commit themselves, nurses can make a deep impression on patients (ibid.). One way of bringing about this effect is to invite the patient to talk, for instance. A conversation might enable nurse and patient to approach one another or even arrive at a common understanding of the patient's situation. This process could contribute to the patients' ability to understand themselves. Psychotic ideas, like Ann's notion of the video recorder, have a symbolic meaning (Benedetti 1974, Monsen 1990), and should be understood and accepted as a way of communicating.

In our view, it is exactly this that is behind the need expressed by the patients (Beech & Norman 1995, Hellzén *et al.* 1995, Cleary & Edwards 1999) – that nurse and patient make a common effort to try to understand the essence of the patient's situation. We guess that this is what Elisabeth actually has in mind. The importance of 'confirming the patient's feeling' or of 'taking patients' feelings seriously' is part of her professional knowledge. Why didn't she live up to these ideals? A key word for the further discussion is the so called professional distance.

The complicated professional distance

Professional distance is a key concept in the discussion of the relationship between nurse and patient. It is a topic, which is debated from a variety of perspectives. One of which is Foucault's (1965/1988) philosophical and historical analysis about the birth of modern medicine and the shifting attitudes towards those designated as insane, or how modern society have created a distance between being 'normal' and insane. The power knowledge relationship, creating a distance between those who suffer from mental illness and the experts, is also illuminated by influential researchers as Latour (1987). The concept of professional distance in nursing was, also, discussed as early as in the 1960s. Based on an empirical study of the nursing service of a general hospital, Menzies (1960) showed how nurses developed techniques to help them to separate the relationship between nurses and patients and to allow them to distance themselves from the suffering patients. This demonstrates that a variety of research questions and disciplines have relevance for the concept professional distance between nurse and patients. In this paper we will continue to use the case as an example and use our chosen theoretical underpinnings to illustrate and discuss some aspects of the problem of professional distance. How is the problem revealed in the relationship between the nurse and the patient?

First of all, the nurse's use of a kind of standard professional language in her statement 'It looks as if you are very desperate'. Secondly, this utterance is employed in a context in which she actually rejects the patient in a more direct way, that is, she tries to make the patient aware of their different perceptions of reality: 'We don't experience things this way'. She distinguishes between the patient's reality and the 'real' or 'normal' reality. There are situations between nurses and patients, when this distinction is of great importance in helping patients towards a better orientation, that is, to understand the difference between the patient's inner private world and the reality the patient shares with the nurse. Elisabeth, however, withdraws from the patient's reality, establishing a manifest partition between the normal world and Ann's world. Ann's reality is not taken seriously. The effect is rejection. Elisabeth has resorted to her institutional power over Ann and over the situation to define what is real and what is not, to define what is true and what is not. To employ definition power means to reject patients.

Alternatively, it is important to mention that distance also can be used to secure the patient's dignity. It might be that the patient's unveiled expressions can create indignity. Or it might be that the nurse, if she confirms the patient's inner understanding and feelings, is running the risk of increasing the patient's despair and hence make his/her psychosis even worse. In letting the patient loose his/her 'normal' reality, the nurse might create an unworthy situation for the patient. The nurses might try to maintain the patients' dignity by creating a distance to the patients' reality. Lawler's (1991) study of nurses caring for patients in hospitals shows that nurses deliberately create distance, for instance in the way they use their body, in order to keep up dignity in intimate and fragile care situations. Undoubtedly, there are situations when nurses care for psychotic patients, in which dignity is maintained by creating distance between the patient and her/his fellow patient. Patients exposing themselves sexually are one example where protection and separation of patients are necessary in order to restore the patients' dignity. In the presented case study we argue that it is reasonable to interpret that the lack of acknowledgement of the perspective of patient's world is a rejection. There is no lack of dignity in the way the patient acts; however, there is lack of dignity in the way the nurse behaves.

There may, obviously, also be rejection for a third reason: a simple personal dislike. One can not take for granted that the patient–nurse relationship will be a mutual, sincere, attached, and honest one. The personal chemistry and establishing the same wavelength can simply be too difficult.

Conclusion and outlook

In the closing chapter we are going to mention some principal aspects of psychiatric nursing, which emerge from the analysis and the discussion above.

To begin with, we want to draw the reader's attention to the discrepancy between the ideals of psychiatric nursing and its actual practice in the wards. It is very common for psychiatric nurses to experience frustration because they do not manage to realize their professional ideals. Nurses point out many reasons for this discrepancy:

1. lack of time for each individual patient, because the nurses are responsible for too many patients with complex problems at the same time;
2. lack of motivation because of insufficient recognition of the value of their work by their superiors; and
3. exhaustion because of conflicts with colleagues from other professions.

In their daily work psychiatric nurses have to cope with an insurmountable ethical dilemma arising from their working conditions. Ruyter & Vetlesen (2001, p. 19) illustrate this dilemma with a line from one of Bob Dylan's songs: 'What good am I, if I know and don't do, if I see and don't say'. The nurses' awareness of what is good in the relationships with patients without being able to practise it, is one of the major challenges in today's psychiatric nursing.

The second aspect we would like to point out in our closing remarks is of even greater importance with regard to the ethical problems and dilemmas involved. This is an aspect touching the very substance of psychiatric nursing, its professional aims. To illustrate the point at issue, let's return to Bob Dylan: What if nurses, those responsible for their education and also those who are responsible for the literature used in instruction, 'do not know' and 'do not see' enough of what should be known and seen? The case presented in this article raises questions that have to do with the professional identity of psychiatric nursing. What should the special competence of the psychiatric nurse be like? What does it actually mean to use oneself as a therapeutic tool? How does it affect the patient and the nurse–patient relationship when the nurse tries to tidy up in the patient's picture of reality? These are serious questions. The appropriate answers could improve the theoretical and practical basis of the field considerably and thus contribute to the quality of care in psychiatric wards. Moreover, improving the quality of care should be looked upon as an ethical demand on the psychiatric nursing profession.

Acknowledgements

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IV

"Only a Manic Depressive!"

The Zone of the Untouchable and Exceeding Limits in Acute Psychiatric Care

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ABSTRACT

The article addresses psychotic patients' fragile boundaries and need for professional help to restore their personal untouchable zone. We examine how nurses move into this inviolable zone and re-establish limits. The theoretical perspective stems from the Danish theologian and philosopher K. E. Løgstrup's concept of our "zone of the untouchable". Interpreted in the light of Løgstrup's thought, the empirical data are drawn from an acute psychiatric setting and focus on one patient in different situations and on her relationships with nurses. The material also contains data from the nurses' discussions and the researcher's experience. The analysis shows how and with which critical and constructive consequences the diagnosis-oriented understanding affects the relationship between patient and nurse, and concludes with clinical recommendations about the premises that should be used when nurses move into the patient's untouchable zone.

Keywords: zone of the untouchable, setting limits, psychotic patients, psychiatric nurses, acute psychiatry

INTRODUCTION

Acute psychiatric care involves limits in several ways. Psychotic patients who are admitted to an acute psychiatric department have fragile boundaries that are easily breached. These can be seen through the patients' painful lack of clarity in their understanding of who they themselves are and who others are. Crossing the boundaries of cultural and social norms for what it is permitted to say and do often creates problems for psychotic persons and their surroundings. Limit-setting measures are both important and difficult when caring for these patients. Although they may experience as necessary and reassuring the limits intended to help them regain their self-control, the opposite may also be the case; they may perceive attempts to impose limits as an invasion of their zone of the untouchable and as an offense against their integrity.

In our daily contact with each other we all have an intuitive understanding of where the limits between us have been set. These are "natural" limits that help preserve respect and integrity. We readily accept each other's social camouflage – or what we will define in this article as the zone of the untouchable. How is this general code of behavior put into effect in professional therapeutic care? How can and should nurses use their professional skills to restore the patient's unstable boundaries? How is setting and exceeding limits perceived by the involved parties? These are questions this article will clarify.

We will present and analyze part of a larger body of empirical material from a locked

ward in an acute psychiatric department in a city in Norway.[i] Patients on the ward

have often been involuntarily hospitalized. Our point of departure is the experience

of a young woman who has been committed to such a ward. We have combined data

from various situations and positions; data from interviews with the patient are

viewed in connection with observations of daily life on the ward and with data

retrieved from discussions about the patient between nurses and other staff. We also

bring in the researcher's own experience of relating to the young psychotic woman.

When interpreting the material we use the Danish theologian and philosopher

Løgstrup's (1997a) concept of what he calls "the zone of the untouchable." We start

with this inviolable zone.

THEORETICAL FRAMEWORK

The zone of the untouchable[ii]

Much of the literary work of Knut Ejler Løgstrup (1905-1981) was dedicated to

analyzing the basic features or conditions of human co-existence (1997, 1997a). He

uses the concept of "the zone of the untouchable" to express the phenomenon that

everybody has the need to impose a protective limit between themselves and their

surroundings (Løgstrup, 1997a, p. 176). However, this does not represent a

permanent filter that is intended to hold the surroundings out or be an innate

protection against invasion. On the contrary, he wants to describe human

vulnerability. Respect and awareness of each other's inviolability is crucial for preserving integrity. Løgstrup (ibid.) refers to this respectful reluctance to lay bare others' motives as "spiritual modesty." It is this modesty that prevents others from feeling mentally invaded. Løgstrup (ibid.) points out that there are no simple rules for how we should conduct ourselves in connection with the zone of the untouchable. It is a matter of discretion and sensitivity in both everyday life and professional work.

Descriptions of the zone of the untouchable can also be drawn from other perspectives and by using other concepts. For example, the dilemma concerning closeness – the distance in the relationship between patient and nurse/therapist – is described in detail in psychiatric literature. Our view is that Løgstrup's philosophy can form the basis of a more critical and constructive understanding of creating boundaries between the patient and the nurse. We have also been inspired by Svein Aage Christoffersen's (2005) perception of professional ethics. In his approach to professional ethics Christoffersen tests Løgstrup's philosophy of the zone of the untouchable. In everyday life this is a matter of setting limits for ourselves and between each other. According to Christoffersen (ibid.), this becomes a significant issue in professional ethics and he raises the question of what happens to these limits when we encounter them in a professional context (ibid., p. 87).

No definition of the zone of the untouchable can be found in Løgstrup's own work, but he described situations that clarify the issue of limits in interpersonal relationships. His approach to the phenomenon of the zone of the untouchable was

based on the question of how professionals, by virtue of their role and their

knowledge, can show opposition to a person they are there to serve without

becoming authoritarian. For Løgstrup the answer is just as simple as it is

complicated: keep to the matter at hand. This requires distinguishing between

motives and reasons.

Motives and reasons

The analytical approach Løgstrup takes to shed light on the phenomenon of the zone

of the untouchable is to make a distinction between motives and reasons in personal

interaction. Communicating with others requires us to accept this distinction.

Objectivity in interpersonal relations is safeguarded by our consideration of each

other's reasons, i.e., we focus on what we explicitly perceive as the substance of the

interaction rather than on any ulterior motives we think the other person(s) may have.

In return we expect others to show consideration for what we say and do.

Let us imagine a discussion among nurses in which one of them has a tendency to

dominate each meeting with her arguments and interests. Maybe she has an irritating

inclination to make sure that she always has the last word and is always the one who

says most about all the patients. Coping objectively with this situation involves

entering into a dialogue about her arguments rather than attacking the possible

motive of an exaggerated need to draw attention to herself or to take herself too

seriously. If such possible motives are brought up, it is highly probable that the

discussion will break down. She may attack others and say that it is their regrettable

feeling of inferiority that is the problem. She will most likely also feel exposed and hurt. Consideration for the effect that defining motives may have on the other person makes us refrain from addressing these motives. We set limits out of respect for the other person. Løgstrup's point is that (almost) everybody has an intuitive sense of the limits between motives and reasons and that in general we do not attempt to discuss each other's motives. However, now and then we do – in situations where there is a need to "clear the air" and to talk about one's own and others' motives openly and intimately. We do not do this to gain control over the person in question but out of trust and mutual respect.

Løgstrup claims that moving from reasons to motives constitutes stepping into the zone of the untouchable, thus rendering the other person defenseless. It is the sense of the other's vulnerability that makes us reluctant to involve ourselves in his or her motives. However, the zone of the untouchable must not be read as a normative concept that encourages superficiality and purely objective discussion about reasons in interpersonal relationships. He emphasizes that motives play a critically important role and govern social relations. Likewise Løgstrup stresses that we may well have poor motives but good reasons. The dominating nurse may have a poor motive but may equally well have good arguments in her discussions about patients. However, the opposite can also be the case; the motive of acting in the interests of a patient may be the best, but the argumentation may falter. The most important point Løgstrup makes is that the distinction between reasons and motives makes it possible for us to keep to the matter at hand and to maintain communication with others.

Things are often different in psychiatric treatment and care; here the motives

constitute the matter at hand.

<center>Being in the power of sick motives</center>

Løgstrup (1997a, p. 179) claims that the mentally ill have come under the power of

sick motives since their control over their personal thoughts and actions has failed.

The illness propels the motives to the forefront, and it is the motives that are to be

diagnosed and treated. We will not discuss Løgstrup's understanding of mental

illness in this article, but we will address his main point – namely that the care of

those with mental illness principally challenges our ability to handle the relationship

between reasons and motives. Encountering patients with mental illness in general,

and psychotic patients in particular, often entails taking into account more than what

emerges through action or utterance – or the fact that motives are exposed because

the boundary between motives and reasons is disintegrating.

The key concept in encounters with people with or without mental illness is keeping

to the matter at hand. How does this affect psychiatric care? Løgstrup emphasizes

that first and foremost it is "professional knowledge" (ibid., p. 180) that ensures this

is done and that enables the person's integrity to be respected and protected. He

claims that respect for the zone of the untouchable consists of objective treatment

and that it helps prevent or hinders – or at least reduces – the possibility that

openness can acquire the nature of exposure and embarrassment (ibid., p. 180). The

principle is obviously easy to support. In psychiatry it is the individual's power of

judgment and professional discernment that decides when it is right to mention a patient's motives and when it is wrong to address them (ibid., p. 178; Martinsen, 1996). What problems do nurses encounter in their attempts to comply with the demands of objectivity in their contact with the psychotic patient's motives?

Løgstrup gives us another clue to help us understand the problem of setting limits for oneself and others. This is associated with the expression "mental reserves." Most of us have a good grip on ourselves and possess extra reserves or capacity that can, for example, control anger, aggression or laughter. We can usually appeal to the other's mental reserves, and the person concerned is able to draw on these, thus avoiding humiliation to him/herself and creating awkwardness for others. Being exposed to others' lack of mental reserves can be an obtrusive and embarrassing experience. Christoffersen (2005, p. 93) describes it as there no longer being anything that can mediate and thus alleviate the relationship in question, nothing more that it is possible to take into account. Psychotic suffering and anxiety may result in a loss of mental reserves, often shown by uncontrolled outbursts of aggression. The nurse's challenge is to look after the patient even though there are no mental reserves to appeal to.

Before we meet a patient who is struggling to create boundaries for herself we will present relevant research from psychiatry that will to some extent be used in the discussion. We will also explain the principles of methodology and research ethics that have been applied in the collection of data.

LITERATURE REVIEW

The literature review shows that the problem of setting limits in psychiatry has attracted considerable attention. It is discussed both as a principle (for example the use of coercion) in the treatment of ill individuals and as specific experience viewed from the standpoint of both staff and patients. Clear limits are imposed on psychotic patients through the use of involuntary admissions, seclusion, restrictions in everyday life, medication, and making diagnoses. Research describes and discusses the question of the professional legitimization and empirical experience of the various measures that address the issue of the balance between closeness and distance and between the constructive and destructive potential of power (for example in Pam, 1994; Lendemeiler & Shortridge-Baggett, 1997; Quirk & Lelliott, 2001; Bowers, Simpson & Alexander, 2003; Hall, 2004; Lelliott & Quirk, 2004; Bowers 2005).

There are also interesting studies from psychiatric settings where the issue of limits is discussed more fundamentally and critically in relation to power. Bowers (2005) argues that it is absolutely necessary to set limits in acute psychiatric care, while others address the problem of the "dual mandate" inherent in creating social control while also having a therapeutic objective (Hall, 2004; Watts & Priebe, 2002). The possibility of coercion as a principle viewed as producing positive effects is discussed critically by Monahan et al. (1995) and by Nicholson, Ekenstam & Norwood (1996). Pam (1994) and Sharrock & Rickard (2002) stress that the

theoretical foundation for setting limits is insufficiently documented and that little literature can therefore be found on the topic. Leifer (2001) claims that the medicalization of people's thoughts, actions, and behavior functions as a form of hidden social control, and that the medical model's perception of illness leads to the use of coercion and limits in acute psychiatry. From the patient's perspective, the manner in which the limits are imposed and how care and power are generally exercised is decisive. According to Thomas, Shattell & Martin (2002), admission to an acute psychiatric department should ideally be experienced as help; patients express their wish for help to understand themselves and their problems (ibid.). Instead, admission is an experience some patients would prefer to forget (Fagin, 2001).

Thomas, Shattell & Martin (2002, p. 105) found that psychotic patients want a "deeper connection" with the staff, and the study conducted by Koivisto, Janhonen & Väisänen (2004, p. 273) demonstrates that care did not reach the "inner world" of psychotic patients. Other studies reveal that patients appreciate nurses who show respect, empathy, and tolerance, and who spend time with them and are available (Beech & Norman, 1995; Cleary & Edwards, 1999; Hellzén, Norberg & Sandman, 1995; Wallace, Robertson, Millar & Frisch, 1999; Lelliott & Quirk, 2004). These studies appear to show that patients want a greater degree of closeness to nurses (Hem & Heggen, 2004). This is an interesting point and refers to the controversial theme of the demarcation between closeness and distance in psychiatric nursing care (as well as in professional relief work in general). Attaining the correct balance

between closeness and distance is presented as a basic professional ideal (Hem & Heggen, 2003). The risk of losing this balance can tilt the situation toward either problematic closeness or problematic distance. Closeness is a problem when the boundaries between patient and nurse are jeopardized and the patient feels invaded and emotionally confused. Nurses/therapists can also lose their own limits and be rendered unable to recognize the boundary between their own and the patient's zone of the untouchable. Distance is the opposite problem and is usually linked to misunderstood superficiality where the patient may feel that they have been treated indifferently and rejected – a problem that is often associated with regarding the patient primarily as a diagnosis. This traditional interpretation definitely has some validity, but in our view Løgstrup's analytical tool can provide a more critical and constructive approach to the problem of setting and exceeding limits.

RESEARCH METHOD AND RESEARCH ETHICS

We were granted a recommendation to conduct the project from the Regional Committee for Medical Research Ethics, and also received an acknowledgement for the obligation to report from the ombudsman for privacy in research/Norwegian Social Science Data Services. Key principles of research ethics such as informed consent, the right to privacy, respect for personal integrity, avoiding exploitation and harm (Declaration of Helsinki, 2004; Roberts, 1998; Roberts & Roberts, 1999) were very carefully assessed throughout the research process. We came across challenging issues regarding how we should resolve the requirement for informed consent from

psychotic patients – a topic we have discussed in detail in another article (Hem, Heggen & Ruyter, 2007). Both the hospital and the ward in question wanted the project to be carried out. The main author planned the practical procedure with the employees who were to be involved in the project in one way or another. The participants were given written and verbal information about the project. The patients and nurses who were interviewed, and the nurses in whose company MHH spent her time on the ward, signed the consent form. To safeguard anonymity, the names of patients and staff in the article have been changed and situations have been paraphrased – without, however, changing their special features.

The study has an ethnographic design. The data material was collected over 30 weeks in autumn 2003/spring 2004 and consists of 343 pages (single-line spacing) of field notes from participant observation (213 hours), and from transcribed interviews with five patients (six hours) and six nurses (group interviews in groups of three: six hours).

In the process of collecting data and analyzing material I became increasingly preoccupied with the phenomenon of limits. This is not surprising since the professional understanding in the field mainly concerns psychotic patients' problems with their own limits, and as a result the setting of limits is an evident therapeutic measure. There are three reasons for the decision to focus on the patient called Maria. First, there were considerable data about her: she was hospitalized for some time and I met her in many different situations, she decided to let me interview her,

and she was often discussed at team meetings and more informally among the nurses at their station. The second reason is that the subject of limits is found extensively in the material – for instance we have data about feelings of degradation when limits are set, about power battles with the staff about the limits issue, and about the staff's focus on the setting of limits as one of the most important therapeutic measures. The third reason for choosing this patient is linked to the fact that she challenged me as a researcher. She was young, intelligent, articulate, and well-educated, which made it easy for me to agree with her when she criticized the way she was treated. For example I could find myself agreeing with her complaints that the staff were far too strict, and I understood very well that she regarded all the decisions, rules and routines more as punishment and provocation than as help. She quite simply intensified my critical view of power in psychiatry. At other times I found her extremely demanding, and I saw – and partly experienced myself – that it was difficult to help her. Nothing was good enough; she diminished both my own value and that of others, and she protested violently against limits. I often also heard the nurses discuss how challenging they thought it was to deal with her. Based on my clinical experience with similar patients I was therefore often struck by how obviously necessary and right the various limit-setting measures were for Maria. However, I gradually discovered how ambivalent and uncertain I felt. One significant explanation for my being able to recognize these feelings was that rather than being an invisible researcher I formed part of the field I was studying (Letherby, 2000). I was *there*, I influenced the field, and I was affected by what happened (Angrosino & May de Pérez, 2003; Engelsrud, 2005; Fontana & Frey, 2003; Rapley, 2001). This

particular researcher role was the result of a proactive choice – but it was not without

its difficulties. I asked myself many times what standpoint I should and could take

(Tedlock, 2003). Assuming the perspective of Maria (and other patients) at the

expense of loyalty to my own occupational group seemed difficult, and it appeared

just as impossible to argue unilaterally for the nurses' professionalism. With time the

discovery of this dilemma developed into an analytical trail that we illuminated with

the help of both Løgstrup's (1997a) concepts (the zone of the untouchable, motives,

and reasons) and a thorough analysis of the obvious contrasts in the empirical data

(Fontana & Frey, 2003). The purpose was to highlight different aspects of the

dilemma so that we would avoid direct criticism or an unconsidered defense of

psychiatry.

Part of the work performed on analysis was centered on a collaboration between the

three authors based on the data about Maria. We read and discussed the material as a

whole, studied parts in detail, and put some parts in correlation with others before

comparing them with the overall impression. The writing process was also vital when

developing the analysis (Richardson, 2003). This took place by our sending each

other a written draft of the analysis for critical comments, elaboration, and

identification of the finer points. We studied carefully how, and about what, the

nurses and the patient talked during the interviews, and compared this with the field

observations. We endeavored to highlight the researcher as the joint creator of

meaning in the process (Ellis & Bochner, 2003; Fontana & Frey, 2003; Rapley,

2001). We concentrated on contrasts (Fontana & Frey, 2003) – for instance, we saw

that the patient and the nurses had somewhat different views of "reality"; the patient

felt she was misunderstood and subject to strict treatment while the nurses

emphasized the importance of clear and consistent limits. This mismatch of opinions

as to what was really at stake is a significant feature of the field. In addition we

focused on differences in relationships and communication between the patient and

the various nurses, which provided the opportunity for further study and for revealing

more subtle aspects of the professional administration of limits. We have also

exploited the fact that we are three researchers with both similar and dissimilar

theoretical and research backgrounds; in total we possess comprehensive knowledge

of the health field in general and of acute psychiatry in particular – clinically and

theoretically as well as with regard to qualitative research (Warren & Karner, 2005).

MARIA – DIAGNOSED AS HAVING BIPOLAR AFFECTIVE DISORDER[iii]

Maria was a woman in her thirties who had been involuntarily admitted due to manic

behavior. She was being treated in a locked ward for several weeks. It was her first

admission and she clearly expressed her despair over her feeling of not being in

contact with herself and her surroundings while at the same time conveying her

opinion that she was not so sick and did not need to be hospitalized. She felt she had

been "tricked" into going to the doctor by her mother to be assessed with a view to

being admitted.[iv] She thought everything was hopeless and she was very willing to be

interviewed so she could tell about her experiences. She said it was a pleasure to sit

and talk to the researcher and to be able to express herself without any suspicion being cast on what she said.

<center>"Killing flies with a bulldozer"</center>

Maria related how afraid she was. She did not really understand what had happened and why she had been admitted. She regarded being secluded in a bare room for long periods as tiresome and felt it was absurd to have her belongings confiscated and to be subject to restrictions on receiving visitors, making telephone calls and going out.[v] She found the staff's use of coercion in connection with medication very upsetting. She also understood that she was manic and that her condition had on occasions recently caused her to go a bit too far. She felt that she was not herself in the period prior to her admission: she slept little, had a high level of activity, and spent more than she usually did. According to Løgstrup (1997a, p. 179) we can say that "she had come under the power of sick motives" due to the lack of control over her thoughts and actions. However, she nonetheless felt that she had been misunderstood and that what she needed was peace, rest, and security. What she both directly and indirectly conveyed as her most radical experience was that she felt she was neither listened to nor believed. Her perception of herself and her understanding of the situation was not taken into account in the treatment. "I felt that perhaps instead of being run over by a bulldozer I could have been run over by a … yes … a small car. I'm just a fly in this system. Killing flies with a bulldozer – well, there's not much point in that, is there?"[vi]

Drawing oneself

Maria has tried to draw her life of the past few years and the drawing gives rise to

several conversations. She says herself that the drawing is intended to show the

upturns and downturns in her life and how she feels that her state of mind has

fluctuated during the last two years. The drawing has curves that go up and down,

supplemented with indications of time – for example when she was depressed –

combined with indications of external events that she linked to her state of mind.

When I asked Maria what she tried to reveal through the drawing she said that she

feels she is very much more than what she thinks she is perceived as on the ward.

"Only a manic depressive!"

The conversation in the nurses' station led us to believe that several nurses and

doctors perceived the drawing as a sign that Maria has a manic-depressive disorder.

Her family have suffered considerable mental illness, and to highlight an assumed

hereditary component in Maria's disorder the term "constitutional"[vii] is used. They

were also concerned that Maria did not view the drawing in the same way as they

did. This was presented as a further confirmation that the diagnosis of bipolar

affective disorder is correct and that she presumably lacks insight into her own

illness.

Later in the conversation the staff discussed Maria's preoccupation with the fact that

she is intelligent, can speak many languages, and has undergone higher education

and attained good grades. "Maria is concerned about building her self-confidence,"

says one of them, and several agree. They stress that this is positive, but that it is also a sign that the patient is trying to distance herself from the diagnosis and consequently from understanding that she is too ill to realize that she is ill. We interpret this as if "building self-confidence" is a confirmation that she lacks insight into her illness. In her conversation with me, Maria says how difficult she finds it not to be regarded as herself, and she does not feel that "they" understand who she really is.

During the conversation about Maria and the drawing, Mona (a nurse) argued that the drawing does not necessarily represent a confirmation of the diagnosis, and that Maria's reluctance to see herself as manic depressive is in fact a resource. However, another nurse, Christina, claims that Maria is resisting the illness-oriented interpretation of her drawing because she does not want to take the medication. Her unwillingness to take medicine and to accept that she is ill confirms the opposite: she is seriously ill and needs medication. The drawing is just one of many signs of this. At this point several of the staff add that both Maria's mother and father have said that she was behaving indiscriminately before her admission – for example she was spending a considerable amount of money, traveling extensively and using the telephone arbitrarily, repeatedly making calls to several people at night. Her mother had finally assumed the heavy burden of having her own daughter involuntarily admitted to hospital. She had expressed her great relief to the staff over the fact that Maria was to be given treatment, that the diagnosis was verified, and that she was receiving medication.

When the conversation turns to Maria's anxiety, a nurse called Susan emphasizes her impression that Maria's anxiety is of a general nature. Everyone agrees that Maria is characterized by anxiety, and the doctor maintains that general anxiety is a key feature of manic depression. Mona, Christina, and some of the other nurses support the opinion that Maria does in fact suffer from anxiety; for example, she had seemed anxious over the past few days when several new patients were admitted to the ward. They are also under the impression that Maria is reassured when the staff sit by her when she is going to sleep.

Regulating life and setting limits

At the team meeting the staff discuss which activities are suitable for Maria. They discuss rather thoroughly her opportunities to receive visitors, go out, make telephone calls, and spend time in the ward (i.e., out of her room). She has a cat she would like to be brought in to visit her. This they will consent to, but the limit for visits is still a fixed half-hour per day. She still needs seclusion. They agree that Maria must be told that it is up to her to follow the set rules. If she shows that they can rely on her she will gradually be given more time outside, more opportunity to make telephone calls, etc. They repeat this several times. They are preoccupied with making their decision as unambiguous and clear as possible since experience has shown that Maria manages to maneuver her way out of agreements and around rules. The discussion includes how they are to handle Maria's wish to watch the early-morning program on TV from 06.30. They agree that if she gets up when the

broadcast begins she can watch it until 08.00. If she gets up later than 06.30, she is still only given until 08.00 – presumably because the day starts at 08.00 with breakfast and other activities.

If we focus on the theme of limits in the extract from the data presented so far, it is clear how these are set through the staff's regulation of Maria's right to daily activities. Decisions are made on how she is to live her life on the ward: what she can do, who she can spend time with, where she can be at what time, and how far she can go when she is outside the hospital. The care concept this is based on is the fact that her own lack of boundaries makes limit-setting measures necessary. If we look back on how Maria experienced her admission, it appears that the regulations for her life that the staff impose make her vulnerable and create pain because she does not understand the purpose of the limits. If we return to Løgstrup's (1997a) concepts, in these situations the nurses and the staff do not show the respectful reluctance to reveal Maria's motives. For the staff, her lack of understanding of the therapeutic program is a confirmation of the necessity to regulate her actions and try to help her regain her self-control and composure. As Løgstrup (1997a) sees it, the nurses' attempts to establish boundaries between Maria and her surroundings constitute a fair handling of her motives – seen from the viewpoint of the staff.

So far we have acquired an understanding of how Maria experiences her admission as well as how the doctors and nurses behave toward her as a sick person and the feelings this provokes in her. Before we go further with the analysis we will briefly

present how Maria appeared in her relationship with the department and particularly

with the researcher (MHH). The project gave the researcher the opportunity to try out

a more everyday assignment-related affiliation with the patient. This experience gave

her a firsthand impression of how challenging it is to change one's role and be

obliged to assume responsibility in her relationship with Maria.

Maria challenges "the researcher"

One of the nurses (Yvonne) asked me if I could stay with Maria while Yvonne

attended a meeting. After a short dialog about the researcher's role and the fact that I

did not have therapeutic responsibility, we agreed that it would presumably give me

a fitting and calm opportunity to have an open conversation with Maria. The

employees had noticed that I got on well with her and that she clearly liked talking to

me and trusted me. I reminded Maria again that I was on the ward to study how the

nurses work with the patients.[viii] Now I was going to relieve them for a while as there

was a meeting, and I enjoyed being with all the patients I had got to know through

the research. Maria immediately replied by telling me how terrible it was to be

hospitalized. She said she had never been in a worse place, that the staff were

spoiling everything for her, that her entire Christmas period had been ruined, and that

she is forced to take medicine. She claimed there were no indications to justify her

hospitalization. "I'm neither suicidal nor psychotic. I'm only a bit manic depressive.

But everybody would be manic if they had to stay in a place like this!"

We went out on the veranda so she could check and send messages on her mobile phone.[ix] It felt somewhat uncomfortable and strange being something other and more than the researcher. The responsibility was heavy even though I was not really doing anything other than my work as participant observer. I was the person who was to impose the limits and ensure that she did not go further than the veranda – and I could not say anything about hoping that she wouldn't get into any mischief while I was responsible since I was afraid of destroying the trust between us.

Afterwards we went into the ward and I offered her lunch, as Yvonne had said I could. It was either open sandwiches or pasta. Maria replied curtly that she did not want either. Irritated, she continued by telling me that she did not get any food on the ward and that she had been given eggs even though she cannot tolerate them. I was a little unsure as to what to do since she was starting to get upset and almost angry. I decided to show her the food. She asked if it was from yesterday, and I confirmed this. She replied brusquely that she did not want old food. "I'll go on a hunger strike," she said, and disappeared into her room, slamming the door behind her. I found the episode distressful, realized I was powerless, and was rather irritated; this is not the way to behave toward others (me) who are doing their best. The thought of the bipolar disorder crossed my mind.

While I was still standing in the corridor wondering whether I should follow Maria into her room, Yvonne came out of the nurses' station with the telephone. At the same time Maria came out into the corridor again and sat down demonstratively on

the floor in front of me. I was somewhat relieved and thought that she was meeting me half-way and was perhaps going to say that I need not be worried about her doing anything silly. Yvonne said there was a telephone call from a girlfriend, but that Maria had to go into her room to take the call out of consideration for others in the corridor. Maria did not move. She sat motionless on the floor looking down. Yvonne then said that she would ask the girlfriend to ring back later. Maria then started to edge her way backward into her room. Yvonne gave her the telephone and closed the door.

This extract shows that Maria challenges people by her way of behaving. It demonstrates how heavy institutional responsibility was for the researcher and that assuming responsibility for administering the setting of limits seemed to change the relationship between the researcher and Maria. To balance between "reasons and motives" (Løgstrup, 1997a) is demanding. This experience will be followed up in the analysis. It developed into dramatic events centered on Maria.

<div align="center">The fronts intensify</div>

By a freak of chance Maria formed an alliance with two co-patients against the staff. It was a sort of protest against the system and it was not very clear what could have been the cause or causes that triggered the protest. One of Maria's co-patients was markedly violent and was assumed to be a risk for the surroundings outside the hospital. The three barricaded themselves in Maria's room. The situation was intolerable and there was some uncertainty as to what the three might get up to in the

room. The staff were obliged to use force to open the door and separate them. The situation ended in a fight, and two of the patients had to be constrained by straps.

On another occasion Maria was at a newsagent's in the neighborhood of the hospital and started shouting when they did not have what she wanted. When it also transpired that she did not have enough in her account to cover the purchases when she was to pay for them by card, she got angry and ran off. She was away for many hours until the police found her in the city and took her back to the ward.

In other words over a long period Maria showed signs that could indicate that she needed help to regulate her behavior. She needed to be protected from exceeding her limits since this created problems for both others and herself. We can say that she obviously was "under the power of sick motives" (Løgstrup 1997a, p. 179). On the other hand, what happens can also be viewed as a destructive process developing between Maria and the nurses. Løgstrup's approach might not sufficiently reflect this relational point. We return to the relational point in the discussion.

Maria's uncontrolled reactions had repercussions for herself in the form of sanctions and a feeling of unworthiness. Then the situation went from bad to worse: she was challenging and demanding, she was angry and in opposition, and she had a high level of activity. She had the courage of her convictions, was quick-witted, and her arguments were largely logical and convincing. I mentioned to Maria that it seemed to me as if a warlike atmosphere had developed between her and the staff. I also said

that it appeared as if she had good contact with some of the nurses, and I asked if this actually was the case.

<center>"That little extra push"</center>

Mona, Ina, and Yvonne were three nurses Maria really liked. She describes them as "… very, very nice – all of them. They brighten my existence, and in fact make this place quite habitable." They made time to be with her; they played games, and took walks with her. They were interested in her and they were kind, and she felt that they understood her. For example, they could say that they understood her difficult position. They trusted her, while also making sure without being too strict that she kept to the limits set. They were safe. "Yes – they were simply themselves and fellow human beings. In a way they were able to see something positive in the negative aspects, were able to give me that little extra push to make progress." She particularly stressed Mona's black humor and the fact that Mona was always cheerful and pleasant: "Especially Mona – she could tell me things in a funny way because she realized that the rules they sometimes gave me were ridiculous. Often she couldn't do anything about it, but she would say 'Today we'll let you go as far as to the park, my girl!' And then she would roar with laughter. In a way she could sometimes see that the doctors were silly, and then I felt she was on my side."

This is about their respect, trust, and humor, and their distance from the standard accepted perception of illness, while at the same time they ostensibly behave in much the same way as the other nurses. May be they manage the "balancing act between

reasons and motives"? (Løgstrup, 1997). We will examine more closely and address

Mona's relationship with the patient in the analysis. The analysis is divided into three

parts that in general follow the main structure of the presentation of the material: first

we consider the interaction between Maria and the department where the

understanding of the diagnosis appears to be pervasive; we then take up the

researcher's experience and give some thought to what such experience can tell us

about the problem of setting limits; finally we consider the good helpers and examine

what they do when imposing the limits that Maria experiences as so different, as well

as what is nonetheless problematic about the good helpers' approach to the patient.

DISCUSSION

The psychiatric diagnosis and interventions in the zone of the untouchable

In the introduction we stated that patients in acute psychiatric care struggle with

fragile boundaries that are easily breached. In many ways Maria confirms the point

made in psychiatric literature that the behavior of psychotic patients tends to

recognize no boundaries and that this intensifies the pain of being psychotic. Weak

limits are often linked to anxiety – particularly annihilation anxiety (Benedetti, 1974;

Haugsgjerd, 1990; Cullberg, 2006). Therapy and care are focused on helping the

patient regain contact with reality by stabilizing the relationship between him/herself

and the environment or by protecting the patient from demanding and/or threatening

surroundings. Maria has many typical problems and shows forms of reaction that

hallmark psychotic states. How can Løgstrup's philosophy on the zone of the untouchable shed light on Maria's experiences regarding the nurses' work?

The zone of the untouchable is an expression of vulnerability. Psychiatry presents a particular challenge since the motives for any action are to be worked through, while in our daily contact with each other we maintain communication precisely by not touching on motives but by restricting the conversation to reasons. Maria openly reveals her own motives and reasons for her actions in various ways. There is little of what Løgstrup terms mental reserves to appeal to that would enable her to regain her self-control. This applies when she goes into the kiosk and loses her temper, when she goes beyond her limits in verbal accusations and sometimes in attacks on the staff. It is difficult to define her outbursts in ways that can lead to processing them through conversations. Her reactions are uncontrolled and she openly reveals her anxiety and confusion. How can we cope with Maria in her naked state?

What is striking in her narratives and in observations from the personnel's conversations is how diagnosis-oriented the nurses are in their approach to Maria. Several of the nurses interpreted Maria's statements within the framework of a psychiatric diagnosis. The work of mapping and interpreting her thoughts, feelings, and actions with the aim of reaching a diagnosis took place every day. The nurses' role in this process was primarily to report their observations of the patient to the doctor, who is in turn responsible for making the psychiatric diagnosis. Everything pointed toward the diagnosis bipolar affective disorder. The language of the

diagnosis did not help Maria's despair; there was nothing in the diagnosis that she

could recognize. It was not her life, as she experienced it, that the diagnosis referred

to. She felt that the account she had given of her life – by revealing her motives

through the drawing – was used against her. The diagnosis expressed a precise way

of interpreting her and admitted others into her zone of the untouchable, which she

felt degraded her intrinsic value. In her eyes the categorical approach had an impact

that did not accommodate her attempts to protest or to suggest nuances. Her response

consisted partly of uncontrolled reactions and marked protests. She had little

confidence in the system and felt she had been put in the wrong place, given the

wrong treatment, and let down by a mother who had instigated her enforced

hospitalization.

Strong criticism

Thinking along Løgstrup's lines leads us to the view that there is extra strength in the

criticism of the diagnosis-oriented approach in the interpretation of Maria's

problems. It is not "only" a matter of being alienated from oneself through the use of

a remote specialist language. Løgstrup's interpretation concerns something much

worse – the act of exceeding a limit and crossing with a specific interpretation into

the patient's untouchable zone. The patient's own interpretation of him/herself has

little or no power of expression. In addition, not only is the boundary to the zone of

the untouchable crossed, it is crossed with a pervasive understanding that is

authoritarian in the sense that it is not submitted for discussion and correction. The

truth about the patient is not made available for its validity to be tested by the person

it actually concerns. Maria's attempts to protest are met as further proof of the correctness of the diagnosis. Maria's vigorous protest about being regarded as merely a disorder is viewed as confirming the validity of the diagnosis. Control over the patient is quite clear, and professional authority has become authoritarian. Maria becomes just a manic depressive. What is also censurable is the fact that the boundary to the zone of the untouchable is crossed in the belief that this is professionally acceptable. Diagnosis-focused professional care affords wide powers, and there are few reservations and little opportunity for awareness of others' limits.

She felt that the drawing she had made and entrusted to them in order to say something significant about herself and to suggest a more nuanced picture was understood in only one way. She was not told this in so many words, but she recognized her own powerlessness as a response to the impenetrability of the illness-focused understanding she felt she was faced with. She did not experience being given freedom and space to express her opinion – a valid opinion about typical manic depressive behavior. If Maria had had the feeling that they were concerned about *her as herself*, it would perhaps not have been necessary for her to be so "warlike" on her own behalf and to induce outbursts and uncontrolled conduct that were difficult to stop.

Is this a basic objection to having and using diagnoses in psychiatry? The philosophical framework and material in this article do not allow a fundamental discussion of diagnoses as a phenomenon. What we are criticizing is the dominating

position that thinking about diagnoses seems to have in the practice of nursing. As it is used for Maria, and as she experiences it, the diagnosis represents a reduction of her as a person. The patient becomes just a bipolar affective disorder. In addition, it is when this reduction becomes the chief concern that the nurses fail to do their job. The clinical view becomes too narrow and no attention is paid to other aspects of the patient. It is Maria's voice that is heard most clearly in this analysis; it is her experience that is interpreted. She felt that the approach she experienced both explicitly and implicitly did not give her space to be Maria; first and foremost she was the manic depressive. She felt this as a strong force, as being "run over by a bulldozer." Any disagreement on interpretations among the staff – for example about her drawing – did not reach her.

Maria also describes how nurses sat with her in her room to reassure her when she was going to sleep. This provided calm and security and dampened her anxiety. It shows that the situation does have some nuances and that the nurses took the motive of anxiety seriously in other ways than through a diagnosis approach. This entails them behaving as environmental personnel and taking this part of their mandate seriously. Nonetheless, as Maria conveys it – and this is supported by data from professional discussions among the personnel – the main impression is that focusing on diagnosis inevitably leads to the stipulation of conditions. This provides problematic access to Maria's motives, access that is marked by mastery and that provides little chance to challenge the power inherent in knowledge of diagnoses.

Another reason for Maria perceiving herself as misunderstood was that her forms of reaction were demanding in the sense that the nurses had to cope with her outbursts, shouts, protests and escapes, and her barricading herself in her room and "hunger strikes." Maria's fiery conduct required "extinguishing." In general in psychiatry, some patients will try to hide their anxiety by withdrawing from their surroundings, while others "mask" their anxiety by their uncontrolled behavior or by disregarding and testing their limits (Cullberg, 2006). Maria did both, but was most characterized by her uncontrolled way of behaving. The nurses understood that Maria suffered from anxiety, but because her conduct was so challenging the focus was often on how her uncontrolled behavior and exceeding of limits could be "handled." It was difficult to create space to work on the underlying anxiety that the nurses also recognized in her. At the same time a more open and exploratory awareness of her motives could perhaps have given her the feeling of being "seen" and understood (Thomas, Shattell & Martin, 2002; Koivisto, Janhonen & Väisänen, 2004).

The researcher's changing role and her powerlessness

What can the researcher's experience tell us about limits? Quite clearly the best relationship Maria and the researcher had was when they had open conversational interviews during which the researcher listened with interest and respect to Maria's account of her life and problems and of her views on the treatment. The open trusting atmosphere allowed the air to be cleared, and Maria talked about the feeling of being taken seriously. The researcher listened with interest and an open mind. Research ethics also helped the limit of inviolability to be kept, and the researcher exercised

great care not to cross the border of what she perceived as Maria's zone of the untouchable. Although the conversation did not have a therapeutic aim, it is possible that it acquired one.

Something happens at the point when the researcher cautiously assumes institutional responsibility. This may be incidental, but there are also grounds to believe that the change in role from relating to Maria as an interested conversation partner/researcher to an "insider" in the system was significant. The researcher's tasks were to ensure that Maria did not break the treatment restrictions that had been set and to make sure that she was given lunch. In addition, it is when Maria's "researcher" is to fetch and serve lunch that a noticeable change occurs. Maria decides to go on a hunger strike because she is not satisfied with the food; she protests and makes the "researcher" uncertain about what to do. Maria is showing power, setting absolute limits, and preventing the "researcher" from doing the job she has taken on. The balance of power is delicate and the researcher realizes that she is powerless. It is extremely interesting that when the "researcher" recognizes her powerlessness, she thinks about the fact that she is dealing with a bipolar affective disorder. The "researcher" is thinking in line with the predominant institutional logic: diagnoses explain behavior. The interesting point is that it is the powerlessness that produces the thought that it is a bipolar affective disorder the "researcher" is faced with. This may safeguard Maria's worth, but it can also offend her integrity. The most interesting aspect for the "researcher" was that the illness-related thought empowered her again and she was able to consider whether or not she should follow Maria to her room. However, a

nurse appears and takes over the situation, stipulating conditions for Maria to receive

the telephone call from her girlfriend. Maria protests again by the manner in which

she edges backwards into her room, thus challenging the nurse's power. Who decides

what acceptable conduct is? In a way Maria is the winner through the fact that the

"incorrect" behavior she used to mark her position was not sanctioned by a refusal

for her to receive the telephone call.

The situation illustrates well how the role drags the player (the "researcher") along

with it. She becomes an administrator of the system and this affects her relationship

with the patient. The conversation was more open and was characterized by trust and

respect when the researcher was only a researcher. The situation also shows clearly

how limits are closely interwoven with power and powerlessness. In addition there

are grounds to draw attention to the constructive aspect of the "researcher's" saving

thought that Maria is a manic depressive. With this the researcher regains her power

and her ability to act. Once again she is ready to consider whether or not she should

take action and follow Maria into her room. Maintaining an awareness that Maria is

ill and that she is confined to an asylum (in other words a sanctuary) also makes

allowances for her uncontrolled behavior and promotes others' tolerance and

acceptance of her.

Professional reserve

We have emphasized several times that in psychiatry motives represent the matter at

hand. However, patients' motives must not always be investigated. On the contrary,

the zone of the untouchable should be protected by giving patients help to re-establish their boundaries. If nurses address the matter with caution – and with a form of "reserve" (Martinsen, 1996) – and focus as much on reasons as on motives, patients can be taken out of a helpless and unworthy situation. For example, it may appear that by keeping strictly to Maria's reasons, the nurse Mona (one of Maria's good helpers) practiced this type of professional reserve – in combination with the fact that she possessed qualities that Maria appreciated. Mona showed respect, understanding, and compassion. Other studies from psychiatry (for instance Wallace, Robertson, Millar & Frisch, 1999) show that patients clearly appreciate such attitudes from staff. However, it is more than the attitudes Maria recognizes in Mona that arouse interest.

What is interesting is that the limits Mona sets for the patient are exactly the same as those imposed in the situations that Maria otherwise describes with great distaste. Nonetheless there is a difference in the attitude or the manner in which the nurse behaves in the limit-setting process. Why is it that this action is stressed by Maria as a positive experience? She is not allowed to go outside the hospital fence. This is decided by others. Her opportunities for movement are considerably restricted. It appears as if Mona's attitude when she conveys the ban promotes trust in Maria. Reading this with Løgstrup in mind gives us a deeper understanding. The nurse is characterized by the fact that she does not speculate on Maria's motives or show interest in them. She takes the reasons – going out to get some fresh air and to smoke – seriously. She understands "the limit is the fence" as an institutional routine they

must quite simply comply with. Mona does this with a wry smile and assumes the institutional responsibility to which she also has a somewhat distanced attitude. She does not appear to focus on either Maria's mental problems or her potential opposition to the rule that the free zone ends at the fence as a confirmation of the illness. She regards with great composure Maria's need to protest against the enforced way of life she is instructed to lead within the hospital. She understands the challenge this represents for Maria, who formerly worldly-wise crossed country borders and enjoyed great leeway in her life. She therefore keeps implicitly to the motives that have characterized Maria's daily life outside the hospital – for example, her need for freedom and respect.

Mona thus recognizes the need to confirm Maria's reasons and motives. This she does while at the same time administrating the system in combination with a sign that shows she is critical of this system. She gives Maria confidence, and this confidence seems to enable Maria to regain her composure; she no longer feels she has to argue or continue her fight against the system – a fight that has previously tipped her out of balance and exposed her in ways that also for her are far from what she wants to be and normally is. This has been threatening for Maria. By triggering Maria's opposition to the system the nurses also threaten Maria's integrity since her zone of the untouchable is not sufficiently robust to maintain the distinction between unbiased formal argumentation and volatile, tumultuous, and raw forces. Mona sees Maria's need to be regarded as a person who does not require her movements to be restricted by rules such as "the hospital fence is the prison wall for you and this is in

your best interests." When the nurse's relaxed and trust-promoting attitude weakens the threatening power of the rule, the rule loses some of its sting for Maria. Maria experiences trust, and consequently signals that she is reliable in the sense that she will accept limits set by the hospital. The existence of the limits becomes less of a problem and it is easier to keep to them.

It can also appear that Mona signals a form of professional reserve in the sense that she follows the claim of Sandanger (1999): a psychiatric diagnosis does not express an "objective" truth that automatically explains why patients are what they are. Mona knows the diagnosis Maria has been given, but Maria feels that it is largely herself – Maria – that Mona focuses on. It can appear as if Mona has an awareness of the rather unconstructive effects the diagnosis may have on the patient and therefore views the diagnosis as a professional frame from which she can keep a certain distance.

CONCLUSION AND MORAL

The point of departure for this article was the acknowledgement that limits are an important and difficult topic in psychiatric treatment and care. Our purpose has been to introduce a way of considering limits that was developed by Løgstrup through his description of the zone of the untouchable. This is an expression he uses for the intuitive boundaries between people, boundaries that help maintain respect and integrity. The general understanding of how we keep our distance from each other

out of respect and the knowledge that our motives are our most sensitive and vulnerable point has only partial validity in psychiatry. The patient's illness is often characterized by the fact that the motives come to the forefront and constitute the core of the therapeutic work with the patient. We have selected an empirical field that is marked by many obvious and visible limits in the form of involuntary admissions, locked doors, etc. It is the less visible limit-setting we have focused on. By interpreting empirical data on the relationship between the patient and the nurses we have drawn attention to the fragility of the patient's zone of the untouchable and how this boundary is crossed by the nurses.

The analysis has shown that there is no simple prescription or absolute truths for how nurses can and should cross into the patient's zone of the untouchable respectfully. We also demonstrate that it is the nurses' professional duty to cross the patient's boundaries. The sharpest Løgstrup-inspired criticism of the manner this is done concerns the nurses' narrow diagnosis-oriented interpretation of the patient's motives. We show how vigorously the patient reacts to being regarded as just a manic depressive, and we interpret the diagnostic approach as authoritarian because it does not give the patient room to resist, correct, and supplement the perception of him/herself. There is also a strong tendency to take control over the other's reactions in the sense that patient protests are interpreted as confirmations of the diagnosis. We have also emphasized and shown that this is not a fundamental criticism of diagnoses in psychiatry. Diagnosis-oriented thinking can give nurses assumed legitimate power and the ability to monitor the patient's lack of conformity to limits. The final part of

the analysis shows how complicated it is to be a good helper in the eyes of the patient – helpers who instill trust and respect in their contact with the patient and who have incorporated criticism of the system into their way of behaving. However, this distance from the system can also create problems when or if the trust between patient and nurse is broken – and not least in relationships with these helpers' co-therapists. These are complex problems we have addressed, but (with support from Christoffersen's thoughts on professional ethics [2005, p. 92]) we are nonetheless bold enough to advance some viewpoints about what should be done.

Nurses must and should have access to patients' untouchable zones. This requires professional skills and must not be an intimate or private relationship between nurse and patient. Gaining access does not grant the liberty to move around freely in the other's zone of the untouchable. Respect for "private life" must still be given high priority. The boundary to the patient's innermost motives must be crossed in the knowledge that this is actually being done and with respect for the patient. It is this respect for the patient as a mentally ill person that means that the boundary is crossed on professional grounds. In psychiatry the question is not *whether* the boundary to the zone of the untouchable should be crossed but *how.* The way this is done requires good powers of judgment, and it is possible that fundamental knowledge of the zone of the untouchable can constitute rewarding additional knowledge to develop this judgment.

NOTES

[i] The terms "MHH"/ "I"/ "me" refer to the work of the chief author (MHH) who collected most of the data. The terms "we"/ "us" refer to the main and secondary authors (KH, main supervisor) or to all three authors (PN, assistant supervisor). The interviews with the nurses were carried out by the main and third author together, and the third author was present in the field for two days with the main author.

[ii] K. Løgstrup applies the concept of what is termed in Norwegian "urørlighetssonen" in his essay "System og symbol" (1997a). As far as we can see, this essay has not been translated into English. However, in his essay "Basic principles in bioethics and biolaw", Jacob Dahl Rendtorff translates "urørlighetsonen" as "the zone of the untouchable" (retrieved September 25, 2006, from http://www.bu.edu/wcp/Papers/Bioe/BioeRend.htm) According to Rendtorff (p.7), the human person's sphere of integrity "has at the same time a spiritual and a corporeal dimension", and it is the spiritual dimension that can be "expressed by the concept of the zone of the "untouchable." He further refers to Løgstrup's division between motives and reasons (ibid.): "In relation to psychiatry he argues that a permanent focus on motives for actions rather than reasons constitutes an intervention in the integrity zone of the individual. The intervention in the zone of the untouchable involves the ignorance of the integrity of the person." In my opinion this is not the whole truth about Løgstrup's way of differentiating between reasons and motives. In my interpretation he says that it might be necessary, from a therapeutic point of view, to work on patients' motives.

[iii] According to the international classification system (the ICD-10 Classification of Mental and Behaviour Disorders) the term "Bipolar Affective Disorder" is used for conditions that are characterized by disturbances in the patient's mood and activity level where these alternate between being elevated and depressed (retrieved September 25, 2006, from http://www.mentalhealth.com) The term is also used in the clinic, most often as "bipolar disorder" and/or as "manic-depressive disorder/psychosis" which was the former diagnostic term.

[iv] A person's relatives can take the initiative to arrange a consultation with the doctor with a view to assessing whether the person in question needs enforced mental health care (Norwegian Act relating to establishing and practicing mental health care, 1999). In this case it was the patient's mother who took the initiative.

[v] When referring to the protection of personal integrity, the Act emphasizes that restrictions and coercion must be limited to what is strictly necessary. For persons undergoing involuntary mental health care in the form of 24-hour stays in an institution, the responsible member of staff can approve curtailments – for example the right to receive visitors, to use the telephone, to participate in outside activities, etc. It is stressed that such measures can only be employed when their gains offset their disadvantages (Norwegian Act relating to establishing and practicing mental health care, 1999). A number of restrictions were introduced for this patient, including in the areas mentioned, since it was considered that her condition would become worse if limitations were not imposed on her behavior.

[vi] The objective of an acute department (and particularly of a locked ward) is for patients to regain their composure and to rest and collect themselves. In the first phase, which can last from some hours to several weeks, it is mainly the staff that supervise the procedures. Gradually, as the patient is regarded as able to take responsibility, attempts are made to enter into a cooperation and negotiations on activities and on goals for further collaboration. The treatment Maria was given in the final phase was therefore in line with professional guidelines and practice.

[vii] The use of the term refers to the fact that it was thought that Maria's disorder could be due to a hereditary weakness.

[viii] I had said this to the patient earlier. There were also notices about the project with a picture of me on the ward's notice boards. I repeated the information to Maria because I was not sure that she had understood that I was the person who was there to do research. The interview with her was held some weeks later.

[ix] It is a rule on the ward that mobile phones must be kept locked in the nurses' station while the patient is in hospital as part of the control and seclusion measures on the ward. Subject to agreement, patients can use the ward's telephone or their own mobile phone.

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V

PERVASIVE DISTRUST –

THE HARD WORK INVOLVED IN CREATING TRUST IN AN ACUTE PSYCHIATRIC WARD

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ABSTRACT

The ideal of trust pervades nursing. The article directs critical attention to this ideal and uses empirical material from acute psychiatry that reveals that it is distrust rather than trust that is prevalent in this field. In the first place our analyses of the data show how distrust is expressed in the therapeutic environment and in the relationship between nurse and patient. Secondly we point out how trust can nonetheless be created in an environment that is characterised by distrust; and thirdly both trust and distrust are exposed as "fragile" phenomena that can rapidly "tip over" towards their opposites. The article concludes that trust is not something that nurses possess or are given, but is rather something that they earn and have to work hard to achieve. Regarding oneself as a potential cause of distrust and an active wielder of power rather than purely as a person who works with trust and to achieve trust can contribute to nurses developing a more realistic view of their practice of the profession. Assuming a realistic middle-way perspective can help them to manoeuvre appropriately between the extremities of excellence and resignation, which in turn can lead to processes that create trust between psychotic patients and nurses.

Keywords: acute psychiatry; creating trust; distrust; K. E. Løgstrup; psychiatric nursing; psychotic patients.

INTRODUCTION

Trust is the object of extensive research in many fields (1). Research into trust ranges from analyses of social features (2-3) to analyses of what takes place between patients and their helpers on the ward and in the doctor's surgery (4-5). It is the latter that is of interest to us. The point of departure of this article is a general understanding that trust represents an absolute basis for nursing care (6-8). In psychiatric nursing emphasis is placed on mutual trust in the relationship between nurse and patient as a prerequisite for ensuring that the therapeutic programme will help the patient (9).

However, the processing of empirical material from acute psychiatry has revealed that it is mutual distrust rather than mutual trust that is predominant in the relationship between psychotic patients and their nurses. It is the mismatch between trust as a normative ideal and distrust as a pervasive feature of the data material that has formed the basis of this article. The thoughts of Knud E. Løgstrup – the Danish philosopher and theologian – on trust as a basic condition for human interaction have had considerable influence on the Scandinavian understanding of the practice of nursing. We use his philosophy as a reference framework for the analysis and discussion of case-based material. The article concludes with a radical demand for a renewal of the ideal of trust.

TRUST AND DISTRUST

The research interest of Knud E. Løgstrup (1905-1981) focused on analysing the underlying features of the conditions necessary for human coexistence. One of his most commonly used

analytical concepts is that of "supreme manifestations of life", and he claims that the manifestation of life pervades whatever we want to do and that it cannot be compromised (10:152). Manifestations of life are supreme in the sense that they form the basis of our actions. According to Løgstrup, trust represents one of these underlying features of life or constitutes a fundamental ontological condition. Trust as a manifestation of life is present in such an elementary way that we do not even regard it as a basic ethical requirement (11-12). For Løgstrup ethics are founded on manifestations of life rather than norms. In this article we will examine Løgstrup's understanding of trust in more detail.

Trust comes before distrust

Løgstrup (13) says that we encounter each other with natural trust – both the people we know well and those we do not know at all. He is of the view that it is only under special circumstances that we confront a stranger with predisposed distrust. Trust comes first, after which distrust appears if there are special grounds for it. At the outset we believe in what others say, and in general we trust each other. These are traits that form part of being human, and any other form of behaviour would be hostile to life. "Human life could hardly exist if it were otherwise. We would simply not be able to live; our life would be impaired and wither away if we were in advance to distrust one another ..." (ibid.:8). As we interpret Løgstrup, he claims that trust is an aspect of our humaneness, and that not only our lives but also our humaneness would disappear if distrust came first. "Trust is not of our own making; it is given" (ibid.:8). And indeed Løgstrup does not conceal the fact that trust is demanding.

Trust is demanding

Løgstrup describes trust as a demanding and hazardous condition for human coexistence: "To trust, however, is to lay oneself open. …" (ibid.:9). All communication, all contact between

people, entails laying oneself open. Løgstrup uses metaphors to portray this: "surrendering himself" (ibid.:16) and "of his going out of himself" (ibid.:16). Displaying trust also makes us vulnerable to others' potential good or evil purposes (14). The trust one shows when with others therefore also constitutes a demand: "of his placing something of his own life into the hands of the other person" (13:16). There is an unexpressed challenge inherent in any encounter: we dare to present ourselves in the hope of gaining approval. To use one of Løgstrup's well-known expressions, this means that we are all responsible for that part of another's life that we hold in our hands. The challenge embodied in human contact is "to shape one another's world" (ibid.:18), i.e. through my attitude I am instrumental in deciding the extent and colour of the other's world (ibid.). Dependence has the inherent condition that any manifestation (speech, action) is conditional on others understanding it. It is about being seen and heard: being "exposed" to the other's gaze, the other's listening (14).

Trust is to lay oneself open

"To trust, however, is to lay oneself open. This is why we react vehemently when our trust is "abused" …" (13:9). We have ventured forth in order to be accepted; disappointed expectation has a very emotional effect on the person in question. If we disregard the trust that someone manifests, it puts this person in an embarrassing position. It is painful – but it is even worse if the person to whom the trust has been proffered meets it with indifference or rejects or abuses it.

As Løgstrup considers trust, laying oneself open is usually a cautious action where we keep our guard: "We hold ourselves in reserve and do not allow ourselves completely to trust one another" (ibid.:19). Such reservations make sense in acute psychiatry since distrust is often a "natural" consequence of being psychotic. Before we present empirical descriptions that show

how distrust and trust are expressed, we will review the methodological principles on which the empirical work is based.

RESEARCH METHODS AND MATERIAL

The study in question has been conducted in an open seclusion unit in an acute psychiatric department in a city in Norway. The main author ('I'/'me'/'my'/'MHH') performed most of the empirical work as part of a PhD thesis. The terms 'we'/'us' refer to the main and secondary author or to all three authors. The study has an ethnographic design and investigates how various occupational ideals – including trust – challenge psychiatric nurses. The data material was collected over 30 weeks between December 2003 and June 2004 and consists of 343 pages (single-line spacing) of field notes from participant observation (213 hours) and from transcribed interviews with five patients (six hours) and six nurses (group interviews in groups of three: six hours).

We were given a recommendation to conduct the project from the Regional Committee for Medical Research Ethics, and a licence concerning the notification requirement from the Privacy Ombudsman for Research. Key research ethical principles such as informed consent, the right to a private life, respect for personal integrity, do-no-harm and no exploitation have been very carefully assessed throughout the research process. The participants were given both written and verbal information about the project. The patients and the nurses who were interviewed – and whom MHH monitored over time on the ward – signed consent forms.

As the research project gradually developed we found that the field was to a large extent characterised by control. This control was clear when we took into account the various security measures that were part of the everyday life on the ward – for example the locked doors, the staff's use of highly visible alarms, extensive staff coverage, and strict regulation of what the patients were allowed to do and when and with whom. To us the patients and nurses often appeared to be in their separate worlds. This became evident through the control and security measures as well as through the nurses' verbal expressions such as "testing", "manipulating", "shunning contact", "argumentative" and "lacking insight into his/her illness". We studied how the nurses and patients respectively talked to us in interviews, and compared this with field observations. The strict control and the distance between patients and nurses can be interpreted as an expression of the staff's distrust of the patients. Likewise we interpret the patients' various actions – ranging from withdrawal to manipulation, threats or uncontrolled physical reactions – as signs of distrust. But we also saw that much of the work performed by the nurses was concerned with attempts to establish trust. In addition we discovered that the patients who had a pronounced distrust of the nurses, doctors and the entire "system" made efforts to show trust despite this distrust. Examples included seeking contact, asking for help in different practical matters, taking the initiative to talk, and the use of humour.

The case we are employing in this article is composed of various parts of the material. The following descriptions are not a continuous series of actions that took place in a limited period of time. Although the case is constructed on the basis of different parts of the material, the description still expresses what we perceive as typical of the acute psychiatric department we have studied. Working in this way means that we have also assured the anonymity of the individuals involved. This entails the names of patients and nurses and the situations in which

they could possibly be identified being changed or re-written to ensure that they now represent typical features of several of the situations we identified.

With regard to the role of the researcher in general and to the analysis work in particular, our scientific activity rests on the concept that we as researchers conduct our research from a specific viewpoint (18-21). This viewpoint has significance for what we present as meaningful and for how we do this. MHH's viewpoint is that she knows the field from her clinical practice and has spent time as a researcher in the field (22). She formed part of the social environment at the same time as she studied it (23). MHH has not entered the world of acute psychiatry and obtained truths. On the contrary she has participated actively in shaping the field in a manner that means that the material presented must be regarded as having been generated between her and the field itself. In other words the data we now have are a result of a joint perception created between the researcher and the research subjects. In addition, the three article authors have been in dialogue with – and interpreted – the material in creative and analytical ways. To create this product we have drawn on the specific context that we ourselves comprised (23-26).

DISTRUST IN PRACTICE

First impression

Early in the morning I accompany Linda, the nurse, to another ward to admit the new patient, Joe. First we are given a report in the nurses' station from a nurse who tells us that Joe had given vent to his feelings violently four days ago on the ward. First he had messed up the entire room with water, after which his violence had included throwing a chair at the window

with such force that the window frame had been "pushed" outwards. He had then been heavily medicated. He had been restrained with belts, but was released after two days since he had become calmer. His programme had involved confinement to his room, and this had functioned well. At the time of our meeting he was still restricted to his room but he was also allowed to spend a couple of hours in the common rooms in the afternoon and evening.

After the brief report, the nurses go through the belongings they have taken care of and for which the patient has been given a receipt to show that they are in the staff's keeping. We then go to meet Joe, who briefly shakes hands with us both and says his name in a low voice without looking at us. Linda tells him that she remembers him from a previous hospitalisation, but gets no response. The three of us then go back to "our" ward where Linda shows Joe around to give him an overview of where he is, expressing herself clearly and instructively in the process.

Linda and Joe then go into Joe's room with another nurse, where Linda and the other nurse go through his baggage. The situation is calm, but Joe follows their actions closely. They explain to him that what they are doing is routine on the ward. Then, with the exception of a couple of garments, they take all his belongings into another room to be locked up, and Joe is given a receipt for what they have kept. Joe asks for his mobile phone. He says he wants to ring a friend. He is told that patients are not allowed to have their mobile phones on the ward, and he asks "Why not?" Linda tells him that it is possible to make free phone calls from the ward, and Joe then goes to lie down.

He gets up again after a couple of hours' sleep, and he seems very drugged: he walks unsteadily and he slurs his words. Linda is worried and discusses the situation with the other

nurses at the nurses' station. One of them says that it is important to assess his condition now since it will have an effect on whether or not the following day he is to be given a new dose of Cisordinol Acutard (an antipsychotic with a calming and sedative effect that is used as an initial treatment for acute psychosis and mania). Linda says this is a difficult decision since on the one hand it is important for their safety that Joe is kept heavily medicated – "It has to be safe for us as well" – while on the other hand she is aware that they must be observant regarding how much medicine Joe can be given before it becomes too much. Linda and one of the other nurses say that they remember him from a couple of earlier short hospitalisations as extremely insecure, vulnerable and afraid in new surroundings, when he can become vociferous and threatening. Two of the others say they have a strong feeling of apprehension and unease when he is around. They agree that they cannot be certain about what he may set about if he feels anxious. They also agree to keep their distance from him, to be polite and correct in the way they treat him, and otherwise to observe the extent to which he seems to be affected by the medication.

For the next half hour Joe sits in the lounge leafing through some magazines. He watches some TV, goes into the smoking room a couple of times and to the toilet. I sit in the corridor and read the newspaper while I watch what is going on. After a while Joe goes over to the nurses' station and knocks on the door. He seems more awake now. He asks if he can have his music system in his room. The nurse who is standing in the doorway says no – unfortunately he can't. She tells him that one of the doctors must first come and talk to him before they know what he is allowed to do. So Joe then goes back to his room, slamming the door behind him. The staff get ready for the team meeting.

The fronts harden

After the team meeting I am sitting in the corridor when Joe comes out of his room with purposeful strides. He addresses Linda, and asks for the belongings the staff have kept. Linda tells him that this is not possible right now, and that he must talk to the doctor first. Joe insists. Waving his arms around and raising his voice he stands right in front of Linda, who backs away a little. He says that she must have the authority to be able to release his personal things. "You must be able to rely on me to be fully capable of looking after my valuables myself!" The others on duty have realised that something is going on and gather at various places near Joe and Linda. Then the doctor arrives, and Joe immediately starts a discussion with him. Joe is red in the face and is leaning forward with his body in an aggressive attitude. He says that the doctor now has the choice of showing whether or not he relies on Joe. The doctor says that he and Linda can talk to Joe in his room. Still looking at the doctor and Linda, Joe shouts loudly: "The only thing I'm asking is that you show that you rely on me to take care of my own things myself!" Then he drops his voice and says with a little smile: "By the way – I've seen you two here before."

Several employees come out into the corridor in response to the growing level of noise. I hear the doctor tell Linda that he will inform Joe that "if we can't rely on you control yourself we must use bed restraints." I do not know if Joe was intended to hear this, but he does and he says: "OK. I'll try to be calm. But then *you* must listen to *me* a bit too!" They sit down in the chairs arranged in the hallway outside his room. Joe says he thinks it is incredibly degrading for him not to be allowed access to his mobile phone. He has friends he knows are worried about him and he would like to tell them where he is. He also says that he does not understand why he is not allowed to have hardly any of his private things in his room. He is on the verge of tears when he says that he feels his whole life is locked up and everything is so difficult for

him. Both Linda and the doctor speak during the conversation: the doctor tells Joe very clearly that many of those on the staff feel very insecure when he is around and that they are all afraid he will get angry and carry out an attack like he did a few days ago. Linda continues and says that the event frightened everyone: they feel that they don't know how he is going to behave, and this is one of the reasons for them being so strict with him. It seems as if Joe understands the seriousness of what they say, and he apologises for being so angry that he lost control. Linda goes on to say that they want to help him with some of the things that are difficult for him right now, and also any practical aspects, but "then it's important that we can trust you to do your utmost to control yourself and that you take responsibility for telling us when you feel uncertain about your ability to remain in control". Joe promises, and thanks Linda and the doctor for taking him so seriously: "I'm beginning to understand that I may seem frightening. I don't mean to, but I get so very upset when such things happen." They move on to making agreements on the use of his mobile phone and access to his belongings, and they agree that Joe is to go out onto the veranda with Linda where he can check the messages on his mobile phone and be allowed to make a couple of short calls. If this goes well, he can have some of his belongings in his room. Joe is calmer and more controlled now. He looks at the doctor and Linda and suddenly says: "Michael and Linda, you are lovely people!" Then they leave. The employees who are left look at each other and smile.

During the next few days Joe is continuously concerned about the fact that he is not allowed to do what he wants. He gets angry on many occasions. There are constant conflicts between him and the nurses. They set limits for him in a good number of situations, but they also discuss these with him, as well as what he is allowed to do and not to do. Joe seems gradually more content and relaxed. He tells me that he thinks being in hospital is a strain – it is particularly the fact that he cannot do what he wants that he thinks is difficult. He also tells

me that he was exhausted and afraid when he came to the hospital and that he only wanted peace and quiet – something that the staff had not understood. "They made me so damn stressed!" he says. But he also tells me about several of the nurses whom he likes and whom he feels he can rely on. "I have the feeling that they want the best for me and that they understand how I feel". But he is looking forward to going home where he can relax and recover after his stay in hospital and "live the life that is mine", he says. In the following we will give detailed analyses of the data material by using Løgstrup's thoughts on trust supplemented by insights from other relevant research.

INTERPRETATION

Structural distrust

First and foremost the material leaves a strong impression of distrust. Joe is locked in, bed restraints have been used on him, and he has had medicine injected into his body against his will. His belongings have been examined, registered and locked up. The locked doors regulate who has access where, and shut him and other patients out of the staff room and the kitchen. The bed with restraints is positioned just inside the entrance door – admittedly covered by a sheet – and is an ever-present reminder that this is a place where superior force can be used. All the employees wear a very visible attack alarm, which reminds both them and the patients that dangerous situations may arise that require brute strength and shrewd handling of conflicts. The employees decide in what areas Joe can spend his time, who he can spend it with and who he can talk to on the telephone and when. The manner in which the department is structured and the highly visible signs of the use of power speak the language of distrust. This insight can also be found, for example, in Crowhurst & Bowers (27).

The nurses' need to take control

The perception of nursing that comes to light from the way the nurses talk about and to Joe is clearly pervaded by distrust. They have taken control in order to compensate for *his* lack of control that was expressed by his uncontrolled physical reactions, throwing water around and throwing a chair at the window. Joe is both strong and dangerous when he gets angry. In this context, lack of control over one's actions points in only one direction – psychosis. Psychosis constitutes thoughts, feelings and/or actions that are out of control. The literature in this field tells us that the threat of impending catastrophes that psychotic patients quite often feel and the intense anxiety and distrust that are associated with such frightening experiences can make them act in ways that create fear and danger for both themselves and others (28-29). Most of the patients in "our" department have been committed to the institution, which in itself is a strong expression of distrust of the patients' ability to take care of themselves. The unpredictability in the field requires the nurses and other professionals to have the competence and ability to take the steps required to protect the patients from themselves, their fellow patients and the staff (29). The discussion between the nurses at their station clearly demonstrates this: it is based on their unease, insecurity and apprehension. We are thus faced with a situation in which distrust meets distrust. However, the party who first tries to instigate contact and trust is in fact the patient. We will look at this more closely in the next section.

Attempts from the patient to establish trust

Joe is sceptical and shows signs of distrust during his first hours on the ward. It is clear that all the control and surveillance measures frustrate and worry him. Once he has rested and has become familiar with his surroundings, he seems to have one specific aim: to come into contact with the nurses in order to get some of his belongings back. By asking to have his

music system and other belongings returned he is at the same time expressing his need to be treated as an adult and as a responsible person. He asks for his mobile phone so he can call a presumably worried friend to tell him where he is. His wish for access to his phone is rejected with a reference to the general rule on the confiscation of phones and to the fact that he can ask for help to ring from the ward. None of the nurses can be regarded as obviously communicative in this situation. They do not take the chance that Joe will behave in a responsible manner towards his friend. The rule takes the predominant place without a more detailed explanation being given. Further responsibility for "the progress of the case" is transferred to the doctor. To quote Løgstrup (13), Joe puts much of what is at stake for him "in the hands" of the nurses. But there is much more at stake for him than gaining access to his own music system and mobile phone: he makes himself vulnerable through his appeal for acceptance. Joe sets out on the risky undertaking of seeking contact, which is simultaneously an attempt to show trust and to invite others to show trust. The nurses clearly do not interpret Joe's move as a request to meet him halfway. On the contrary, as Løgstrup would say he is met with a wall of silence and his appeal is rejected.

The degradation he experiences through having all his identity-creating belongings taken from him, the subsequent silence and the lack of relevant information represent an encounter with an institutionalised distrust that in turn reinforces his own. We see a vicious circle in which distrust increases and in which the patient's vulnerability is further strengthened through his encounter with "the system". We can also observe what several researchers (30-32) have pointed out – that patients' subjective experience is not taken seriously as a basic premise for taking action in practice. As Lorem says (33:74), Joe is "exposed" to the type of power that is inherent in "being deprived of something vital as a human being – the possibility of accounting for oneself". Researchers have also pointed to the possible connections between

rigid rules and patients' agitation, uncontrolled reactions or violence. Ryan & Bowers (34:701) claim: "Coercion can lead to disengagement, alienation, mistrust, and prevent the individuals from reaching their potential for self-management". The fact that the relationships are extremely asymmetrical makes the patients' vulnerability obvious, a fact that is discussed in several studies (35-38). It is appropriate to point to such connections in Joe's case.

Acute psychiatry is a complicated field where it is easy to stand on the outside with romanticised notions about how therapeutic life on the inside can be lived. Experience and research show that structure is required to moderate and modify aggression (39). Operating within a permanent and acceptable balance between control and freedom constitutes a great challenge. In the case of Joe and the nurses it appears that the manner in which the nurses enforce the rules make him so dejected and angry that in the worst case it could have ended up with uncontrolled physical reactions on his part. Our opinion is that it is primarily in the enforcement of the rules that we can see the nurses neglecting their responsibility. They do not take an active initiative towards Joe and they disregard his invitations to mutual understanding and the establishment of trust. They protect themselves behind institutional rules and the doctor's responsibility. It is in fact Joe who tries to create contact and trust. The fact that the nurses withdraw contributes to strengthening the distrust. We will investigate more closely what happens when the nurses physically withdraw to their station.

Retreat to the nurses' station

The nurses make a collective retreat to their station. They leave Joe in peace. He must wait for the doctor – they are also waiting – and they take no initiative. The whole situation is put "on hold" with a reference to a lack of authority to take action. They only respond when Joe asks for something, and they try to limit any contact by saying that he must wait. They discuss

among themselves the importance of medication. They seem to be of the view that it is essential to find the optimal balance between putting an adequate chemical "lid" on Joe without him being too "drugged". The necessity for him to be chemically buffered is based on their assessment of not being able to trust his ability to control his thoughts, actions and feelings. The need to ensure everyone's safety – including Joe's – through control is presumably the governing factor for this train of thought. The close connection between control and safety is also shown by Johansson, Skärsäter & Danielson (40). The nurses talk together: they share professional opinions, their impressions of Joe as unpredictable, and knowledge about him from a previous brief hospitalisation. Distrust is woven into the professional perceptions. Joe probably experiences their barricading themselves into the nurses' station as indifference. His distrust is strengthened by the fact that he is left on his own while the nurses have a network and a sense of security in belonging together to which he has access neither socially nor physically (the nurses' station is a locked room reserved for employees).

The nurses disclaim responsibility in two ways: firstly they indirectly transfer the responsibility over to Joe by referring to the fact that it is Joe and his illness that are the cause of the deadlock situation; secondly they place the responsibility with the doctor: it is the doctor who must decide what is to be done. Both these factors appear to legitimise their withdrawal to (for them) a safe and protected zone – their station. In our opinion, the fact that Joe's frustration and unease – his distrust – increases cannot only be ascribed to his psychosis. We believe that focusing on interaction is decisive – the interaction that takes place between Joe and the nurses. In the following we will examine situations where trust is created, and we will discuss how the nurses could have acted differently.

DISCUSSION

Responsibility for crating trust

In the section above we have given priority to showing how the nurses neglected to take the opportunities that were created by the patient, and how they evaded and disclaimed responsibility by referring to administrative procedures. We will now assume a different angle and present situations in the case where trust is evident. We ask: what characterises interaction that takes the opportunities to establish mutual trust?

As the "conversation" between Joe, the doctor and Linda becomes more intense, the way in which the situation will develop remains open. It could lead to the use of coercive measures against Joe. He is threatened with the use of restraints, but something "tips" the situation over towards efforts from all those involved to make contact and to find peaceful solutions. Threatening another person with putting him or her in restraints is a demonstration of power of unusual force. It can be and is explained by the nature of the psychosis, but also by the distrust that has become the hallmark of the culture. Joe obeys, and along with Grimen (41) we can say that he is forced into trust. The situation could have been different: a breakdown could have resulted, with subsequent chaos that would have ended up in the use of superior physical force. The fact that Joe conforms puts him in a position where he can show and receive trust. Linda and the doctor act in the same way and the situation instantly becomes much calmer. Joe takes the initiative again. He changes his form of language and says abruptly that he recognises both the nurse and the doctor. This makes things "progress" in a positive direction and produces a situation characterised by mutual endeavour.

Linda and the other nurses now use their formal authority to maintain contact between themselves and Joe. Working to achieve contact can be understood as making efforts to achieve trust. It is a matter of interaction between patient and nurse – a challenge in itself. Trust does not come from deeper layers in the individual (10): trust demands hard and conscious work. It is clear that the vicious circle has been broken and that all the parties involved are working to achieve trust. What happens during the following days provides examples of this. Efforts to create trust acquire meaning in the light of Løgstrup's (13) interpretation of trust as an aspect of our humaneness. It is a strain to distrust other people. To enable the nurses and Joe to "live together", both parties make great efforts to find out what can be done. To cite Løgstrup (ibid.), the manner in which the nurses (and the doctor) meet Joe's requests helps to strengthen his dignity and independence – both at that moment and in the long term. The relationships are nonetheless still highly asymmetrical, and the situation is volatile.

Should the nurses have assumed responsibility earlier?

A reasonable question to ask in the discussion of the material is why the nurses did not approach Joe more positively earlier and more often. Could they have "coaxed him" so that the situation would have "tipped over" towards trust at an earlier stage? Joe is in a vulnerable and dependent situation: his control is fragile and he is in strange surroundings. He needed a nurse who more decisively and clearly could have created an overall perspective for him and given him reasons he could have understood and lived with. For example Linda could have said that she understood that it can appear odd that he has to make his calls from the department's telephone rather than ringing from his own mobile phone. She could have given Joe more thorough reasons for the rule by telling him that it is a general rule that the department has found appropriate to follow until they get to know the individual patient a bit

better. She could have assumed a more distanced and critical attitude to the rules under which she works. She could have offered to be the patient's "lawyer" and said that when they meet the doctor they would talk about the matter together and find a solution with him.

With regard to creating trust, it also seems reasonable to "order" Linda and the other nurses to spend time together with Joe and the other patients rather than barricading themselves in their station. This could presumable have helped to calm the situation since they would have established their presence as clear and accessible to Joe (and the others). Another important fact is that Linda could have made it clear to Joe that she understands that he has a lot to cope with and think about, and that he can be quite sure that "we will do everything we can to help you". For example she could have expressed her unease and insecurity towards Joe: the fact that she and the others become anxious when Joe is short-tempered and persistent. She could thus have helped to create a world for Joe in a constructive manner (13:18). Our aim in mentioning these various possible methods of handling such situations is to underline the importance of establishing contact between patient and nurse at an early stage. This has been pointed out by several researchers. VandenBos, Odland, Jakobsen & Folmo (28) ascertain the importance of helpers establishing themselves as unambiguous and willing to understand and of them trying to create meaningful emotional contact with patients.

In this context it is interesting that patients put their trust in nurses' interpersonal skills. Research shows that patients emphasise qualities such as care, tolerance and respect as decisive for creating trust. The ability to listen and understand, and to spend time and be available, contributes to building relationships (30-32, 42-46). Thomas, Shattell & Martin (38:105) found that psychotic patients want a "deeper connection" with the staff, and the study conducted by Koivisto, Janhonen & Väisänen (48:273) demonstrates that care did not

reach the "inner world" of psychotic patients. In our case material, Joe states clearly that the nurse's thoughtfulness and understanding of what is at stake for him is crucial. Analyses have shown that an understanding attitude of this type requires far more than good personal qualities on the part of the nurse. Continuous efforts are needed in the unstable reality of psychotic patients. But this also demands more than efforts: it requires nurses to be aware of what can "tip over" the situation and how this can happen. There are significant possibilities and challenges inherent in everyday situations: recognising, seizing and utilising positive opportunities requires nurses to have the willingness and ability to retain a critical and analytical attitude to the system they administrate, and to have the courage and strength to become involved in order to "coax out" solutions.

SUMMARY AND OUTLOOK

The point of departure for the article has been the emphasis given in the literature in this field to the importance of trust in therapeutic relationships, as well as our main empirical findings concerning distrust as a striking feature of the acute psychiatric department we have studied. This paradox has been investigated using Løgstrup as the theoretical reference framework. Løgstrup presents trust as an ontological condition for human interaction, and points to the unnaturalness of distrust fundamentally pervading interpersonal relationships. Our findings do not indicate that we dispute Løgstrup's ontological interpretation with empirical facts – on the contrary: Løgstrup's argument for trust as a basis provides support in at least two ways. Firstly the empirical material shows that being distrustful poses a great strain on the person(s) in question and for the surroundings. Joe, the nurses and the doctor are trying hard to cope with a situation that is difficult to handle, where nobody really knows how they are to

manoeuvre and where it is difficult to come into contact with each other. Secondly, although the whole situation is characterised by conflict and insecurity, the empirical data shows how it becomes calmer when contact and trust are established.

In the article we have shown both that distrust is expressed and how this is done. Delicate processes of interaction are at stake, and both trust and distrust can be "tipped over" towards their opposite. We have also illustrated how conditions can be created for developing trust in relationships that are characterised by distrust. Much depends on the professional aspect: trust is not something the nurse is given, it is something that he or she earns (49). It is primarily the nurses (and the doctors) who are responsible for working to ensure that situations "tip over" from distrust to trust. The work of creating trust is demanding.

Nurses must acknowledge that this tough field of practice demands something very special from them. The remedies do not consist of employing more staff (thus indirectly generating more time) and offering higher pay (thus indirectly generating greater motivation). Efforts must be made to counteract tendencies to portray nurses as victims (of patients' psychotic madness and of doctors' decrees). The role of victim provides plenty of opportunity to act as administrators who obey the system. Countercultural competence must be achieved. This means that we are presenting a radical challenge that demands hard work – not only in the relationship between patients and nurses but also in professional development in practice and in education and research.

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VI

QUESTIONABLE REQUIREMENT FOR CONSENT IN OBSERVATIONAL RESEARCH IN PSYCHIATRY

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Informed consent represents a cornerstone of the endeavours to make health care research ethically acceptable. Based on experience of qualitative research on power dynamics in nursing care in acute psychiatry, we show that the requirement for informed consent may be practised in formalistic ways that legitimize the researcher's activities without taking the patient's changing perception of the situation sufficiently into account. The presentation of three patient case studies illustrates a diversity of issues that the researcher must consider in each situation. We argue for the necessity of researchers to base their judgement on a complex set of competencies. Consciousness of research ethics must be combined with knowledge of the challenges involved in research methodology in qualitative research and familiarity with the therapeutic arena in which the research is being conducted. The article shows that the alternative solution is not simple but must emphasize the researcher's ability to doubt and be based on an awareness of the researcher's fallibility.

Introduction

Informed consent represents a cornerstone of ethically acceptable health care research. Research participants in the field of psychiatry are often particularly vulnerable and much thought must be given to research ethics.[1–5] In this article we will highlight problematic aspects of the requirement for informed consent in acute psychiatry. We will use empirical data from a study conducted in an acute psychiatric department to discuss how to understand and cope with the dilemmas that inevitably arise in such a challenging research field.

The study in question was conducted in a locked ward of an acute psychiatric department in a city in Norway. (The main author ('I'/'me'/'my'/'MHH') performed most of the empirical work as part of a PhD thesis. The terms 'we'/'us' refer to the main and secondary authors or to all three authors.) The study focuses on how nurses

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use power in their interaction with psychotic patients in ways that either promote patients' dignity or have a degrading effect. The study has an ethnographic design and data were collected by participant observation over a period of 30 weeks and by interviews with nurses and psychotic patients.[6–11]

This article was occasioned by an injunction from a supervisory body that demanded informed consent to be acquired at all times from all patients admitted to a locked psychiatric ward. It has proved impossible to comply with this injunction. After several weeks of compliant, doubtful and somewhat unsuccessful attempts to follow the consent rule, we reached a point where we had to make a choice: the study would either have to be abandoned in its current form as a research project based on empirical data, or the method would have to be changed. We chose the 'non-compliant' alternative after consulting the National Committee for Medical Research Ethics, which is an advisory and co-ordinating body for the regional research ethics committees,[12] and after gaining the support of the hospital and the university institute management for our decision. The project was continued with the requirements that general information on the project be made available and that respect be shown for any patient reservations about being observed.

The empirical basis for the discussions in this article was derived from the 'non-compliant phase' of the project. The purpose is to show why a practice that is governed by rules, and which has the objective of acquiring consent for research from psychotic patients, is inappropriate. We also wanted to demonstrate how and with what problems and misgivings an alternative and more flexible, situation-orientated practice was developed.

Before we present empirical data in the form of the case studies that constitute the basis of the discussions, we will first give more details about the reasons for the injunction we were obliged to contravene.

Supervision

In Norway there are three bodies that are ascribed the task of supervising health care research. First, there are the Regional Committees for Medical Research Ethics[13] that function as independent advisory and guiding bodies. Second, we have the Norwegian Social Science Data Services[14] that assess aspects of privacy protection in particular. Neither of these two bodies made any comments on this study. The third body, the Directorate for Health and Social Affairs,[15] takes decisions on cases that involve access to information that is subject to confidentiality and on dispensations from the duty to observe confidentiality.

The reason we had to contact the Directorate for Health and Social Affairs was because health care personnel are obliged to prevent unauthorized persons from gaining access to confidential personal information with which they become familiar in the course of their work. In this context a researcher is considered an unauthorized person. In a letter dated 8 September, 2003 (reference 03/3889T7TS LRH), the Directorate therefore concluded that, pursuant to the Norwegian Health Personnel Act:

> ... on the basis of a total assessment of the project as a whole and since Section 29 of the Health Personnel Act does not provide justification for permitting observation, a

dispensation for conducting this project cannot be granted. In the opinion of the Directorate, any performance of the project must be based on consent from all patients attached to the hospital ward involved.

Three case studies to illustrate reasons for non-compliance

Below we present data that describe in some detail the relationship of the main author (MHH) to three patients, Ida, David and Tom. It was not possible to acquire explicit and informed consent to my presence from any of these three. The use of discretionary judgement from one situation to another was a common feature of the relationships.

Ida: 'Oh, please! Don't make me ...!'

Ida was acutely psychotic and had delusions and paranoid ideas. She was cautious, did not say much, and was polite and pleasant. I found her somewhat guarded in her contact with co-patients and employees and with me. To a certain extent she kept to her room, frequenting the common rooms for only short periods. However, after two weeks a form of contact had been established between us. I wanted the best for her: she was fragile and this was her first hospitalization. I also thought that Ida could be a significant participant. She was intelligent and reflective. When we came across each other in the corridor or when Ida came into the sitting room to chat with her co-patients, nurses and/or me, there was an instant rapport between us. Two days before she was to be discharged I asked her if she would consider being interviewed. She consented, and we made an appointment for the following day. Ida said she thought she had something important to tell me about her very first frightening experience of being psychotic and being admitted to an acute ward.

However, Ida seemed evasive the following day. When I cautiously reminded her of our appointment, she said she thought other patients would have more to contribute than her. I felt intuitively that I should keep my distance and leave her alone. She was discharged shortly after this encounter. The doubt about what had happened in my relationship with Ida preoccupied me. I recognized my eagerness to obtain information from her, information that I presumed would be extremely valuable, although there was something in her obvious vulnerability and withdrawal that made me also withdraw. I constantly consulted the nurses about those I was planning to recruit as participants; they gave me the impression that Ida would prefer to forget the entire psychosis, get out of hospital and carry on with her life. I did not find this interpretation convincing and I was left with no good explanation or advice about what was the 'right' action for a researcher.

Ida was re-admitted two weeks later. She seemed very ill. She talked incoherently and walked restlessly and unsteadily back and forth. She was unkempt and could not manage to dress herself or eat without help, but she remembered that I was a researcher in the department. I did my best to keep my distance at the same time as I tried to send her positive glances that were intended to signal: 'I'm still here, but I won't force myself on you.' I was in doubt about whether my message was understood. Maybe Ida thought I was keeping my distance as a sign of my disappointment over her previous refusal to be interviewed? It could also be that

my presence in the unit disturbed her. I felt uncertain about how to understand and tackle the situation.

One day Ida came up to me and said clearly and urgently, almost shouting and imploring: 'Oh please! Don't make me take part in the research project!' This episode made a deep impression on me, but it was also a relief. The uncomfortable situation was resolved. Her outburst was overheard by a nurse who told me that Ida was struggling with numerous voices and that she had the feeling of being under surveillance and steered by strong powers. Among the struggle and chaos, the nurse had realized that Ida was also fighting against 'tests' and being the victim of an experiment. I was grateful for the nurse's explanation and Ida's demonstration. The situation was also relevant to the question of whether participant observation poses an unacceptable additional strain on psychotic patients in an acute psychiatric department.

David: 'Will I get royalties from the book sales?'

David was a mature man who had been admitted involuntarily for psychosis. He had a long record of illness with several admissions. He functioned relatively well for periods and managed to use his creative abilities in his job. He had seen the notice about the research project and immediately made contact when he saw me. I perceived David's willingness to participate in the project as unusually intense. I tried to calm him down and to take the consent proceedings slowly. David became irritated and told me loudly and clearly that he really had a lot to contribute to the research. He almost ordered: 'Write down everything I say!' He was restless in his movements and disturbed many of the other patients.

I experienced many dilemmas resulting from his intense wish to take part in the project. I tried to withdraw by sitting elsewhere or talking to others, but he followed me and urged me once again to listen to everything he said about Norwegian psychiatry and his experience as a patient. I tried to keep my distance and reminded him that it was not primarily the patient's life I was focusing on but the nurses' work with patients. Aggressive and forthright, David replied: 'Them – the nurses – they don't work at all.' It was without doubt an interesting patient experience, and I followed it up in different ways that provided valuable data about David's experience of being pathologized and ignored.

Some days later he was again excessively eager about his commitment to the project. I now noticed that his interest was more positive and more factual. Applying the consent I had obtained, I started a new conversation with him. He proved to be skilled in writing and he had several intelligent questions about the research project. We sat in the common room in the unit and chatted for almost half an hour about psychiatry, nurses and research. He wanted to discuss how the doctoral thesis was to be written. He visualized a best-seller that would bring in a large income. I explained that I was going to write articles. He saw that as a poor solution and argued strongly for a book in which his experience could be given focus. When he had decided that a book must be published, he suddenly asked in total seriousness: 'Will I get royalties from the book sales?' My attempts to correct him seemed only to reinforce his opinion and he repeated it continuously. He became more insistent in his arguments and did not let me out of his sight. His behaviour towards me illustrated the problem of power dynamics and setting limits in psychiatry (the actual subject of the research project).

His 'quest' for the researcher's attention provided me with valuable data while also making me uncertain about whether it was right to include him in the research out of consideration for his own good (he was in a locked ward in order to regain his peace of mind). It was also annoying to be exposed to David's intense and persistent interest. It was a relationship from which it was almost impossible to escape. I noticed that to cope with the situation I activated the knowledge and experience I had acquired as a psychiatric nurse. My role varied between that of therapist and that of researcher. I activated a knowledge base that gave me power in the situation and that also enabled me to handle David's persistence. For a person researching the power dynamics of nursing care, this mixture of roles provided data and was interesting in itself, but it was also unpleasant and problematic.

Tom: 'Damn nosey status seeker!'

Tom was also very interested in the research project that he had read about on the notice in the corridor. His interest developed differently. I had heard at the morning meeting that Tom was unstable and that his behaviour towards women often emphasized sexual aspects. Tom appeared as I entered the sitting room. We introduced ourselves, and he said that the research project looked interesting and he would like to participate. He thought he had experience to contribute as he was older than me. He gradually became more interested in me than in the research. He was seeking contact. One day when we sat in the corridor he stroked my arm gently and made a comment about the jacket I was wearing. Suddenly he said, 'You really are nice-looking!' I thanked him for the compliment, sat there calmly and did not regard his interest as disagreeable or sexual, but rather as his way of making contact. We talked a lot, and he told me about his difficult life in and out of psychiatric institutions. He told me about his sadness at not fulfilling his own and others' expectations of his career. He appeared to be a gifted man with artistic talents. This changed shortly afterwards.

For some days there was considerable unrest in the department, with several new admissions, aggression, piercing screams and vandalism in the sitting room. Tom could not tolerate the changes in the environment and became disturbed and very anxious. One day when I entered the unit he shouted: 'You just walk around here snooping. Damn nosey status seeker! You don't know anything! You're a careerist! Just keep away from me with your research!' I was upset because the accusations were crass and I found them unreasonable, but I did not have the 'right' to argue. My task was to observe, converse and make notes. I was there primarily to do a job rather than to take on the function of therapist, even though I once again experienced that it was difficult to make a distinction between the roles. I thought Tom's reaction should be understood in the light of my having unlimited development opportunities while he had ended up fighting for his mental health and regretting an abandoned career. He saw that I was upset and suddenly expressed concern about having been so angry. He apologized again and again; he assured me that the project was important and that he would do all he could to support it.

This episode was a new challenge for me. I wondered how to handle Tom, the course of his illness and his consent to the research. Should I take into account the fact that at his most anxious and insecure time he had turned his back on me and withdrawn his consent? Could I regard it as an episode and an exception that confirmed his 'yes' to the consent? Was his consent to participation merely a fulfilment of his wish for contact

with a person who had time to sit and listen? Was this an ulterior motive that was acceptable from the viewpoint of research ethics?

I was present the day Tom was discharged. He felt calmer and was ready to leave. He shook my hand and thanked me politely for the time and attention I had given him and hoped that his contribution would be useful for my research.

Summary

The case histories leave an impression that the research was conducted in a field where both the patients and the ambience are characterized by great despair, sadness, rapid changes in atmosphere, insecurity and aggression, but also by pleasure and new opportunities. The unreliability of informed consent is clear and the patients' fluctuating capacity[2] to assess what they are being asked about is striking. The above descriptions show how demanding it was to relate to these patients and how I repeatedly had to activate my skills as an ethically conscious researcher, participant observer and psychiatric nurse. My doubt about what was right and what was wrong is clearly conveyed.

Discussion

With empirical data on problems concerning research ethics as our starting point, our discussion will now cover three different standpoints. We start with the most extreme solution to the dilemma facing us: that the project should not be carried out because it was impossible to obtain informed consent. We then discuss the practice that was established and study more closely the research ethics issues that arose, particularly the consent problem. In the third and final part of the discussion we outline and argue the necessity of the researcher applying discretionary judgement and a flexible, more situation-orientated approach to the ethical challenges linked to vulnerable patients' integrity.

No research without consent

One consequence of the injunction to obtain consent and the subsequent problems in the research field was the conclusion that the injunction from the supervisory body (the Directorate for Health and Social Affairs) made correct practice impossible and that the project would therefore have to be terminated. The Directorate underlines the importance of protecting psychotic patients owing to their vulnerability. This is a standpoint we support. Furthermore, the Directorate claims that psychotic patients are so vulnerable that it is unacceptable to involve them in schemes in which a researcher participates in the field for a long period. Does the patient's vulnerability therefore preclude the researcher being integrated into the therapeutic arena? The practice that was developed in this research project indicates a negative reply to this question.

The descriptions of Ida, David and Tom show, as the Directorate points out, that psychotic patients are vulnerable owing to their vague and to some extent flawed understanding of reality. They are afraid, and they probably experience existence as unpredictable and fragile. The descriptions, however, likewise show that, despite their vulnerability, they are brave and 'strong': they interact with the people around them,

they are humorous and they dare to express their opinions, often with great force. The descriptions also show that the researcher was in doubt when she met both the patients' strength and their vulnerability, and she activated different types of competence to handle the situations. We consider the doubt to be positive, and so far have restricted ourselves to stressing that vulnerability is a complex phenomenon. There are grounds to question whether the perception of psychotic patients as vulnerable contributes to devaluing them and deprives them of their legal capacity, with the result that they are not expected to be able to take decisions and be rational in certain areas.[2,16,17] We do not rule out that it may be a positive experience for patients who have limited autonomy to meet a researcher who has interest in their experience because they are then approached with expectations of having their own opinions.[18]

Conducting the type of research described here is closely connected with co-operation in the workplace and gives employees an insight into how a researcher handles situations with patients/research participants. When we decided to continue the project despite the fact that it was not feasible to implement the injunction, the decision was influenced by support from professional circles both within and outside the department where the project was conducted. Solid backing from the practice field, the university and the research ethics bodies inspired us to continue collecting data. This meant that individuals with wide and comprehensive expertise in research ethics, professional ethics, psychiatry and qualitative research methods considered the research ethically acceptable and did not agree with the public supervisory body's instructions.

It is also worth mentioning the need to develop knowledge of what takes place in psychiatry. For some time, acute psychiatry has been the frequent object of strong criticism, partly because it is regarded as a field that is closed to access. Research can help to bring to light both critical and constructive aspects of therapeutic practice. There is clearly a need for knowledge about what happens on a daily basis in an acute psychiatric department: what creates dignity and what degrades patients?[19] An interesting example from our material that shows the ambiguity of care concerns the setting of limits for David. Setting limits for patients' behaviour can be degrading, even though it is necessary to promote dignity at that moment and in the long term. The way in which limits are set may appear demeaning, but the process can also create dignity and must be interpreted in the light of the specific context. Knowledge of this type of process between patients and employees cannot be acquired if the researcher does not participate and try to understand what is happening.

Consent is not only consent

At the very first meeting with the department/research field, MHH was struck by how data on the field flowed in continuously, even though the intention at the start was only to obtain consent. Being shut in and locked up, hearing shouts and seeing bed restraints etc provides information about power in therapy. The point is that collecting data cannot be separated from requesting consent in this type of research.[2,3,5,20–22] MHH's attempts and investigation to determine how far Ida, David and Tom should be involved in the research shows how important it is to establish a relationship that can form the basis for assessing what is in the best interest of the participant. Establishing relationships with psychotic persons takes time and is demanding. It is inevitable that information is acquired in the process of obtaining consent, and in this

type of research it is therefore not possible to distinguish between procuring information and being present, which entails the researcher having access to information that is subject to confidentiality.

The fact that there is a connection between achieving information about patients and that negotiations about consent may take time also sheds light upon another issue that has been a focus in qualitative research for the last 10–15 years, namely, 'process consent'[21,23,24] or 'ethics as process'.[25] These concepts have been discussed in several ways, based on different kinds of research projects.[24-26] A common trait, however, is that there seems to be a growing awareness of the dynamic qualities of qualitative research (especially participant observation). An understanding that consent is given once and for all is both insufficient and misleading. From the stories of Ida, David and Tom we would like to point out two issues. First, it is obvious that their consent was invalid because of their rapid shifts of opinion about whether or not to participate in the research project. Their consent had to be continually negotiated. Second, the relationship and communication between the patients and MHH was at times based as much on MHH's therapeutic skills as on her research competence. Her professional background in psychiatry was of vital importance for her ability to interact with the psychotic patients and take into consideration whether or not she could rely on their willingness and abilities to be part of her research.

The three narratives from the 'non-compliant phase' illustrate that, in different ways, these patients had a somewhat unclear understanding of to what they were consenting. Ida, for example, wanted to relate her experience even though it was frightening for her to talk about what she had been through. However, she had consented and MHH could have exploited the situation and maintained that 'consent is consent'. (Those who were interviewed signed a consent form. At that time Ida had not given her written consent to being interviewed.) Ida was in an extremely psychotic state on her second admission, thus research would have seemed the same to her as 'tests'. She may also have presumed that tests and observations of her would be made secretly. A common problem with psychotic patients is that they feel they are being monitored and recorded. Ida was worried about having contact with a researcher she thought would make records and carry out tests. MHH experienced ambivalence between not burdening the patients with information and explanations on the type of research she was conducting while realizing that patients like Ida could develop 'crazy' and disturbing associations such as that research in psychiatry involves tests and perhaps manipulation. The ambivalence reinforced the doubt about whether her daily collection of data in the department was too stressful for the patients. Would the knowledge the project provided in the long term justify the strain expressed directly or indirectly by the patients?

A dubious feature of researchers who comply with the rules is that they follow standards and procedures rather than endeavouring to exercise discretionary judgement in their assessments. It is tempting to simplify the complex and difficult aspects, and thus claim that the research is safe and ethically acceptable, even though this is not necessarily the case. How can consent show that no persuasion, inveigling or coercion occurred?[27] The point of consent is that it is intended to prevent those taking part in research being deceived or exposed to coercion; but full consent is an illusion.[27] MHH felt relieved on the days she had obtained consent from all the patients (in the 'compliance phase'), but there was still a nagging doubt because she knew that several of them had signed a document without understanding what it implied. She therefore

felt she had behaved unethically, even though in formal terms she was in the right. The fact that she chose to be 'non-compliant' did not make her daily work less complex. On the contrary, throughout the 'non-compliance process' she was constantly aware that she should check and appraise the value of any consent. Ida provides an example of obtained consent that soon became refusal to participate.

The whole question of consent seems strange in a department where limits are strict and clearly defined by the staff and where the patients are largely deprived of the authority to decide for themselves. Ida's reactions illustrated that the practice created anxiety and insecurity among the patients. Tom's frequently ambivalent attitude to the project also shows that he was not competent to give informed consent because he regarded MHH as 'damn nosey'. Both the employees and MHH found such conduct unnecessarily disturbing for a treatment unit where the key concepts were security, calmness and structure. David was unambiguous in his desire to participate and he undoubtedly had extremely valuable experience to contribute. The reason MHH was reticent was that she did not consider him competent to give consent. His interest in the project also faded as he became less psychotic and regained greater control over himself, but MHH could have taken his consent as given and thus placed less emphasis on his failing competence.

Flexible and extended perception of consent

So far our discussion has focused on a dual standpoint: 'yes' and 'no' to consent. The message is that it is important to consider psychotic patients' vulnerability and consent, but this must be negotiated depending on the situation and by using a complex knowledge base. It is neither feasible nor acceptable to found actions only on rules.

Several authors have disputed the view that qualitative research methods are 'harmless' compared with research that involves trials of new types of treatment, and that the rules for consent are less stringent for this type of research.[3,28] Research involving the researcher participating actively in the field/department poses a major risk of offending the patient's integrity. For example, the concept of a mutual relationship between researcher and patients conceals the fact that research exploits others for the purpose of creating knowledge.[29,30] Ida is an example of a participant who agreed to be interviewed only to withdraw her consent vigorously later. She appeared to be troubled by MHH's presence and by her possible participation in the research. Indeed, she misunderstood the type of research involved and refused corrective information. MHH was in doubt about whether Ida was harmed by her presence. Similarly, one can also question whether David and Tom (who were respectively indiscriminately persistent and ambivalent to the project) were so disturbed by MHH that their disquiet and insecurity increased. We are left with doubt, and we give the researcher the benefit of the doubt. Here, as well, assessments from the staff were critical for MHH remaining in the field. We believe that MHH's knowledge of psychiatry and her experience with psychotic patients' insecurity were of help and ensured respect for the patients' integrity. We believe that in general the risk of distress was low.[2,31,32] Nonetheless there is a danger of following the customary power patterns that can degrade patients. Contact with patients/participants constitutes a continuous challenge that must be interpreted and

handled according to the situation, and it demands 'a wide and robust concept of reflexivity' (p. 134).[22]

We argue that it is appropriate not to view research ethics in isolation but to consider which other sources of knowledge a researcher can use to ensure good and acceptable research practice. Further discussion therefore includes professional knowledge and qualitative research competence as relevant knowledge bases.

Clinical competence and research ethics

Requirements regarding ethical awareness and safeguarding patients' integrity are basic concepts in psychiatry. MHH's professional background enabled her to behave with sensitivity and respect. For instance she withdrew (not exerting pressure on Ida when Ida retracted her consent to the interview) or accepted verbal attack ('damn status seeker', 'you just walk around here snooping') in a matter-of-fact way and calmly. MHH's response was founded on clinical experience from psychiatry, where developing skills in accepting what patients express represents a major form of competence. Managing specialized knowledge is ultimately dependent on the person in question. The researcher's individual aptitude – and ability to exercise good professional judgement – is therefore vital for participant observation to be carried out in an ethically acceptable manner. However, professionals with a high degree of ethical awareness may still behave unethically in their research. Researchers with qualifications in psychiatry who are accustomed to frequenting the power structures of an acute psychiatric arena may be blind to their own exercise of power and offensive behaviour. This is a major argument against the importance of specialist knowledge. Nonetheless, MHH's clinical experience and theoretical knowledge of psychosis may also have been an advantage in enabling her to manoeuvre her way around the acute ward in the best possible manner. Several authors have maintained that treatment providers have relational skills that can be used in research.[33,34]

Considerations concerning how close or distanced MHH was to be at any time are expressed in the descriptions and analyses of Ida, David and Tom. One example is her anxiety about having threatened Ida on the question of her being interviewed. Managing knowledge of psychosis includes attempting to interpret patients' statements – both spoken and unspoken – about how much close contact they can handle. It was also necessary to check one's personal interpretations by talking to the employees and listening to the professional discussions they held. Even if specialist knowledge and clinical experience are important, thoughtful researchers should also have a conscious relationship with the psychiatric context of which they are part. The knowledge one acquires is developed in a certain area and has certain assumptions about the person and the mental disorder. However, it is difficult to imagine that a project such as ours could have been carried out if MHH had too greatly disregarded the prerequisites on which her work was based.

Consideration of knowledge interests can also obscure the researcher's ethical awareness. The compromise between knowledge acquirement and personal protection is demanding. Good management of specialized knowledge is therefore hardly a satisfactory prerequisite for ethically acceptable research.

Methodology competence and research ethics

Research methods are related in complex ways to research ethics and professional practice.[35] Qualitative approaches are often justified by an interest in researching for meaning, subjectivity and experience. Qualitative methods are characterized as phenomenological and sensitive to context. The distinctive characters of various research methods are connected to positions of scientific theory, where the relationship between researchers and the persons and contexts to which they link their research is perceived as mutual and dynamic. Emphasis is given to the researcher as a creative person. Researchers' reflectivity is connected to their consciousness of how they create themselves through interaction with the field in which they are conducting research. The perception that the relationship between the researcher and those researched is intersubjective breaks with the norm of researchers' neutrality.[6–11,36,37]

The shift in method towards the dialogical relationship between participant and researcher is of importance for research ethics. The requirement for researchers to have reflected on their own self-awareness can promote a clearer consciousness of their responsibility to take care of the research participants' well-being. In our project, MHH's self-reflection and consideration for the participants were expressed in several ways. She tried to be aware of the impact her presence had on the patients. With David and Tom it seemed that the expectations they created as participants were exaggerated compared with MHH's intentions. The extent to which her awareness of how they perceived her should have guided her towards assuming a more distanced position can be discussed. The main reason for being in the common rooms with them was that she felt she was not harming them. When they were anxious and afraid, MHH – just like the employees – was given a misunderstood role. It may well be that the patients were exposed to no greater 'risk' through MHH's presence than that they would have experienced anyway as a result of their current state.[2,38] When they improved, their reactions were somewhat different: David was no longer particularly concerned about her, while Tom continued to be curious, perhaps because of his great need for contact, which was largely satisfied by MHH. This shows that, through being part of what they are studying, researchers take on a normative role. The role of researchers is not objective; they therefore bear a special responsibility.

Concluding remarks

In this article we have shown that the principle of obtaining informed consent is extremely problematic and does not guarantee ethically acceptable research practice. One-sided monitoring of the requirement for patients who participate in research to give informed consent can appear directly opposed to the good intentions and can give the researcher an unjustified free hand to collect data. Based on experience of qualitative research in acute psychiatry we have shown the ways in which psychotic patients daily challenge researchers to take responsibility and to think carefully about the extent to which patients can and should be included in research.

We conclude that a reasonable criterion is that those involved are given information and have the right to refuse. This is not sufficient, and researchers must take continuous responsibility for assessing what is in the best interest of patients. The assessment is demanding and has no standard solution. Good research judgement is

needed and this must be exercised in the context of each situation. Discretionary assessments require the researcher to possess high ethical awareness, good insight and experience of qualitative research methods, combined with specialist therapeutic competence. This is no simple prescription. It rests on an awareness that doubt must be respected and that researchers' assessments and their understanding of situations may be erroneous.

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