

Encounters with patients in forensic inpatient care.

- Nurses lived experiences of patient encounters and compassion in forensic inpatient care.

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Thesis for Licentiate degree in Nursing Sciences

Mid Sweden University

Sundsvall, 2020-10-23

Akademisk avhandling som med tillstånd av Mittuniversitetet i Sundsvall framläggs till offentlig granskning för avläggande av licentiatexamen, 2020-10-23 10:30, M204, Mittuniversitetet Sundsvall. Seminariet kommer att hållas på svenska.

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Printed by Mid Sweden University, Sundsvall

ISSN: 1652-8948

ISBN: 978-91-88947-74-1

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Mid Sweden University Licentiate Thesis no. 174

Dedication

To Åsa, Alma & Astrid – the most important thing in life is you

Table of content

Abstract	vii
Summary in Swedish	ix
List of papers	xi
Preface	xii
Introduction	1
Background	2
<i>Psychiatric institutionalisation – a historical perspective</i>	2
<i>Forensic psychiatry</i>	5
<i>Forensic nursing</i>	7
<i>Nurse–patient encounters</i>	10
Rationale	12
The purpose of the study	14
Philosophy of science and design of the study	15
Design	15
Methodological framework	16
Phenomenology	16
Hermeneutics.....	17
<i>Hermeneutics and the research participants</i>	18
<i>Author’s preunderstanding and preconceptions</i>	19
Methods	20
<i>Settings</i>	21
<i>Participants</i>	21
<i>Data collection</i>	22
<i>Analysis method</i>	24
Ethical considerations	25

Findings.....	27
<i>Paper I.....</i>	<i>27</i>
<i>Paper II.....</i>	<i>30</i>
Discussion.....	34
<i>An interpretation of studies I and II.....</i>	<i>36</i>
<i>Being sensitive and responsive.....</i>	<i>37</i>
Keeping distance	40
Methodological considerations	45
Conclusion.....	51
Suggestions for further research	52
Implications for practice.....	53
References.....	55
Acknowledgements	65

Abstract

Background Forensic psychiatry is characterised by compulsory care and long hospital stays, where nurses care for patients with severe mental illness, who often have committed crimes. The main objective is to rehabilitate the patient to once again become a part of society by improving mental health and decreasing the risk of criminal relapse. This is mainly achieved through encounters with the patients. Encountering patients in forensic psychiatry means coming face to face with suffering and the duality of caring, doing what is best for the patient and protecting society.

Aim The purpose of the study was to obtain a deeper understanding of encounters with patients with mental illness in forensic inpatient care as experienced by nurses.

Method This licentiate thesis consists of two studies (I, II), both conducted with a qualitative design. A total of 13 nurses working at a forensic psychiatric hospital in Sweden were recruited through a purposive sample to participate in the studies through narrative interviews. Study I was analysed with phenomenological hermeneutics in line with Lindseth and Norbergh (2004) in order to illuminate the lived experience of nurses' encounters. Study II was a secondary supplementary analysis, which applied hermeneutics in line with Fleming, Gaidys, and Robb (2003) to gain a deeper understanding of nurses' compassion in forensic psychiatry. The two studies were merged to provide a comprehensive understanding in this licentiate thesis.

Findings Study I illuminated the meaning of nurses' lived experiences of encounters with patients with mental illnesses in forensic inpatient care, that is the nurses' desire to do good despite being confronted with their own emotions as fear, humiliation, and disappointment. Encounters were also occasionally perceived as positive, awakening emotions of compassion, competence, pride, trust, satisfaction, and gratification regarding the patient's recovery. However, a source of conflict was the struggle between doing what was best for the patient and protecting society. The study comprised of four themes: *being frustrated*, *protecting oneself*, *being open-minded*, and *striving for control*. Study II aimed to gain a deeper understanding of nurses' compassion in providing forensic psychiatric inpatient care with three themes: *recognising suffering and need for support*, *responding to patient suffering*, and *reacting to one's own vulnerability*. Abstracting to a main theme of *being compassionate in forensic psychiatry which is described as an emotional*

journey, an ongoing inner negotiation between own vulnerability and expressions of suffering. This inner negotiation of making sense of patients' plea and how they were perceived was crucial for determining the development of compassion rather than turning to control and rules as a means to protect oneself.

Discussion A interpretation of the studies (I, II) revealed two topics, *being sensitive and responsive* and *keeping distance*, which were reflected upon against the theoretical framework of Kari Martinsen. The studies showed that nurses faced a variety of encounters that forced them to face their own vulnerability and that trust could reduce power imbalances as well as help deal with societal, man-made constructs. The nurses' encounters with incomprehensible expressions of suffering also show that nurses need to find a way to make room for "expressions of life"—taking a step back and turning their gaze inwards – in order to regulate their own emotions. This may better equip nurses to encounter patients with compassion and kindness rather than turning to norms and rules to protect themselves and guard their own vulnerability. Rather than distancing themselves from the patients, nurses can instead take a step back to come closer to their patients.

Summary in Swedish

Bakgrund Rättspsykiatrisk vård kännetecknas av tvångsvård, långa sjukhusvistelser, där vårdare tar hand om patienter med allvarlig psykisk ohälsa, som ofta begått brott. Huvudsyftet är att rehabilitera patienten så att denne återigen blir en del av samhället, förbättra mental hälsa och minska risken för återfall i brott. Detta uppnås främst genom vårdande möten med patienterna. Att möta patienter i rättspsykiatrisk vård innebär att stå inför lidande och dualiteten i att värna om patientens bästa och skydda samhället.

Syfte Syftet med studien var att få en djupare förståelse om bemötande av patienter med psykisk ohälsa i rättspsykiatrisk vård ur vårdarens perspektiv.

Metod Denna licentiatavhandling består av två studier (I, II), båda genomförda med en kvalitativ design. Totalt 13 vårdare som arbetar på ett rättspsykiatriskt sjukhus i Sverige rekryterades genom ett ändamålsenligt urval för att delta i studierna med narrativa intervjuer. Studie I analyserades med fenomenologisk-hermeneutik i linje med Lindseth och Norbergh (2004) för att belysa den levda erfarenheten av vårdares möten. Studie II var en sekundär kompletterande analys. Som analyserades med hermeneutik enligt Fleming et al (2003) för att få en djupare förståelse av vårdares medlidande inom rättspsykiatrisk vård. De två studierna slogs samman för att ge en omfattande förståelse i denna licentiatavhandling.

Resultat Studie I belyste betydelsen av vårdares levda erfarenheter av möten med patienter med psykisk ohälsa inom rättspsykiatrisk vård. Däri framkom vårdares vilja till att göra gott trots att konfronteras med egna känslor som rädsla, förnedring och besvikelse. Möten upplevdes ibland som positiva, känslor av medlidande, kompetens, stolthet, förtroende, tillfredsställelse och glädje väcktes när det gäller patientens återhämtning. En källa till konflikt var dock kampen mellan att göra det bästa för patienten och att skydda samhället. Studien består av fyra teman, ”att vara frustrerad”, ”skydda sig själv”, ”att vara öppensinnad” och ”sträva efter kontroll”. Studie II syftade till att få en djupare förståelse av vårdares medlidande när det gäller att tillhandahålla rättspsykiatrisk slutenvård. Teman skapades; ”Erkänna lidande och behov av stöd”, ”svara på patienters lidande” och ”reagera på ens egen sårbarhet”. Dessa teman abstraherades till ett huvudtema, ”vara medkännande i rättspsykiatrisk vård, vilket beskrivs som en känslomässig resa”, en pågående inre förhandling mellan patientens uttryck för lidande och egen sårbarhet, denna inre förhandling om att känna patientens vädjan och hur detta upplevdes

var avgörande för utveckling av medlidande och för att vårdarna inte skulle vända sig till kontroll och regler som ett sätt att skydda sig själv.

Diskussion En sammanfattande förståelse av studierna (I, II) avslöjade två områden "att vara känslig och lyhörd" och "hålla avstånd", vilket återspeglades i ljuset av Kari Martinsens teoretiska ramverk. Detta visar att vårdare ställdes inför olika patientmöten som tvingade dem att möta sin egen sårbarhet. Att förtroende kan minska maktbalansen, men också problematiken med att ta itu med samhälleliga och olika sociala konstruktioner såsom regler och normer. Att möta obegripliga uttryck av lidande innebar också att vårdare behövde hitta ett sätt att ge plats för "livsuttryck", ta ett steg tillbaka, vända blicken inåt för att reglera sina egna känslor. Således kunna möta patienter med medlidande och godhet, inte vända sig till normer och regler för att skydda sig själv och egen sårbarhet. Således inte distansera sig från patienterna, utan istället ta ett steg tillbaka för att komma närmare patienten.

List of papers

This licentiate thesis is based on the following studies, referred to in the text by their Roman numerals:

- I. Hammarström, L., Häggström, M., Devik, S.A., Hellzén, O. (2019). Controlling emotions – nurses' lived experience caring for patients in forensic psychiatry. *International Journal of Qualitative Studies on Health and Well-being*, vol.14.1, 1682911. doi:10.1080/17482631.2019.1682911

- II. Hammarström, L., Devik, S.A., Hellzén, O., Häggström, M. (2020). The path of compassion in forensic psychiatry. *Archives of Psychiatric Nursing*. doi <https://doi.org/10.1016/j.apnu.2020.07.027>

Preface

After spending the greater part of my adult life working in forensic psychiatry as an assistant nurse, nurse and eventually a specialist nurse, I have always been fascinated with nurse–patient relationships – something that has pulled me back to forensic psychiatry despite working in other contexts. Regardless of whether you are a nursing student, practitioner or tutor, patient encounters are inevitably the centre of your practice. This is the very moment the nurse and patient come face to face and the gift of nursing is supposed to be received by the patient, something that is very evident in forensic psychiatry. For me, the ability to isolate this singular aspect of nursing and the care given was and still is very intriguing. Conducting these studies meant being able to contribute knowledge that will hopefully enrich forensic psychiatry and nursing as a subject. My hope is that the studies will also provide insight and knowledge that inspires reflection with the potential to improve the care given through Sweden’s forensic psychiatric hospitals.

Introduction

In this study, the intention was to obtain a deeper understanding of encounters by illuminating nurse–patient encounters through the eyes of nurses working in a forensic psychiatric setting. The study intends to clarify the meaning of the nurse–patient relationship in everyday encounters. These encounters are included in the care given at a forensic clinic, which is described in this study through the perspective of the nurses who deliver care intended to ameliorate the suffering of patients with severe mental illnesses, thus restoring health and playing a key role in the patients’ reintegration into society.

Contrary to popular belief, the majority of time spent within forensic inpatient care consists of encounters rather than structured events (Rask, Hallberg, 2000). Encounters within forensic psychiatry are often unplanned, unstructured, and happen during everyday activities. Nurses often find themselves in situations alone with the patient, where the encounter could be seen as an opportunity for sharing and a chance to lend an helping hand (Rytterström, Rydenlund, Ranheim, 2020). Capitalising on this opportunity means making an effort, closing the gap between the two individuals, and meeting the other with respect and dignity (Gustafsson, Wigerblad, Lindwall, 2013). Working in a forensic setting also means navigating within an environment with rules, coercion, threats, and violence, often finding oneself alone with individuals that can be perceived as intimidating or dangerous (Rytterström, Rydenlund, Ranheim, 2020).

Swedish health care is governed by generally applied rules and regulations, which state that nursing care is founded upon certain values and a belief in a humanistic view of humanity (SFS, 1982:763). Controversially, there is a gap

between what the law stipulates and the actual care given, a gap that has been described by Skar and Söderberg (2018), whose research emphasises the content of care from the patient's point of view. Their research has looked at how patients express dissatisfaction, the prevalence of meagre and overlooked care, patient suffering and the overall sense of being treated poorly, concerns that have proven to be widespread, especially in forensic inpatient care (Hörberg, 2008; Sjögren, 2004). Previous research also indicates that nurses are finding it hard to make time for the patient (Nortvedt, 2001). Hörberg's (2008) extensive research in the field of forensic nursing suggests that nurses working in a forensic setting struggle with their duties. The struggle of navigating between the duality of doing what is best for the patient and also dealing with the responsibility of adapting to rules and legislation that surround the delivery of care make it hard for nurses to know how to act in certain situations.

Background

Psychiatric institutionalisation – a historical perspective

The following section describes psychiatric institutionalisation up to the phase-out that began in the 1970s. The contemporary picture of mental illness has a historical background, and following its historical footsteps can provide an understanding of contemporary forensic psychiatric care. According to Lidberg and Wiklund (2004), mentally ill offenders have always been treated differently. Historically, the purpose of care was to keep these individuals separate from the rest of society by placing them in hospitals with indefinite periods of care. In today's Sweden, an individual who has committed a crime due to mental illness and is considered a danger to himself/herself or others can be referred to forensic inpatient care (Innocenti, Hassing Lindqvist,

Andersson, Eriksson, Hansson, Möller, Nilsson, Hofvander, Anckarsäter, 2014). Forensic psychiatry has two main purposes: treating the patient and protecting society from additional harm (Sjögren, 2004). In order to protect these patients from harming themselves and others, they are often cared for in particularly secure environments where the focus is on managing their mental illness and recovery as well as a risk assessment for future criminal behaviour. Unlike other countries, forensic psychiatry in Sweden is not limited in time (Rytterström, Rydenlund, Ranheim, 2020). This means that institutional forensic psychiatric care can be seen as the last remaining remnant of institutionalised psychiatry, with its long periods of care, which is why a historical review can help explain the difficulties nurses currently face within forensic inpatient care.

Qvarsell (1982) states that the 1800s should be seen as an important time period for how mental illness has historically been perceived. It was during this period that the view of the mentally ill changed from individuals suffering from something unexplainable to individuals suffering from something curable that can be explained from a medical viewpoint. As time passed, science also advanced and political views became more and more progressive, which greatly affected the treatment of people previously classified as insane (Qvarsell, 1982). This meant that for the first time, these individuals were not simply considered to be a problem that needed to be kept away from society by shuffling them off to various institutions, but individuals in need of care and treatment (Qvarsell, 1982).

This was considered the starting point of the very first mental asylums in Europe. In 1855, the first Swedish mental hospital, Konradsberg, was built, followed shortly after by Danviken and Vadstena (Qvarsell, 1982). In parallel

with the expansion of the mental hospital system, society was also starting to grasp the impact of mental health policy decisions. In the mid-1860s, there were approximately 1,000 patients admitted to mental asylums in Sweden alone, and at the beginning of the 1900s, there were about 4,600 patients admitted under psychiatric care (Qvarsell, 1982). During this time, the concept of treatment became a central aspect of the care patients received, forcing the mentally ill to be hospitalised and subjected to moral fostering under the supervision of doctors (Flygare, 1999). The number of admitted patients greatly increased by 1930 to 16,000 individuals. As the need for more mental hospitals arose, Säter's mental hospital was built, which housed up to 1,600 admitted patients in the 1950s. Qvarsell (1982) described the mental hospitals from this era as grandiose and wasteful, large buildings with giant gardens that became, self-governing and self-sufficient – almost small communities. The hospitals sometimes even had their own churches and cemeteries, a final resting place for both staff and patients alike. The hospitals were organised into three different wards depending on how “uneasy or disturbed” the patient was. In addition, there were also so-called special wards with enhanced security features, such as extra bars for the windows and a promenade area surrounded by high walls. There were also two so-called permanent pavilions (closed wards) at the Säter and Västervik hospitals. Having a permanent pavilion meant that the building had particularly strict security features that made it more difficult to escape. In practice, there were two groups of patients who were placed in a permanent pavilion: very difficult patients who were transferred from other hospitals and those were deemed to be especially dangerous (Garpenhag, 2012).

From the 1930s to the 1970s, the number of patients admitted to Sweden's mental hospitals increased to 40,000. Unfortunately, the number of spaces

available for inpatient care did not increase in line with the increase in patients, as the expansion of Swedish psychiatry came to a halt. This immense need became the catalyst for the construction of a number of new mental hospitals, Beckomberga, Lillhagen, and Ryhov. Beckomberga was Sweden's largest mental hospital at the time, accommodating a staggering 2,000 patients. In retrospect, this period also represents the peak of the Swedish mental hospital system, as the introduction of psychiatric medication greatly impacted the delivery of care. Starting in the 1950s, medications that were previously lacking now played a major role in psychiatric care, becoming readily available treatment options for anxiety disorders and psychotic disorders among others (Qvarsell, 1982).

According to Sjöström (2000), this period in the mid-20th century was marked by a change in rules and legislation regarding psychiatric care that did not have the intended effect. The intention of this legislation was to shorten the length of compulsory care, which, in retrospect, was not the result. Legislation in 1967 did represent a major shift in policy making from the state to the county councils, forcing the counties to manage the 36,000 patients admitted to Swedish psychiatric care at the time. This was also the starting point of the merger between psychiatric care and somatic care, which in the closure of many of the major psychiatric hospitals. In the 1980s, a vast majority of the major psychiatric hospitals in Sweden closed their doors for good. Today, most of the psychiatric patients admitted are found at psychiatric clinics and public hospitals.

Forensic psychiatry

Forensic psychiatry is considered to be a specialised and distinct area of psychiatry, which is characterised by extended periods of care (Melzer, 2004;

Shaw, Davies, Morey, 2001; Vorstenbosch, Bouman, Braun, Bulten, 2014) and a desire to remain at the forefront of what can be considered a safe, therapeutic, and secure environment (Seppänen, Törmänen, Shaw, Kennedy, 2018) . These characteristics make the specialisation the closest link to the psychiatry practices of the past. The delivery of care is governed by the law, i.e. deciding whether a crime was committed while suffering from a severe mental illness, and relies heavily on medications. The view of justice itself can be seen as quite complex and rather outdated (Adshead, 2013). Forensic psychiatry encompasses investigative activities and care, treatment of offenders sentenced to forensic psychiatric care, and involuntary treatment of those who have committed a crime as well as private citizens. Even though the principles and aim of forensic care can be seen as universal, the laws and regulations governing the delivery of care differ greatly from country to country (Edworthy, Sampson, Völlm, 2016; Sampson, Edworthy, Völlm, Bulten, 2016). The Law on Forensic Psychiatric Care (LRV, 1991:1129) treats the special conditions that apply in the case of forced psychiatric care for arrested, detained and convicted persons who are transferred to forensic psychiatric care by the court as a criminal sanction. Under LRV, care is primarily delivered at five of Sweden's regional clinics, Säter hospital, Sankt Sigfrid's hospital in Växjö, the forensic clinic in Vadstena, the forensic clinic in Sundsvall, and the Karsudden Regional Hospital (Strand, Holmberg, Söderberg, 2009). Aside from these major clinics, forensic care is also delivered at smaller wards around the country, primarily for individuals who are cared for under the act on Psychiatric Compulsory Care (LPT, 1991:1128), including individuals who are in immediate need of inpatient psychiatric care and have not committed a crime. In order to receive care under any of these to laws, the patient must be suffering from severe mental illness, a judicial term including individuals who, according to SOSFS (2008:18), suffer from

psychosis, have a distorted perception of reality with confusion, thought disorders, hallucinations, delusions, depression with attempted suicide, severe personality disorder with impulsive behaviour, and occasionally kleptomania, pyromania, and sexual perversions. Approximately 300 to 400 patients are referred for forensic psychiatric care every year, with about 1,400 inpatients in Sweden per year. The majority of forensic psychiatric patients are men, have a mean age of 41.2, and have committed some form of violent crime. The diagnostic panorama in forensic psychiatric care is broad, with a clear majority of patients (approximately 60 per cent) receiving care for schizophrenia or various forms of psychosis and 51 percent having a lack of insight into their own mental illness (Innocenti et al, 2014). Approximately 65 percent have previously been sentenced for some type of criminal act, which is often accompanied by a history of drug abuse. It is not uncommon for patients to relapse into violent crime when they once again become a part of society (Krona, Nyman, Andreasson, Vicencio, Anckarsäter, Wallinius, Nilsson, Hofvander, 2017).

Forensic nursing

Forensic psychiatry is a context with many “natural encounters” that demand a great depth of knowledge (Rehnsfeldt, 1999). This field of psychiatry is characterised by long hospital stays (Melzer, 2004; Shaw et al., 2001; Vorstenbosch et al., 2014) and can be highly complex in terms of whether the care delivered is viewed as care or control (Austin, 2001; Burrow, 1991; Holmes, 2002, 2005; Kettles, 2006; Maroney, 2005; Peternelj-Taylor, 1999; Peternelj-Taylor, Johnson, 1995; Sekula, Holmes, Zoucha, DeSantis, Olshansky, 2001). Face-to-face interactions in psychiatric nursing create opportunities to impact mental health through encounters where the individual who is starting the rehabilitation process is greeted, independent of the

different variables associated with the illness (Hellzen, Asplund, 2006). An encounter can never replace medication or therapy, but it can fill the void where therapy is insufficient. This is something that is especially relevant in today's psychiatry, where the caregiver works very closely with the patient. The fact that the patient has committed a crime may be a source of stress and frustration in these encounters and in the development of a trust in the relationship (Harris, Happell, Manias, 2015). Seeing the person behind the criminal act is an act of interpersonal caring and authenticity and stems from the principle of goodness. The caregiver must see themselves as a tool in rebuilding a caring relationship, where trust, time, and security are the foundation (SOU, 2006:100). In forensic care, as little as 30 minutes per day can be allocated to the actual delivery of treatment, consisting of 1 hour and 36 minutes of structured activities. The remaining time is spent on different activities, such as rest, various encounters with other staff members (Sturidsson, Turtell, Tengström, Lekander, Levander, 2007), and social interactions (Rask, Hallberg, 2000).

There is much that is not known about how nurses respond to patients' expressions (Myklebust, 2019), though it has been shown that forensic psychiatric care tends to either be fostering or caring (Hörberg, 2008). Caring for patients who have committed criminal acts is a source of stress and frustration for nurses (Harris et al., 2015) and can also be a source of distress, as encounters may mean delivering care alone with an individual who has committed a serious violent crime (Rytterström, Rydenlund, Ranheim, 2020). Being able to care for and establish a relationship with the patient is essential for the patient's recovery (Rydenlund, Lindström, Rehnsfeldt, 2019). Relationships are established through empathy, genuineness, and compassion (Möllerhøj, 2018; Wyder, Bland, Blythe, Matarasso, Crompton, 2015).

Compassion should guide a nurse's actions when encountering the suffering of others (Halifax, 2014). The inability to comprehend suffering may become an obstacle to compassionate action and reflection (Hsu et al., 2012).

There is currently very little research available regarding forensic nursing within a Swedish context. Despite this, there are a few major contributions to the subject of forensic nursing the author wishes to highlight in order to provide the reader with an overview of the context studied and to acquaint the reader with the purpose of this thesis. Authors that have had an especially profound impact on Swedish forensic nursing are: Rask (2002), Sjögren (2004), Hörberg (2008), Rydenlund (2012), Olsson (2013) and Kumpula (2020). Rask (2002) examines nurses work in forensic psychiatry and the content of nursing, how patients and nurses perceive various nursing activities, and supporting actions. This study also highlights responsibilities, actions, what nurses focus on in conversations with patients, and how satisfied nurses are with their work duties. Sjögren (2004) focuses on the care of patients who have committed sexual abuse against children. In order to provide effective care, caregivers need time for existential reflection in order to understand how they are affected by the patients they care for and to understand and encounter a different lifeworld. Hörberg's (2008) aim was to describe care in forensic psychiatry based on how it was experienced by those who provide care and by those who are cared for in a maximum security ward. The results showed that patients perceived psychiatric care as non-caring, adapted to the demands of the nurses. This study emphasises the corrective and disciplinary nature of forensic care and the balancing act in forensic nursing between care and fostering. Rydenlund (2012) contributed to a deeper understanding of this with a hermeneutic analysis of the caring conversation between nurses and patients who are enduring tremendous suffering. Olsson

(2013) reflects on patient and staff experiences of the turning points in care that led to recovery and a reduced risk of violence, which were characterised by feelings of vulnerability. This is described as a sensitive process that needs to be supported by trusting relationships. Kumpula (2020) describes the complex interaction between protection and care from a gender perspective. Kumpula states that male and female nurses tend to be linked to different roles and duties, that protecting society tends to be a higher priority than caring, that males have a paternal role, and that females have a more maternal role.

Nurse–patient encounters

Encounters between nurse and patient are at the heart of healthcare. It is in these encounters that the most important tasks are carried out to relieve suffering (Björck, Sandman, 2007). Being able to relieve suffering also means being able to interpret suffering over extended periods of time, which can be seen as a tiring task as nurses do not always feel that they have the necessary resources (Kumpula, Ekstrand, 2013). In the interaction between patient and healthcare staff, the patient's need for care is identified and forms the basis for treatment and rehabilitation. Increasingly, research is also showing the importance of nurse–patient encounters for positive treatment outcomes (Stenhouse, 2011). Respect, support, and commitment are examples of important professional attributes for the success of the patient. This is especially true when viewed from the patient's perspective, as these professional attributes are closely linked to satisfaction with care (Wagner, Bear, 2009).

An encounter can be seen as a relationship between patient and nurse, between two individuals who are in close contact with one another. Research has shown (see, e.g. Carlsson 2010) that there must be mutual trust and that both

parties must actively contribute to ensure the quality of the encounter. In forensic psychiatry, encounters are often unplanned and sudden, which means nurses also need to be open and prepared given the uncertainty of how patients will react. For example, greeting a patient with “open arms” means being open to others, but it also means risking harm (Rytterström, Rydenlund, Ranheim, 2020). According to Dahlberg and Segesten (2010), an encounter means that the nurse supports and strengthens the patient's health processes, a meeting where it is the nurse’s responsibility to ensure that the encounter will be caring by using his or her knowledge and skills. This requires that the nurse be compliant and open to the patient's lifeworld, making sure that the care is based on the patient's needs and is adapted accordingly. Even if the nurse–patient relationship is asymmetrical, research (Gustafsson, Snellma, Gustafsson, 2013) shows that the relationship must be based on mutual respect and a humanistic and altruistic value system (Jahren Kristoffersen, Nortvedt 2005). In forensic psychiatry, finding human similarities could mean, for example, making an effort, respecting dignity, and doing something extra for an individual who is perceived to be violent or intimidating (Gustafsson, Wigerblad, Lindwall, 2013).

Although the nurse’s mission is to promote health and alleviate suffering, Eriksson (1994) has identified a suffering that she refers to as “caresuffering”, a suffering that arises from staff behaviour, which should be seen as unnecessary suffering that can create feelings of powerlessness. Caresuffering means that the two parties do not align despite being in the same context. You speak without talking, meaning you speak at different levels, which leads to encounters characterised by inadequacy. According to Kierkegaard (1996), confirmation is the secret of conversation; confirmation is hearing what the other person is saying and responding accordingly. With the help of words,

we are put into relational and social contexts where experiences can be shared (Lögströp, 1978). Skjervheim (1996) developed and expanded upon Kierkegaard's thoughts and argued that as humans, we encounter each other through language, meaning that language is central to the encounter. In a care setting, this means for example, that the staff listens to what the patient has to say and responds.

Rationale

Everyday encounters and social interactions constitute a major part of forensic nursing. As stated earlier, encounters are the foundation of nursing and caring in a forensic inpatient setting. It is in these encounters that nurses are given the opportunity to have an impact on the patients' lives by giving the gift of nursing to alleviate suffering and to equip the patient with the necessary tools to achieve rehabilitation so that the patient can lead a safe, independent, and productive life. Caring in forensic psychiatry means being on the front lines, helping people who have committed crimes, and providing sensitive and compassionate care, often while being exposed to threats, violence, and sometimes incomprehensible expressions of suffering for extended periods of time.

In the evaluation of treatment in forensic psychiatry, SBU (2017) states that more research is needed in order to develop forensic psychiatry, it is of ethical importance. The results show that the need of research that can support the development of nursing is great, both for treatments, nursing and encounters. In the systematic overview of experiences of nursing, encounters and environment in forensic care, there were not enough Swedish articles with

qualitative methods found. Not enough to draw any conclusions in form of meta-analysis. Nursing and encounters are meaningful for the patient's rehabilitation and initiatives to develop this further is greatly encouraged. It is also reasonable to assume that research that focus on nurse-patient encounters could generate knowledge which may be used to develop best possible care and contribute to prevent negative consequences such as use of coercion, burned out caregivers, deteriorating patient health and recruitment challenges in forensic psychiatry care.

Forensic nursing is based on the value of "seeing the person behind the crime", nurses are supposed to use themselves to create a relationship with the patient, who is given the opportunity of processing, reflection and growth as a person. The Swedish Agency for Health Technology Assessment and Assessment of Social Services, or SBU (2017), describes a knowledge gap in Swedish forensic psychiatry regarding psychosocial interventions, such as encounters, and a lack of in-depth knowledge garnered from qualitative studies. The agency asserts that it is of special importance to focus on nursing research in forensic psychiatry, on what it really means for nurses to act as both guards and care providers at the same time, and to define the framework and content of what falls under the umbrella of forensic psychiatry. With increased knowledge about the phenomenon of encounters in forensic psychiatric inpatient care, nursing can hopefully evolve to become an even more caring profession. In this way, nurses can be better equipped to help patients improve, thus reducing the risk of destructive behaviour and potentially contributing to a decrease in recidivism, which is the main objective of forensic psychiatry.

The purpose of the study

The purpose of the study was to obtain a deeper understanding of nurse–patient encounters with patients with mental illness in forensic inpatient care as experienced by nurses. The study consists of two papers with the following aims:

- Paper I to illuminate the meaning of nurses’ lived experiences of encounters with patients with mental illness in forensic inpatient care.

- Paper II to gain a deeper understanding of nurses’ compassion in providing forensic psychiatric inpatient care.

Philosophy of science and design of the study

This qualitative study applies hermeneutics and phenomenological methods, meaning that the epistemology and methodology applied in the study are derived from the philosophy of phenomenology and hermeneutics. For the purposes of this study, I view epistemology as the theory of knowledge. The methods used represent the way we construct the new knowledge we describe (Carter, 2007). This study is based on open-ended questions, resulting in narratives of the participants' lived experiences of the phenomenon studied. These lived experiences are highly subjective (phenomenological). In order to understand respondents' narratives, I must interpret (hermeneutics) them to gain a better understanding while being aware of my own preunderstanding.

Design

In order to achieve the aim of the study, a qualitative design was used, that included phenomenology and hermeneutics. To answer issues regarding experiences and meaning, a qualitative design is preferable (Patton, 2015). Designing qualitative research is a reflexive process where various processes are carried out at the same time, for example, collecting and analysing data, refocusing the research question, discussing theoretical standpoints, and recognising threats to validity, where each process shapes the others (Mays, Pope, 2000). The essential scientific perspectives and the methodological framework that influenced the process are described in more detail below.

Methodological framework

Phenomenology

The narratives of nurses caring for patients with mental illness in forensic inpatient care were focused on the lived experience of each individual. The basis of phenomenology is the lived experience, as it is in this experience that we can examine all sides of a phenomena (Husserl, 1970). Lived experience is based on the individual's experiences of the lifeworld and cannot be regarded as something objective that can be reconciled with a true picture of the phenomenon. Instead, the lifeworld can be defined as the reality of everyday life and something we take for granted (Bengtsson, 1998). Through narratives, we gain access to people's lived experiences and the emotional reactions that result from these experiences. The fundamental purpose of phenomenology is to present the common meaning, i.e. the reduction of the individual experiences of a phenomenon or concept to a meaningful whole, thus presenting the universal essence of the phenomenon (Creswell, 2018) by investigating and discovering what is constant in all the variations of the phenomenon (Lindseth, Norberg, 2004). According to Riceour (1976), who was greatly influenced by Husserl, a central question in phenomenology concerns the meaning of the lived experience of a phenomenon, i.e. an interpretation of what a text is saying and what it is talking about (Riceour, 1995). According to Riceour (1976), we can never understand another's experience, but we can understand the meaning of the other's experience.

Ones' lived experience is private, and its true meaning can only become comprehensible and public when expressed in text. A text that is analysed in order to grasp not only what the text is saying, but also what the text is talking about. Only then will the true meaning of the lived experience unfold, what is

called the utterance meaning, which is acquired from the individual's lifeworld (Riceour, 1976). A phenomenon exists in our lifeworld, in our natural attitude, and is described by Husserl (1970) as a display of numerous items organised in space and time for us to perceive, always there, and the foundation for all shared human experiences.

Husserl (1970) explains that we take different phenomena for granted, and that in order to understand a phenomenon's true meaning, we need to dispense with our previous knowledge (*epoché*). Only then may the phenomenon be revealed and show its essential meaning, its essence (Husserl, 1995). According to Dahlberg, Dahlberg and Nyström (2008), research that requires a phenomenological attitude is characterised by openness to the lifeworld phenomenon and ongoing reflection on the meaning and bracketing of one's preunderstanding. Moustakas (1994) adds that this approach also requires setting aside personal experience in order to become truly objective, thus perceiving a phenomenon or concept for the very first time. Riceour diverges from Husserl and reaffirms the assertions of Heidegger, arguing that one's preunderstanding cannot be completely disregarded, for it is only through our one preunderstanding that we can understand the meaning of the other (Kristensson Uggla, 1994).

Hermeneutics

Words are polysemic, meaning they have more than one meaning, and to understand different meanings requires interpretation (Kristensson Uggla, 1994). The origin of Hermeneutics dates back to ancient Greece and is derived from the word *hermeneuein*, meaning "to interpret", and *hermeneutike* (*techné*), meaning "the art of interpretation" (Honderich, 1995). Hermeneutics is defined by Riceour (1991) as "the theory of operations of understanding in

their relation to the interpretation of texts". The main objective for the hermeneutic author is to understand the meaning of the text, liberating the utterance's meaning, which is not to be confused with recognising the utterer's meaning (Riceour, 1976). The process of understanding goes through "*what the text is saying to what it is speaking about*" (Riceour, 1982). Hermeneutics implies reflecting upon one's ability to understand and reflect on knowledge. It is not possible to dismiss one's preunderstanding, instead Gadamer (2004) suggests that it is only through becoming aware of one's preunderstanding and recognizing it, that we can truly understand. We strive towards openness in order to make what was previously unknown one's own (Riceour, 1976).

Gadamer (2004) suggests that it is not possible to view history objectively, as we all play a part in our own history. Consciousness is instead determined by the fusion of the individual's horizons. Horizon here means the very limits of what one can see and understand, the whole of what can be grasped or understood by a person at a certain point in time in a specific situation. Once our preunderstandings, language, openness to meaning, and imagination are explored, we can combine horizons, past and present, to create a "fusion of horizons". Riceour (1991) implies that interpretation is thus a form of movement where the text can only be understood when each part is connected back to the whole, and the whole can thus only be understood from its parts.

Hermeneutics and the research participants

In order gain a deeper understanding of the participants' lifeworld and lived experience, I set out to interpret these experiences through a hermeneutic framework. My effort to create an understanding meant managing my own preunderstanding (Gadamer, 2004), something that is not possible without gaining insight into one's cultural horizon from which we interpret ourselves

and our surroundings (Gadamer, 2004). Understanding the participants' narratives meant getting in touch with my own knowledge and previous experience with the context being studied (Frank, 2004). As new knowledge arose and was merged with old knowledge to create a "hermeneutic circle", where the whole could not be seen without its parts and the parts not without its whole, a "fusion of horizons" finally appeared, presenting a new understanding (Gadamer, 2004).

Author's preunderstanding and preconceptions

The main author's personal experience in forensic psychiatry is based on work experience as an assistant nurse, registered nurse, and specialist nurse in psychiatric care. A preunderstanding of forensic nursing is relatively rare due to the fact that few fields within nursing involve encounters with patients with severe mental illness, individuals who have committed crimes, for extended periods of time. Forensic nursing also means facing intimidation and violence over extended periods of time. The main author's own personal experience has undoubtedly influenced how the nurse's professional role and encounters with patients are perceived. Over the course of this study, preunderstanding was an area the main author constantly reflected upon in order to curb the author's own naturalistic intentions and to maintain a truly objective standpoint where different phenomena could be viewed from other perspectives. At the same time, having worked in the studied context also offered the potential advantage of being seen as trustworthy in the eyes of the participants, allowing them to be open and honest during the interviews and making it possible for the author to comprehend and make sense of the studied context. The main author's preunderstanding has therefore presented a challenge, but it has been viewed overall as more of an asset than an obstacle.

Methods

With regard to the overall aim, a qualitative design was used for both studies (Table 1), as a qualitative design is preferred when attempting to explain and explore an issue that calls for a detailed and complex understanding that is derived from the first-hand accounts of individual respondents (Creswell, 2018).

Table 1 Overview of papers

Paper	Aim	Participants	Data collection	Analysis method
I	Illuminating the meaning of nurses' lived experiences of encounters with patients with mental illnesses in forensic inpatient care.	13 participants, 5 RNs ¹ (among those 3 SRNs ² and 8 ASNs ³).	Narrative interviews, 2018/09-2018/10.	Phenomenological-hermeneutic approach (Lindseth, Norberg, 2004).
II	Explore and interpret nurses' experiences of compassion when caring for patients with mental illness in forensic psychiatric inpatient care.	13 participants, 5 RNs ¹ (among those 3 SRNs ² and 8 ASNs ³).	Secondary supplementary analysis of paper I, 2019, narrative interviews, 2018/09-2018/10.	Hermeneutic approach (Fleming, Gaidys, Robb, 2003).

¹ Registered nurses, ² Specialist nurses in psychiatric care, ³ Assistant nurses with special training in psychiatry.

Settings

The participants in the study were all currently working at a forensic hospital (clinic) in Sweden. The clinic consisted of approximately 180 employees and 100 patients in total, with 8 wards each housing approximately 12 to 15 patients. Most patients are men aged 25-45 years who were convicted of some type of violent crime. Approximately 60% of the patients have schizophrenia or another psychotic disorder. The nurses work with a so-called “contact personnel system”, where two or more nurses work especially close with a specific patient. The nurses work closely with the patients, as spending time together is a fundamental part of the nursing care provided. Other tasks involve administering medications, helping patients with difficulties in day-to-day living routines, and assisting patients on parole. A psychiatrist makes his or her round at least once a week, and most patients are assigned a specific psychologist. During these meetings or rounds, the nurses may often assist or participate in a variety of ways.

Participants

The participants were all recruited from the same forensic clinic and consisted of 10 men and 3 women [median (Md) age = 36 years, age range = 28–67 years]. Participants had worked in forensic psychiatric care between 5 and 46 years (Md = 11 years), and there were 5 registered nurses, 3 of which were specialist nurses in psychiatric care, and 8 assistant nurses, all with special training in psychiatric care. The characteristics and demographic data of the participants are described in Table 2.

Table 2 Demographic data of the participants

Demographic factors	
Gender	
Women	n=3
Men	n=10
Age, Md (Range)	36 years (28-67 years)
Years in forensic nursing care, Md (Range)	11 years (5-46 years)
Profession	
Registered nurses	n=2
Specialist nurses in psychiatric care	n=3
Assistant nurses	n=8

Data collection

Invitations were mailed to the heads of the clinic and each ward with information about the study, and an approval form. Consent was gained from the head of clinic. Nurses were recruited with a purposive sample. All nurses in the study had experience caring for patients with mental illness in forensic inpatient care. In the presentation of the results of the study, all staff were referred to as “nurse” to conceal their identities. All interviews were conducted at the forensic clinic at a location chosen according to the participants’ preferences. Even though the interview locations were chosen by the participants, they were encouraged to select a quiet atmosphere without any distractions, an environment where the participants felt safe and could speak as openly as possible. The narrative interviews were one-on-one

interviews that consisted of open-ended questions in line with Mishler (1986). The interviews were recorded and transcribed verbatim by the first author. The verbatim transcriptions of the audiotaped interviews were validated, i.e. the texts and the tapes were compared, and any non-verbal information was added to the transcribed interviews (for example laughter, silence, changes in tone of voice).

The interviews lasted from 41 to 60 minutes (M=48min). The participants were encouraged to share their stories about their lived experiences of encounters with patients with mental illness in forensic inpatient care. Questions asked during the interviews were, “Can you tell me about an encounter with a patient that evoked negative feelings?” and “Can you tell me about an encounter with a patient that evoked positive feelings?” Further questions included, “How did you feel?”, “Can you tell me more?”, and “Has that happened before?” The main questions were designed in such a manner that they could be perceived as either positive or negative. This was done intentionally to trigger the participants’ recollection of situations connected to their lived experiences and to hopefully gain access to their narratives and life stories. The line of thinking is that it can be easier to recall experiences that have been emotionally moving, and asking about specific situations is a technique that is proven to be effective when conducting narrative interviews (Drew, 1993).

The second study was a supplementary secondary analysis of the data collected in the previous study (Paper I). Life stories represent unique data in that they are collected primarily for single use but can also be stored for secondary use in future research. A secondary supplementary analysis is not based solely on reusing data but an effort to reshape data in an in-depth investigation of an issue from a primary study (Heaton, 2004).

Analysis method

Phenomenological-hermeneutic interpretation

Paper I was analysed according to Lindseth and Norberg's (2004) concept of phenomenological-hermeneutic interpretation, where the process of interpretation and analysis of text goes through three phases; a naive understanding, structural analysis, and comprehensive understanding. This process can be viewed as a movement between understanding and explaining, a movement between the whole and parts of the text, and a movement between what the text is actually saying and what it is indicating. During the naive understanding, an overall awareness of the text is constructed by reading the text over and over, which ends in a formulation of the initial understanding of what the text is about. The structural analysis is a more precise form of analysis used to reveal parts and patterns and seeking to clarify the text through outdistance and a critical way of being. This was achieved by analysing all the meaning units, which were then sorted into themes and subthemes. The last and final phase in establishing a comprehensive understanding is an analytical, in-depth interpretation of all three phases (Lindseth, Norberg, 2004). Altogether, this interpretation produces a comprehensive view of what the text represents as a whole. In this third step of the analysis, a deeper overall understanding of the phenomenon is sought in relation to the research question and the studied context through reflection on the naive understanding and the explanation of structural analysis in relation to the researcher's own understanding, results from other studies, and theories relevant to the phenomenon.

Hermeneutic interpretation

Paper II was analysed using hermeneutic interpretation according to Fleming et al., (2003). The text was analysed in four steps. In the first step, the text was read as a whole and was expressed as a fundamental meaning. Gaining an understanding of the text as a whole was the starting point of the analysis; the fundamental meaning influences every other part of the text. The second step exposes a meaning of understanding, which is done by examining each sentence of the subject matter. These are formalised and sorted into subthemes, with the author being aware of and challenged by his or her preunderstanding. During the third step, attention is brought to the hermeneutic circle and fusion of horizons, where the text is seen as a whole that is dependent on its parts and parts that are dependent on the whole. All sentences, subthemes, and themes were related to the initial fundamental meaning. Once the understanding is expanded to a whole once again, the meaning of the parts can broaden. The final step involved finding passages that could explain the text and create a deeper understanding. These steps were repeated numerous times until the authors could settle upon a shared understanding of the text.

Ethical considerations

The two studies in the present study have been carried out in accordance with the ethical principles of the Declaration of Helsinki (World Medical Association, 2013). The project was approved by the Regional Ethics Committee (No. 2018/157-31). Narrative interviews were conducted with nurses, who provided informed consent to participate after receiving written and verbal information. Participation was voluntary, and the nurses could

withdraw at any time without consequence. Before each interview, the nurses were provided with information concerning the interview and were again asked if he or she was willing to participate. According to Kvale and Brinkmann (2014), the social relationship between the interviewer and the interviewee is of importance for the knowledge that emerges through research interviews. This requires the interviewer to be aware of the interview environment. Kvale and Brinkmann (2014) emphasise the importance of creating an environment that promotes a balance between the knowledge of the interviewer and feelings of independence among the participants. An interview situation also requires constant awareness of ethical concerns. i.e. the four ethical principles that served as the foundation of the present study. Transparency requirements have been met by informing the study participants about the intention of the study, its disposition, and any potential risks and benefits of participation. The participants' right to self-determination has been observed, as the participants had the opportunity to decide whether they wanted to participate, on what terms participation took place, and how long participation would continue. In this study, the participants participated fully on a voluntary basis. Furthermore, I clearly informed participants of the opportunity to withdraw from interviews at any time if they so wish, given the potential consequences of participation – negative and positive. As an interviewer, I took measures to minimise the risk that a dependent would develop between myself and the interviewees. The requirement to maintain anonymity has been observed with regard to the use of collected empirical data. Information that can reveal a participant's identity will not be published. If the interviews happened to arouse feelings of unease, there was a plan for the participants that included contact with the unit manager and authors of the study, something each participant was informed about at the beginning of each interview along with contact information for the persons mentioned above.

Findings

Paper I

Paper I illuminated the meaning of nurses' lived experiences of encounters with patients with mental illnesses in forensic inpatient care. The structural analysis comprised of four themes: *being frustrated*, *protecting oneself*, *being open-minded*, and *striving for control*.

The theme *being frustrated* referred to nurses' feeling distressed because of the internal struggle between their own expectations and will, and realistic expectations and what they actually could do for the patient. This included emotions of perceiving of oneself as strong, taking on responsibility, acting independently, and sometimes falling short in the case of unachievable demands. The inability to determine how to reach the patient filled the nurses with a sense of confusion. These feelings of confusion were rooted in the struggle to get through to the patient while being faced with the reality of the patient's criminal past, which often involves actions that seem wrong, illegal, and totally unjustifiable. Nurses stories revealed a sense of perplexity, resignation, and hopelessness when they did not see results from their hard work manifested as progress in the patient's condition. This often left the nurses feeling powerless and not in control. The inability to meet demands that were sometimes perceived to be unrealistic felt wrong and reinforced feelings of hopelessness.

The fact that they so often needed to process feelings of disappointment seemed unfair at times, though this was considered to be a part of the nurses' work, something that they just had to "live with". Being faced with the

responsibilities and expectations that go along with delivering care in a forensic setting also made the nurses aware of the importance and difficulties of being understanding towards the patient, often resulting in a sense of failure. Being repeatedly rejected when intending to do good was a major concern and led to a sense of frustration among the nurses.

The theme of *protecting oneself* mainly consisted of encounters with patients that aroused negative emotions. Caring for patients with mental illness in forensic psychiatry also means encountering individuals who have committed criminal acts, sometimes violent crimes against children or other crimes that are violent in nature. This can mean that nurses find it difficult to know how to approach the patient, as they are filled with a feeling of uncertainty and doubt regarding the complexity of the patient's history, which awakens feelings of uncertainty or doubt, often expressed as "everything felt wrong".

When encountering patients with a history of violence, where nurses could not predict when or if the patient was going to act out, different feelings arose. With these patients, nurses were not prepared to pay the potential emotional price and to handle intense emotions that could arise in the event that a violent incident did occur. Instead, nurses found themselves being on their guard, trying to stay one step ahead. At times, the nurses' prior experiences informed them that a frightened patient is a dangerous patient. Caring also meant being humiliated in front of others, which aroused emotions that were difficult to defend oneself against. Not being able to change the situation and stand up for themselves further intensified feelings of being exposed, of being unable to act as the way they should.

Nurses pointed to trust as a major aspect of a caring relationship, and this meant having the courage to open up and take the patient seriously. Trust also meant becoming predictable, adjusting the balance of power within the nurse–patient relationship as the patient became more involved in their care, enhancing togetherness, and decreasing paternalistic behaviour by *being open minded*.

Developing compassion and seeing “the person” and not only “the patient”, thus letting the patient’s expressions make an impression, allowed nurses to become conscious and identify the patient’s vulnerability. Recognising the vulnerability of the patient’s situation and feeling sympathy for the patient reinforced an empathic approach; the ability to reflect upon the patient’s expressions enabled a deepened understanding and relationship. Nurses found themselves dealing with their own vulnerability when dealing with their patients’ vulnerability. Nurses reported feelings of frustration, sadness, and loneliness, all of which represent a sense of compassion towards the patients that allows empathy to guide their interactions with certain patients.

Caring in a forensic setting was described as complex due to the high-security environment and the balancing act between doing what was best for the patient and protecting society, which for the purposes of this paper is called *striving for control*. Along with the fact that patients were sometimes ill, provocative, or threatening, nurses reported that they regulated their emotions so they would not lose control in certain situations. This meant taking a step back and finding a space to breathe.

Illuminating the meaning of nurses’ lived experiences of encounters with patients with mental illnesses in forensic psychiatry revealed an environment where nurses face threats, violence, humiliation, and resignation. This

environment creates feelings of frustration and causes nurses to always remain on guard in case of sudden unpredictable situations. Despite delivering care in what was described as a harsh environment with challenging encounters, where the nurses' very existence was sometimes threatened, the nurses were able to let the patients' expressions make an impression and develop a sense of mutual vulnerability. This involved regulating emotions and taking a step back when necessary in order to get closer to the patient. The nurses' narratives also pointed to the development of trust and compassion, which guided their actions in encounters and became catalyst for decisions based on the patients' needs. The overall interpretation of the narratives depicts the moral challenge nurses face in handling their own emotions while trying to empathise and assess patients' expressions. This meant that even if they were placed in a vulnerable situation that steered them towards self-reflection, situational assessment, and compassion for the patient, if they overcame this moral challenge, the nurses were able to control themselves, the situation, and the patient.

Paper II

This study aimed to gain a deeper understanding of nurses' compassion in providing forensic psychiatric inpatient care. The main theme of **being compassionate in forensic psychiatry** is described as **an emotional journey**, an ongoing inner negotiation between the patient's expression of suffering and the nurse's own vulnerability, an inner negotiation that tries to make sense of patients' pleas. And the way these pleas were perceived was crucial for the development of compassion and the delivery of care that avoided turning to control and rules as a means to protect oneself. This emotional journey involved nurses working in in-patient forensic psychiatric facilities, who face some of the greatest challenges in the medical/psychiatric field, but who also

have tremendous opportunities to develop relationships with people who are suffering in numerous ways – physically, spiritually, and emotionally. Compassion was seen as one possible response to these expressions of suffering, something, however, that was changeable over time and tended to fluctuate. The response to suffering could also mean turning to rules and control, taking on a paternalistic role while doing what was best for the patient and not abandoning the patient.

The initial theme, *recognizing suffering and need for support*, refers to the complexity of caring, the dualism between being a guard and a care provider. Expressions that made an impression also caused nurses to turn their gaze inwards. Sensing that patients were in need of help aroused feelings of compassion, for example when patients threatened to take their own lives. These expressions were clear and the patient’s suffering was obvious.

When expressions of suffering were not as obvious, the nurses had to rely on their own knowledge and previous experience. Patients sometimes showed an unwillingness to receive help, often hiding in their rooms. This made it hard for nurses to grasp what expressions of suffering meant, which was something the nurses reported to be an important aspect in the development of compassion. Not being able to “get close” to the patient promoted feelings of frustration due to the fact that nurses had to repeat care activities over and over without receiving any form of feedback. When patients were perceived as confrontational or threatening, nurses felt threatened, insecure, and afraid. Being exposed to violence or intimidation sometimes meant that nurses did not know how to cope with the situation and was a source of anxiety that prevented nurses from getting to the bottom of the patients’ suffering.

The second theme, *responding to patients suffering*, referred to nurses’ attempts to make sense of various expressions of suffering and trying to

provide an adequate response when encountering the patients. When suffering was obvious and the patients showed a willingness to participate in their own care, the nurses responded with increased enthusiasm. In other cases, where the patients had no interest in participating in care, nurses often found themselves in a position of having to persuade the patient. This was seen as a tiresome effort and had an influence on further engagement in the long run. The nurses' narratives were interpreted as being grounded in genuine worry for the patients.

Nurses also found themselves being flexible in erratic situations where they would not let their emotions take over. Nurses emphasised that they would not show emotions in front of the patient and would instead maintain a façade of calm and comfort. This façade was grounded in the best of intentions, not only for themselves but what was considered to be best for the patient. Controlling emotions was seen as an act of compassion. When they were unable to maintain this façade or even lose control to a certain extent, nurses immediately took a step back, removing themselves from the situation and coming back at a later time when expressions of suffering were better comprehended. Nurses thus regulated and adapted their behaviour in vulnerable situations in order to maintain control.

The third theme, *reacting to their own vulnerability*, and this study in general, made it evident that nurses devoted a great deal of effort to delivering the best possible care. The nurses reported that this was easier at times, especially the times they received positive feedback and established a relationship with the patient. This was seen as a remedy for the nurses' own feelings of frustration and suffering that arose from the times patients rejected the nurses and the care provided. In cases like these, nurses instead found themselves more withdrawn and resigned. The tendency to become resigned also stems from the notion of failing as a nurse and as a person, as someone unable to succeed

with the task at hand. In addition, being exposed to negative comments for extended periods of time had an impact on the nurses' level of compassion, resulting in a situation where nurses had to motivate not only the patient, but also themselves. Nurses also reported to encounters with patients that were perceived as threatening and intimidating, encounters that did not directly awaken a sense of compassion. These encounters instead aroused a sense of shame that stems from not knowing how to handle these patients by setting one's own feelings aside. In these situations, nurses reported that they did not feel that they were being compassionate.

There was much to be learned from nurses' feelings of compassion. Caring in forensic inpatient care sometimes meant facing incomprehensible expressions of suffering. Being able to understand seemed to be the key to developing and maintaining compassion. Understanding started a chain of events within the nurse, not only in terms of interpreting suffering, but also in reacting to and acting upon suffering and the nurse's own vulnerability. This chain of events could lead to the nurse becoming persistent, but it could also lead to the nurse being resigned or feeling overwhelmed by a sense of shame. When nurses reported that they did not understand suffering, they still stood their ground by being there for the patients, which could also be interpreted as a sign of compassion. Forensic psychiatry is unique in the sense that it is characterised by long hospital stays, which meant that nurses inevitably had to turn their gaze inwards to deal with their own emotions and sensibility in order to make sense of a sometimes incomprehensible environment. The long duration of care also meant that compassion was not static and was instead changeable over time. Practicing and modelling compassion is fundamental to the well-being of all individuals, highlighting the fact that the role of compassion in forensic inpatient care reinforces the trend towards more compassion in care in general.

Discussion

The overall aim of this study was to obtain a deeper understanding of encounters with patients with mental illness in forensic inpatient care as experienced by nurses. This study shows that these encounters are largely characterised by the nurses' efforts to control their emotions so that they can make sense of sometimes incomprehensible expressions of suffering. In order to be able to encounter a patient with compassion, nurses described a strategy of taking a step back, regulating their own emotions, and reflecting on goodness, trust, and compassion. This is something that is described as an ongoing process due to the long hospital stays in forensic inpatient care, as compassion is described as something that is changeable and fluctuating. Nurses also report being influenced by the two contradictory roles, namely guarding and caring.

In this study, Kari Martinsen's (1943-present) nursing theory has served as the theoretical framework. Martinsen's theory is grounded in philosophy and phenomenology and evolved from questions about how nursing is operated for the weakest individuals, how to avoid failing the people who need care the most, and how nurses are able to care for these people (Alvsvåg, 2018). Martinsen's theory of care is useful because her theory emphasises relationships as fundamental in people's lives and that people are interdependent. This dependence on others becomes extraordinarily clear when you are in a situation where a need for help arises, for example in case of injury, illness, or when an individual's life is dependent on the care of others. In situations where people share their everyday world and have something in common, understanding for one another becomes the base, the shared foundation between people (Kristoffersen, 2006). According to Martinsen (1993), care is inherent in all human existence and interactions. As

this study focuses on encounters and the caring relationship, which Martinsen describes as altruistic and a relationship characterised by a need for help where one party provides care without expecting anything in return, it seemed logical and useful to use her theory to develop a deeper understanding of nurse–patient encounters in forensic psychiatric care.

Martinsen is greatly influenced by fellow phenomenologist Knud Eiler Løgstrup (1905-1981), whose philosophical assumptions relate to the phenomena of human existence, namely hope, trust, compassion, and the openness of speech, which is explained as a sovereign or spontaneous life utterance (Martinsen, 1993). In her texts, Martinsen referred to the French philosopher Michel Foucault (1926-1984) and his views of the other in caring. Martinsen’s questions concerned how it is possible to think of phenomena such as madness, power, freedom, and care in light of certain specific societal conditions (Alvsvåg, 2018). For Martinsen (1989), caring is about how people relate to each other and show concern in daily life. This is also fundamental to nursing as it is relational, practical, and moral (Alvsvåg, 2018), where moral aspects take precedence, as morality shows itself through caring activities (Martinsen, 2005). For Martinsen (1990), morality is expressed as a sense of empathy and reflection, which allows caring to be expressed through nursing. According to Martinsen (2000), being a good Samaritan means letting oneself be touched by the others suffering; before we can truly understand, we must first be touched emotionally.

Conclusions drawn from the findings of study **I** and **II** included the revelation that the meaning of nurses’ experiences of encounters with patients in forensic psychiatry centres around controlling emotions. The moral challenge of handling one’s own emotions while trying to empathise and assess patients’ expressions means being placed in a vulnerable situation, which pushes nurses

into self-reflection, situational assessment, and compassion for the patient. If successful in this environment, nurses were able to control themselves, the situation, and the patient. In this section, I will elaborate on and discuss how this knowledge may be useful for the understanding of enabling encounters in forensic psychiatry that are based on caring.

I will start by discussing some different meanings derived from the caregiver–patient relationship in daily encounters between patients in forensic psychiatry and their caregivers as reported by the nurses **(I)**.

I will emphasise the importance of acknowledging and being emotionally touched by the patient in these encounters **(II)**. Here, I will discuss the role of compassion as a resource and a key to opening doors in the care encounter. The discussion chapter will conclude by addressing the meaning of the concept care encounter from a Caring Science perspective, based on the two studies presented in this thesis.

An interpretation of studies I and II

In order to achieve a shared, deepened, and new understanding of the phenomenon studied based on the findings of Studies I and II, a comparison and interpretation of the two studies was conducted in which an explicit link between the findings **(I, II)**, the selected theoretical framework, and relevant literature was made. The results from the two empirical studies **(I, II)** were compiled based on a careful reading of the studies, raising new questions about how nurse–patient encounters in forensic psychiatric care can be understood. I therefore undertook to explore these encounters and the meanings they conveyed. After reaching a shared first impression of the two studies that described how nurses performed encounters in an environment

where they simultaneously act as guards, this interpretation integrated perspectives from both studies based on the phenomenon “encounters in forensic psychiatry”.

Being sensitive and responsive

The empirical results show that the nurses face different types of encounters that push them towards sensitivity in their responses to the patients' various expressions of suffering. Developing trust is crucial to the caring relationship and means having the courage to open up to the patient and take the patient seriously. The establishment of trust in the nurse–patient relationship means that the relationship between the parties becomes predictable (I). Trust also means that the power imbalance, which puts the patient in a much more vulnerable position, is reduced through the patient's participation (Selvin, Almqvist, Kjellin, Schröder, 2016). All this plays out in an environment where the overarching goal is to prevent recidivism and minimise violent behaviour among patients through external frameworks characterised by structure and power (Davies, 2007; Delmar, 2012).

When discussing social constructs and their implications for the discussion of forensic psychiatric care, it is natural to turn to the writings of the French philosopher Michael Foucault (1995). However, the examination of man-made constructs is not enough. It is also important that we do not lose sight of constructs that are not man-made, for example acting from one's core of goodness and restraining one's naturalistic intentions in order so see the other. Danish philosopher Knud Ejler Løgstrup's (1997) work is focused on these very constructs, which is a focus that one cannot ignore in a discussion about forensic psychiatric care. If these man-made constructs are a reality that we must take into account, they constitute only the framework of the studied

context. However, it is often necessary to go outside the boundaries of a particular framework, something that Foucault also demonstrates in his discussion of “human freedom potential” (Martinsen, 2007). Legislation also adds to the discussion of the non-man-made constructs, which influences each and every human and forms the basis of the type of care given. At a time when everything in society is considered constructed, this perspective on care represents a critical voice that highlights a perspective that points to our responsibility to take care of each other (Delmar, 2012).

The Norwegian nursing philosopher Kari Martinsen is strongly influenced by Lögstrup’s thinking and highlights these non-man-made constructs (pre-cultural). She states that this is basic to man’s existential conditions, for example, that life is vulnerable and finite, that we are dependent on what life gives us, and that we are dependent on each other. These are phenomena that are prerequisites for life, that life is dependent on, which we often take for granted. It is phenomena such as trust, mercy, openness, hope, joy, and love, which Lögstrup calls the sovereign utterances of life, that constitute the basic and given conditions of life that man has not created. Martinsen (2000) refers to these utterances as “expressions of life” that man is fundamentally dependent upon. Although they are given to us, we have the power to make room for these expressions of life between us, but we also have the power to limit this space (Martinsen, 2006). If the room for the expressions of life is confined, misery, hopelessness, despondency, insecurity, and unhappiness may arise. In this way, the man-made constructs concretely influence expressions of life.

The results of our studies (**I**, **II**) show that nurses encounter different expressions of suffering in their daily work. Feelings of trust are important to care (Zegwaard, Aartsen, Grypdonck, Cuijpers, 2017) where trust means

having the courage to open up to the patient and take the patient seriously (Rydenlund, Lindström, Rehnsfeldt, 2019). Confidence means that the relationship between the two parties becomes predictable, and the power imbalance between the nurse and the patient decreases (Cutcliff, Happell, 2009; Karnick, 2016). The nurses seem to exhibit feelings of satisfaction when the patients participate in the care provided (**I, II**), which is consistent with the findings of Hellzén and Asplund (2006) and Rytterström, Rydenlund, and Ranheim (2020). Caring means showing courage in the uncertain and unpredictable situations that nurse–patient encounters may entail. When exposed to threats or attacked, both physically and mentally (**I**), nurses must protect themselves by reminding themselves that the patients are ill, rather than taking an attack personally or responding with anger (**I, II**). Nurses need to use self-insight and understanding to avoid making a bad situation worse. This often involves taking a step back to regulate themselves (**I**). According to Martinsen (2005), caring and sensibility are closely linked in a practical situation. There is always a risk that the relationship will be compromised if the patient's actions are not perceived as good by the nurse and motives appear obscure (Vincze, Fredriksson, Wiklund Gustin, 2015). According to Lögstrup (1983), in order to be guided by compassion and sensibility, the nurse's actions must be based on the fact that the nurse is "tuned in". This means being able to interpret the patient beyond words and actions, hearing the patient's tone, and being able to interpret it carefully. Being tuned in means not crossing the border into the patient's "untouchable zone", meaning that which is personal and private (Lögstrup, 1983). If nurses manage to achieve a tuned-in state, the two parties are able to face each other in a person-to-person encounter, the so called "room of awareness" (Devik, Enmarker, Hellzen, 2013).

In summary, person-to-person encounters seem to occur to a lesser extent in our studies (I). These encounters often seem to be linked to the patient's compliance with the care provided as demonstrated in the studies (I, II). This part of the study indicates that there is a connection between whether the nurse is tuned in and sensitive, thus being able to interpret and understand the patient's present situation, and the ability to open up to the room of awareness. If the nurses are not tuned in, they regulate themselves and the present situation.

Keeping distance

The empirical results show that the existing structure, with a focus on surveillance, makes it difficult to create nurse–patient encounters (I). Interviews about daily life in the department revealed similarities with Foucault (1995), who writes that institutions like prisons consist of a variety of instruments for subjugating inmates, instruments that all are used in a deliberate way. The findings in our study show how this structure, with its rules and norms, impacts everyday life and the care given (I). In every situation, nurses are often forced to make crucial judgments based on rules and norms that are counterproductive to care (Peternelj-Taylor, 2003; Vuckovich, Artinian, 2005; Federman, Holmes, Jacob, 2009).

As a professional care practitioner, a nurse requires both professional knowledge and humanity in the relationship with the patient and life in general, as human behaviour is governed by ideals and norms. In addition, the nursing profession also has the nurse's professional ideals to live up to (Hoej, Johansen, Olesen, Arnfred, 2017). Moral and social norms as well as occupational norms often present difficulties, as they can be contradictory and

often point to different considerations. This situation often presents ethical dilemmas for the nurse in the relationship with the patient (Marangos-Frost, Wells, 2000; Höglund, Holmström, 2008).

When facing difficult situations, people usually turn to norms and rules for guidance (Grönkjær, Curtis, Crespigny, Delmar, 2011). The problem is, according to Martinsen (2005), that the rules and norms often specify what we can do, not what we should do. Rules and norms are created by people and provide guidance and direction for our words and actions in social contexts. The application of rules and norms requires sensitivity and critical judgment when we are caught in complex situations. Lögstrup (1997) emphasises that it is not enough that we know the requirements, norms, and rules since they rarely provide satisfactory and unambiguous formulations. These norms and rules should be met by sensitivity and critical judgments which requires insight.

The results of our studies show that the nurses invested a lot of time and energy in their daily work to provide the best possible care for the patients (**II**), which reaffirms the findings of Rytterström, Rydenlund, and Ranheim (2020). However, caring in a forensic setting also meant being confronted with incomprehensible expressions, which is described in both studies (**I, II**). These situations arise when a nurse is emotionally affected by patients' expressions of threats, violence, and provocative behaviour, or if the patients did not cooperate (**I**). It is reasonable to assume that such situations include a majority of the nurse–patient encounters in our study (**I**). This situation forced nurses to take a step back and distance themselves from the patient as a way to regulate themselves (**I, II**). Self-regulation seems to be an important part of the studied phenomenon (**I**), which becomes evident in study (**II**), as it indicates how taking a step back affects the experience of compassion (**III**).

Having the time they needed helped the nurses respond to and cope with the patient's actions (Ewalds-Kvist, Algotsson, Bergström, Lützen, 2012). The participants' narratives (I) suggest that compassion is something that the nurses have managed to refine or sometimes develop over time (II). Being in an incomprehensible context over a long period of time could perhaps help nurses unravel expressions of suffering as well as their own responses. Although norms and rules are based on good intentions, they are created by human beings (Lögstrup, 1997). They are formulated to instil basic values and are best applied in the situation they are created for. But it is often in unique and concrete situations that humans call on these norms and rules to create order. However, we realise that the good intentions behind such a norm may not be fulfilled if the rule or norm is literally followed (Holmes, Murray, 2011).

Nevertheless, there is a risk in taking a step back, namely that nurses will treat the patient like a stranger and thus become anonymous. Bauman (2007) sees this as a strategy similar to what Goffman (1966) calls "civil inattention", in other words, a situation where observing from a distance is the only sensible approach. In such cases, there seems to be a risk that nurses will choose to focus on monitoring and thus minimise contact with the patient (III). Nurses' feelings of compassion could also be troublesome as the years pass, as they can feel a sense of being "burned out" (III). And it sometimes happens that we must depart from the law (Martinsen, 2000).

If regulating oneself means responding to the patient's actions and decreasing feelings of hopelessness, which may be seen as a temporary break, this also means establishing contact with the non-man-made constructs (pre-cultural), thereby seeing the person behind the suffering (Skjervheim, 1996; Wennerberg, 1996). According to Martinsen (2005), a nurse who is not "tuned

in” may have difficulties reading the patient’s expressions, and will therefore not be guided by compassion and sensibility.

However, as emphasised above, the nurses’ strategy of regulating emotions could result in a risk of failing to be compassionate (II). Nevertheless, regulating emotions should not be seen as something that is only negative. The Dalai Lama (2003) claims that *“For someone to develop genuine compassion towards others, first he or she must have a basis upon which to cultivate compassion, and that basis is the ability to connect to one’s own feelings and to care for one’s own welfare... Caring for others requires caring for oneself”*.

Another side of regulating emotions may be that it is a therapeutic act to provide compassionate care to patients, as there must be a balance between compassion and care for the patient as well as for oneself. From this perspective, the act of delivering care can be seen as a sign of self-compassion (Neff, 2003), and is important to highlight. Nurses need to learn to understand themselves and be compassionate towards themselves. In order to become someone of significance for the other, nurses must first become accepting and understanding towards themselves to prevent self-contempt and to become the best version of themselves. According to Maben, Adams, Peccei, Murrells, and Robert (2012), the welfare of nurses and the quality of care are mutually interdependent. In order to deal with difficult situations, it is common for nurses to cope by distancing themselves from the patient (Mackintosh, 2007), which was also evident in our interviews (I).

Self-compassion could be interpreted as synonymous with a caring culture that promotes selfishness within the health care profession, but as Adam and Taylor (2014) point out, self-compassion should be seen as a "responsible

selfishness", manifesting itself as self-kindness, common humanity, mindfulness, and being understanding of oneself instead of applying self-critical judgment. This calls for viewing one's own experiences as a part of something greater rather than in isolation and dealing with painful thoughts in a balanced way instead of over-identifying with them. If applied correctly, self-compassion is something that can encourage a positive self-attitude (Neff, 2003).

In an institution that harbours emotional pain and suffering, self-compassion is a foundation for compassionate care and therefore essential (Dutton, Lilius, Kanov, 2008). According to Martinsen (2005), care for the self and others is mutually interdependent. By practicing an emotion regulation strategy, care providers can embody the role of health promotion (Blake, Harrison, 2013).

In summary, the philosophical examination of our empirical results **(I, II)** contributes a nuanced understanding of the nurse–patient encounter in forensic psychiatric care. This examination reveals aspects that are embedded in the encounter and highlights the need to revisit the encounter to increase our understanding of it. Martinsen's (2000) line of thinking is in line with Lögstrup's (1997) philosophy when she discusses ethics and expressions of life, such as trust, mercy, love, and openness. This becomes evident when the nurse encounters particularly challenging situations, situations where expressions of life are at risk of being transformed to its opposites.

Care, in general, aims to support patients and their health processes (Henderson, Nite, Harmer, 1978). Our study indicates that nurses use a strategy of taking a step back in a majority of encounters in order to cope **(I)**. This is a strategy that may provide the nurses with the opportunity to become more sensitive towards the patients and use discerning judgement in the

encounters (II). As supported by the philosophical analysis of the empirical results, we maintain that there are built-in risks in nurse–patient encounters. This means that the caring potential that lies in non-man-made constructs may become overshadowed by man-made rules and norms.

According to Martinsen (2000), sensitivity and discerning judgement are demonstrated in respect for human life, professionalism, and the norms of “the good nurse” together with the thoughtfulness and reflexivity of the individual nurse. Self-compassion as a form of self-care should not be judged as selfish, and should instead be seen as essential and a foundation for compassionate care. Our view is that encounters in forensic psychiatry should be based on a theoretical foundation of the philosophy of caring, thus providing a deeper understanding of the nurse–patient encounter.

Methodological considerations

In order to understand a complex human phenomenon, knowledge of phenomenological and hermeneutic philosophy and methods is required, as these approaches seek answers to questions about human existence and related questions. However, the two approaches have a slightly different focus: phenomenology emphasises rigor and the importance of a descriptive approach that does not include interpretation, while hermeneutics emphasises interpretation and methodological flexibility (Dahlberg, 2019).

The motivation behind using two different methods was to support the author’s ability to interpret the meaning of the data from the interviews in a way that allowed me to develop a new understanding of the phenomenon

studied (McConnell-Henry, Chapman, Francis, 2009). To that end, the methodological approach drew from hermeneutics, which can be understood as a way to facilitate the interpretation of the parts in light of the whole, or a way to move from a preunderstanding toward the formation of a new understanding (Alvesson, Sköldbberg, 2018).

The fact that I have worked in forensic psychiatric care could be seen as a weakness, as this experience constitutes my preunderstanding of the field I intended to investigate in this study. Preunderstanding can be a weakness in that it can influence how I describe and interpret the data collected. When it comes to describing the data, my aim has been to keep my preunderstanding in check, that is, departing from my naturalistic approach in the data analysis in order to strive for a more phenomenological approach. In this way, the risk that I would be guided by my own prejudices and preconceived opinions about what I intended to study was minimized. My familiarity with the studied context meant being faced with the challenge of becoming aware of my own prejudices and preconceptions through self-reflection and discussions with co-authors. My preunderstanding can also be seen as a strength, as I am familiar with the context in which data was collected (Studies I and II). Being familiar with the subject also meant that the participants might feel that they could share their stories honestly and openly, which could be seen as a strength. In combination with the literature, this familiarity shaped the "lens" through which I interpreted the empirical data, which, at the same time, was something I needed to keep under control during the analysis.

By linking the lifeworld perspective of phenomenology with the focus of hermeneutics, interpretation, and understanding, the meaning of the phenomenon studied could be understood. Riceour (1976) argues that

phenomenology has a mediating character in relation to what hermeneutics reveals, and hermeneutics does not constitute itself without phenomenological conditions. The choice of methods is based on the ontological and epistemological issues of philosophy, where, according to Mackay (2005), the philosophy is based upon Husserl's view of epistemology and Heidegger's ontology. The Hermeneutic phenomenological approach (Lindseth, Norberg, 2004) has its basis in Husserl's and Heidegger's philosophies, while the chosen hermeneutic method (Fleming et al., 2003) is based on Gadamer's ontological hermeneutics, which is in turn based on Heidegger's philosophy. Altogether, the selected methods are intertwined to form the scientific theoretical approach to the study.

Since knowledge from the context in which the phenomenon is studied is limited, the use of a homogeneous selection strategy has been deemed to be preferable when data is obtained from a specifically defined group, as it provides a deeper understanding than if data were collected from a more varied and heterogeneous sample. A purposive sampling strategy was chosen since, according to Polit and Beck (2016), it is an adequate way of recruiting participants over a limited period of time. The sample size in the studies was based on the concept of information power, as described by Malterud, Siersma, and Guassora (2015), which is a method to determine the appropriate number of participants needed in relation to the amount of information generated by the sample. The appropriate number depends on how narrow or broad the aim of the study is, the specificity of the participants' experience of the phenomena, and whether an established theory is applied. After applying Malterud et al.'s (2015) criteria, we arrived at 13 participants as an acceptable sample size. All nursing staff were included and referred to as nurses. This allowed us to gain as much insight into the studied phenomenon as possible,

as encounters in forensic psychiatry are not something that are exclusive to certain professions. On the contrary, forensic psychiatry is based on a team approach, where professionals work close to the patient with all members of the team. A specifically defined group (a homogeneous sample) was selected based on the fact that there were few studies found that focused on nurse–patient encounters in forensic psychiatric care. An advantage of a homogeneous sample is that the stories are based on an identical context. In narrative studies, where participants are asked to provide a narrative about a particular phenomenon, it is important that they have experience with the actual phenomenon. Hence a homogenous sample was therefore deemed to be a suitable fit (Creswell, 2018).

The selected qualitative designs can be seen as complementary and are based on the same interview questions and interview method in both studies. The questions could be perceived as dichotomous as they primarily reflect specific events and patients that have had a major impact on the participants. This could mean that lived experiences that had less of an impression on the participants have not been revealed in the text. In this study, narrative interviews were used as a data collection method. The aim of the interviews was to identify the meaning of the phenomenon in question as they come to light from the narrator's point of view. Critical incident technique (CIT) (Flanagan, 1954) was used as a way to collect narratives from the informant's lived experience as well as his or her reactions and problem-solving strategies in the nurse–patient encounter. Since the intention of the interview was to identify the meaning of the participant's lived experience of the phenomenon studied, CIT was a valuable technique for capturing the person's lived experience and reactions to that experience. The weakness in using this technique is that most nurse-patient encounters can be seen as "everyday

encounters", and as such, may exclude certain stories that have not had a profound impact on the participants.

In addition to the Hermeneutic phenomenological analysis in Study I, a secondary supplementary analysis of the data material in Study II was selected. The choice to reanalyse data that had already been collected from Study I was based on the opportunity to establish a different understanding, which was seen as possible based on the assessment that additional information was available in the existing data material. In areas where already existing data is limited, complementary reanalysis (secondary supplementary analysis) of existing data can be used, which, according to Heaton (2004), is to be regarded as a valuable method. However, this requires a deeper analysis of the data material, which is satisfied in this study through the choice of the hermeneutic method (study II).

In secondary research, there is always the issue of "data fit", as the data used was originally collected for another purpose. Nevertheless, qualitative data sets that are relatively unstructured tend to be rich and diversified, allowing us to determine which topics should be investigated further. Problems with "data fit" are especially relevant when data is missing, data is derived from a deductive standpoint, or when there is a divergence between the aims and methods of the two studies. This is less likely to be an issue in a supplementary secondary analysis where the focus of the second inquiry relates to matters which are, by definition, closely related to the original work. Reusing one's own data is also an advantage, as the author is "familiar to own data" (Heaton, 2004).

According to Patton (2015), the use of different methods involves a type of methodological triangulation, which strengthens the study's credibility and thereby its trustworthiness. Triangulation, however, is not achieved simply by using different methods, it is also important to triangulate by using multiple theories when interpreting data and by using multiple analysts when reviewing findings from the data (Patton, 2015). With detailed information on study participants, sampling, and context, transferability is enabled to other similar contexts and areas, which also increases the research's trustworthiness. The dependability of the research is also determined by this, as the information enables the reader to judge whether the results can be transmitted to similar departments or situations or for use by other researchers to repeat the study (Shenton, 2004). The data neutrality (confirmability) consists of ensuring the reader that the findings are based on the informants' lived experiences and do not solely derive from the researcher's experiences. This is reinforced by quotes from the informants, which gives the reader access to basic data and thereby provides an opportunity to assess reasonableness in the interpretations made. Confirmability is also motivated by rigor. This means that the analysis is done with attention given to credibility, meaning that it is well described and detailed. Any philosophical belief regarding the qualitative inquiry in the research should also be described, as this increases the overall trustworthiness (Patton, 2015).

It is possible to interpret a text in different ways. Our findings therefore constitute one of several possible interpretations (Riceour, 1976). The phenomenological perspective focuses on the person's lifeworld and lived experience, and thus requires openness to the interviewee's experiences (Lindseth, Norberg, 2004). The gateway to this lifeworld is provided through the individual's narrative, with all its symbols and metaphors that must be interpreted using both explanation and understanding (Riceour, 1976). In line

with the hermeneutic tradition, issues of trustworthiness are a matter of rigour throughout the process, a process that aims to arrive at possible interpretations, not to reveal an absolute truth. Therefore, our intention has not been to generalise the findings, instead, the method of interpretation should follow the direction opened up by the text and be sensitive to the demands the text puts on the reader (Riceour, 1991) and should be seen as one argument in an ongoing discourse (Riceour, 1976). Our interpretation represents what we have found to be the most useful way of understanding the phenomenon studied. Therefore, this study offers one perspective, which may constitute a basis for further reflection about the nurse–patient encounter in general and in forensic psychiatry in particular.

Conclusion

The previous research in this field has given little or no attention to the nurse–patient encounter in the daily care of patients. This is a context in an institutional environment that is characterised by high levels of security, where patients receive care for extended periods of time. The main findings in this study give new meaning and nuance to the nurse–patient encounter in forensic psychiatric care. The examination of the data reveals aspects that are embedded in these encounters. It becomes apparent that expressions of life, such as trust, mercy, love, and openness, constitute an important ethical foundation when the nurse encounters particularly challenging situations. otherwise, in situations such expressions of life is at risk to be transformed to its opposites.

Martinsen (2000) describes a quest for “person-oriented professionalism”. This is important given the fact that forensic psychiatric care is a complex field due to the ambiguity of both caring for patients and navigating legislation in terms of the deprivation of liberty and involuntary treatment situations. For nursing staff, this entails both caring for and exerting control over the patients in this context. Nurses thus have a dual mission to provide care and to discipline. Nurses are also asked to see people with severe psychiatric illness as human beings who have the right to person-centred care, that is, health-oriented care that aims for patient participation in both their own health and care processes. However, it is important when introducing person-orientated care that attention is given to safety and risk issues. In order to achieve a healthy social climate, it is important that the nurse asks himself or herself how the encounter manifests itself.

Suggestions for further research

This study demonstrates that there is a need for more research with a focus on the nurse–patient encounter in forensic psychiatric care. In the following section, I will briefly go over further research that is needed based on the findings presented in this study.

According to previous research (e.g. Rydenlund, 2012), philosophical considerations of care in the care of people with severe mental illness in forensic psychiatry are underexposed and need to be developed further. In this study, the focus is on the nurse–patient encounter, which I see as an important aspect of forensic psychiatry. The results of the study indicate that compassion is an important part of the nurse–patient encounter if these encounters are to be transformed into a caring encounter. This study presents findings from a secondary supplementary analysis (Study II) of interviews with a focus on the

lived experience of nurse–patient encounters (Study I). In order to deepen the understanding of self-compassion in the forensic psychiatric context, new stories are needed that are based on specific interview questions about self-compassion.

Another important finding in this study relates to self-regulation and regulating one’s own emotions, which proves to be an important aspect of the nurse–patient encounter. However, we have more to learn about the meaning of regulation of emotions in encounters. Is it positive or negative for the encounter? Therefore, additional narrative interviews with a focus on regulation of emotions are needed to increase our understanding.

Of course, studies that seek patient perspectives based on the aspects of the nurse–patient encounters described above are also needed, that is, studies that focus on the phenomenon of compassion, regulation, and the lived experience of forensic psychiatry.

Implications for practice

The findings of this study have implications for practice. The study emphasises the fact that moral aspects are important in the delivery of care, otherwise there is a risk that, in the nurse–patient encounter, nurses will oppress the patient and limit their ability to live as autonomous agents in an institutional forensic psychiatric environment. By creating an environment where, in the encounter, the nurse is allowed to act based on professional discerning judgement and a personal interest in the welfare of the patient, it may be possible for nurses to respond to the patient’s needs and demands. How will this be possible? As I see it, it is about a combination of professionalism and human knowledge, a knowledge that must be transformed

into practical actions. According to Wittgenstein (2009), human knowledge cannot be devoted through literary studies, only through practical experiences. This is in line with Lögstrup (2014), who states that education is a necessary foundation but not of the utmost importance what is more important is personal sensitivity and wisdom. It seems to be a significant factor that nurses are given the opportunity and environment to reflect upon compassion, expressions of suffering, and their own vulnerability, a space where they can reflect upon everyday encounters with patients. This may be achieved through further education, where the above-mentioned phenomenon is given a greater focus. Increasing awareness regarding such matters could improve encounters and nurse–patient relationships and has the potential to develop the quality of care given and to reduce the risk of recidivism while improving the overall health of patients and staff alike.

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Acknowledgements

A great big thank you to Mid Sweden University and the department of Nursing for allowing me to take part in this education and deepen my knowledge while completing this study.

A special thank you to all of the participants in these studies, for opening your hearts, sharing your stories and the numerous cups of coffee. Without you, none of this would be possible; see you soon.

To my tutors: Professor Ove Hellzén, for taking me under your wing, introducing me to the world of research, showing me the fun in theoretical discussions, structural analysis, and comparing social constructs. All jokes aside, thank you not only for sharing your vast knowledge but also for being a good friend throughout my PhD studies, which has sometimes proven to be a troublesome time.

To Siri Andreassen Devik. Embarking on this journey also meant getting to know probably one of the brightest minds and kindest people I have ever meet. Thank you, not only for sharing your knowledge but also for the way you do it. I hope the future holds another trip to your beloved hometown of Namsos.

To my main tutor Marie Häggström, for always having my back, being there for me, especially as times got stressful, encouraging me to push on when in doubt and keeping me motivated and structured. The fact that you placed your trust in me, and vice versa, is something that fills me with confidence as I move on with my studies.

A great big thank you to all of you who have contributed with numerous readings and seminars regarding my work. You all inspire me and teach me new things.

To all my colleagues at the department of Nursing at Mid Sweden University. Thank you for being great friends. Lars Lilja, whenever I mention where I work, people ask about Lilja. The embodiment of being cool and kind at the same time. A true friend whom I appreciate very much, don't forget to pet Sigge. Anette Björk, thank you for showing me the ropes and being my mentor as I started my work at the university. Josefine Davén, fellow PhD student, colleague and friend, wishing you the best of luck in your studies; can't wait for another book reading. Angelica Lodin-Sundström, what goes in the safe, stays in safe. K-G Norbergh, whom I had the privilege of having both as a

tutor and colleague. A true role model, wishing you a happy and well-deserved retirement. To those I forgot, I'll get to you in my final thesis.

To all my friends at my former workplace in forensic psychiatry, you will always be my forensic family, always having a special place in my heart.

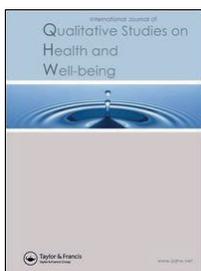
To past and present PhD students, thanks for the great support.

To my friends outside of the realm of academia, thank you for always being supportive and listening to my incomprehensible talk about my work, for encouraging me and always having my back and being helpful, taking my mind off research when needed, you know who you are.

To my parents Ulf and Lena. Thank you for always supporting me and my choices in life through what can sometimes seem to be endless studies. You are the best parents one could wish for. Love you! To my sister Helena, always standing up for those who need it the most. Always fighting for equality and justice for all. And of course, for being the best sister.

To Åsa, the better- and good-looking part of me. Without you I am nothing, my best friend, mother of my children and the true love of my life, "*Till Jorden*". To my two loving daughters Alma & Astrid, without you, we are not a family. The best and most important thing in life are you girls. Daddy loves you.

Paper I



International Journal of Qualitative Studies on Health and Well-being



ISSN: (Print) 1748-2631 (Online) Journal homepage: <https://www.tandfonline.com/loi/zqhw20>

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To cite this article: Lars Hammarström, Marie Häggström, Siri Andreassen Devik & Ove Hellzen (2019) Controlling emotions—nurses' lived experiences caring for patients in forensic psychiatry, *International Journal of Qualitative Studies on Health and Well-being*, 14:1, 1682911

To link to this article: <https://doi.org/10.1080/17482631.2019.1682911>



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Controlling emotions—nurses' lived experiences caring for patients in forensic psychiatry

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ABSTRACT

Purpose: Nurses working in forensic psychiatry often encounter offenders who have a severe mental illness, which may cause ethical challenges and influence nurses' daily work. This study was conducted to illuminate the meaning of nurses' lived experiences of encounters with patients with mental illnesses in forensic inpatient care.

Methods: This qualitative study employed narrative interviews with 13 nurses. Interviews were audiotaped and transcribed verbatim and analysed following a phenomenological-hermeneutic approach.

Results: Four key themes were revealed: "Being frustrated" (subthemes included "Fighting resignation" and "Being disappointed"), "Protecting oneself" (subthemes included "To shy away," "Being on your guard," and "Being disclosed"), "Being open-minded" (subthemes included "Being confirmed," "Developing trust," and "Developing compassion"), and "Striving for control" (subthemes included "Sensing mutual vulnerability" and "Regulating oneself"). Further, working in forensic psychiatry challenged nurses' identity as healthcare professionals because of being in a stressful context.

Conclusions: Dealing with aggressive patients with severe mental illnesses threatens nurses' professional identity. Nurses must attempt to empathize with patients' experiences and respond accordingly. Utilizing strategies rooted in compassion such as self-reflection, emotional regulation, and distancing themselves when necessary may enable nurses to more effectively respond to patients' needs.

ARTICLE HISTORY

Accepted 16 October 2019

KEYWORDS

Encounters; forensic nursing; forensic psychiatry; lived experience; nurse-patient relationship; nursing; phenomenological-hermeneutic approach

Introduction

Forensic psychiatry provides services for offenders with severe mental illnesses (Nedopil, Taylor, & Gunn, 2015). Patients have often committed acts of violence (Rydenlund, Lindstrom, & Rehnsfeldt, 2019). According to Vorstenbosch, Bouman, Braun, and Bulten (2014) one third of the offenders who commit these acts have a severe mental illness, if a diagnosis is established after a forensic psychiatric examination, the person will likely be admitted to forensic psychiatric care, which is characterized by long hospital stays. In an environment that is characterized by security (Doyle, Quayle, & Newman, 2017) and can be experienced as restricted (Olausson, Danielson, Berglund Johansson, & Wijk, 2019). The caring relationship is central to forensic nursing (Encinares, McMaster, & McNamee, 2005) and a major part of care consists of nurses' encounters with the patient (Tenkanen et al., 2016), and Rask and Brunt (2006) notes that nurses should promote conversations with patients. Patients may receive as little as half hour and 1.5 hours per day for treatment and structured activities, respectively (Sturidsson, Turtell, Tengström, Lekander, & Levander, 2007). Social interactions constitute the remainder of the work according to Rask and Hallberg (2000).

To interact with people in psychiatric nursing creates possibilities to affect patients' mental illness, and it is a key component of the rehabilitation process (Hellzen & Asplund, 2006). A caring conversation between the nurse and the patient could indicate an improvement in the patient's health (Rydenlund et al., 2019); however, there is currently scant research concerning these encounters. There is some evidence that healthcare professionals can be judicial; do not listen; and lack the adequate competence to address hopelessness, apathy, anger, and sorrow (Harris, Happell, & Manias, 2015). The fact that the patient has committed a crime may cause stress and frustration, thus damaging the potential relationship between nurse and patient and fostering mistrust (Harris et al., 2015).

Forensic psychiatric care is complex, regardless of whether the care is viewed as care or control (Kettles & Woods, 2006; Maroney, 2005). Little is known about how nurses respond to patients' experiences (Myklebust & Bjorkly, 2019). Løgstrup (1997) presented a phenomenological-hermeneutic ethical demand—he stressed that encounters with other people come with a distinct responsibility: people exist together and are dependent on each other.

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People extradite themselves to a “me and you” relationship. Examples of such actions are to show trust, mercy, openness, and honesty. When they are absent, it is an indication of a selfish, modern world, and the ethical requirements transform into a duty.

Since the care is characterized by constraint and coercion, patients’ dignity may be offended through objectification (Jacobson, 2009). Rask (2002) stressed that a trusting relationship between the patient and nurse can improve forensic care; however, this requires a deeper understanding of nursing in forensic care. It is known that a caring relationship is of importance, but to what extent and how these encounters unfold in clinical practice is relatively unknown (Goulter, Kavanagh, & Gardner, 2015). There is a plea of nurses to be caring, protecting and trustful (Tingleff, Hounsgaard, Bradley, Wilson, & Gildberg, 2019). According to Hörberg, Sjogren, and Dahlberg (2012), patients in forensic care express that this trusting relationship is missing. The question is, how can forensic care that is custodial and corrective be based on nursing, and how can caretakers equip themselves with the necessary tools derived from nursing and ethics according to Hörberg (2015)?

Meeting other people comprises a permanent fusing between understanding and impression by establishing trust in inter-human relationships. Meeting another person comes with expectations—an anticipation that the other will receive us and fulfil our expectations. Løgstrup (1997) posits that, if the expectation is not received, there is a risk of meaninglessness. It is necessary to evaluate the care from the nurses’ perspective (Selvin, Almqvist, Kjellin, Lundqvist, & Schroder, 2019). Nurses must be supported so that they provide care that eases patients’ suffering and prevent future crimes. If feelings like fear, disorientation, and anger become the foundation of care, the caretakers will not be able to ease patients’ suffering (Sjögren, 2004). Nurses endeavour to make patients submit to the care, thus becoming manageable and displaying positive behavioural adaptation. According to Hörberg (2008), the complexity of forensic care is that nurses’ tasks are contradictory—they are supposed to care, guard, and protect; connect with the patient; create a trusting relationship; ease the patients’ suffering; and improve their health and wellbeing. Letting a patient’s expressions become the nurse’s impression, confronting the nurse with the risk of letting intuition and emotions affect his/her caregiving (Devik, Enmarker, & Hellzen, 2013). The aim of this study was to illuminate the meaning of nurses’ lived experiences of encounters with patients with mental illnesses in forensic inpatient care.

Materials and methods

Qualitative research involves studying things in their natural setting, attempting to make sense of, or interpret, phenomena and the meanings people bring to

them (Creswell & Poth, 2018). These meanings constitute individuals’ lived experiences and can be expressed through reflection on actions in narratives (Lindseth & Norberg, 2004) of nurses encounters with patients with mental illnesses in forensic inpatient care.

Procedure and setting

Narrative interviews were conducted with 13 participants, based on a model of sample size in qualitative selection and information power (Malterud, Siersma, & Guassora, 2015). All participants worked at a forensic hospital in Sweden. The clinic consists of approximately 180 employees and 100 patients. Most patients are men aged 25–45 years who were convicted of some sort of violent crime. Approximately 60% of patients have schizophrenia or another psychotic disorder. An invitation to participate was mailed, with written information about the study and a consent form, to the heads of the clinic and each ward. Study approval was obtained by the head of the clinic.

Participants and data collection

A purposive sample was recruited among nurses with experience of caring for patients with mental illnesses in forensic inpatient care. The interviews were conducted at the forensic clinic, at a preferred place chosen by the participants. Participants were 10 men and 3 women (median (*Md*) age = 36 years, age range = 28–67 years). Participants had worked in forensic psychiatric care between 5 and 46 years (*Md* = 11 years), and there were 5 registered nurses, among those 3 specialist nurses in psychiatric care and 8 assistant nurses, all with special training in psychiatric care.

In the presentation of the results, all staff are referred to as “nurse” to conceal their identities. Data collection was conducted through recorded, individual, and narrative interviews with open-ended questions (Mishler, 1986). Participants were asked to narrate their lived experiences of encounters with patients with mental illnesses in forensic inpatient care. The interviews lasted from 41 to 60 minutes (*M* = 48 min). The main questions included, “Can you tell me about an encounter with a patient that evoked negative feelings?” and “Can you tell me about an encounter with a patient that evoked positive feelings?” Further questions included, “How did you feel?,” “Can you tell me more?,” and “Has that happened before?.” The first author transcribed the interviews verbatim.

Phenomenological-hermeneutic approach

The interview text was interpreted using a phenomenological-hermeneutic approach (Lindseth & Norberg, 2004). The process of interpreting the text goes through three phases: naive understanding, structural analysis, and comprehensive understanding. During the first

phase, the naive understanding the text was read many times with an open mind; this was to get an overall awareness of the text, which ends in a formulation of the initial understanding of what the text is about. The second phase, the structural analysis, is a more precise form of analysis to recognize parts and patterns and to seek clarification of the text through outdistance and a critical way of being. This was achieved by analysing all the meaning units, which was sorted into themes and subthemes. The last phase of analysis was the comprehensive understanding, which is a form a dialectic movement between explanation and understanding; it is a way of seeing the whole considering its parts, and the parts considering the whole. It is an analytical, in-depth interpretation of all three phases. Altogether, this interpretation produces a comprehension of what the whole text represents. The process of interpretation is not linear; rather it is a spiral, dialectic movement between the parts.

Ethics

All participants received information about the research both orally and in writing. All participants provided written consent, which was stored by the first author. Participation was voluntary, and all interviewees were guaranteed confidentiality. All participants could, at any time, cease participation. All participants were provided with the first author's and supervisors' contact information. Ethical approval was obtained by the regional ethical review board (no. 2018/157-31) and was conducted per the Declaration of Helsinki (WMA, 2008).

Results

Naive understanding

During their work, nurses face various patient expressions. The encounters are based on nurses' willingness to do well; however, they are sometimes characterized by violence, resistance, and threats—thus creating various obstacles that arouse feelings of frustration, disappointment, fear, and humiliation. Contrastingly, encounters can also be positive, evoking feelings of competence, compassion, satisfaction, pride, trust, and pleasure concerning patients' recovery.

The text implies that encounters with patients who commit serious crimes can be arduous to understand and difficult to navigate for nurses, owing to the long-term care and ambivalence that occurs because of the diverse aspects of care including protecting society and doing what is best for the patients. These opposing views are also described as a potential source of conflict—a conflict based either on caring and alleviating suffering or on guarding and fostering patients. However, letting patients' expressions make an impression and thus sensing their vulnerability can guide the nurses in regulating their own feelings.

Structured analysis

Multiple structured analysis resulted in four themes and ten subthemes, see Table 1. The presentation of the essential meanings of the phenomenon—nurses' encounters with mental ill patients in forensic inpatient care—is written in present tense and describes how the phenomenon is; i.e., the meaning and not what the participants said about it.

Table 1. Overview of themes and subthemes.

Being frustrated	Fighting resignation Being disappointed
Protecting oneself	To shy away Being on your guard Being disclosed
Being open-minded	Being confirmed Developing trust Developing compassion
Striving for control	Sensing mutual vulnerability Regulating oneself

Theme 1: being frustrated

Being frustrated means being upset about one's limitations as a nurse concerning what they want and what they can do for the patient. It includes feelings of seeing oneself as strong, taking on responsibility, acting alone, and coming to short for unattainable demands. The feeling of perplexity around what it means to care for forensic psychiatric patients is strong. Nurses sometimes do not know how or what to do or say to reach the patient, except that they know what the patient has done is wrong, illegal, and totally unjustifiable. This theme consists of two subthemes: fighting resignation and being disappointed.

Fighting resignation

Not having anything to orient themselves to after the care creates a sense of perplexity, resignation, and hopelessness—despite repeated attempts to reach patients.

"Hopelessness isn't an unusual feeling; it can come over you sometimes. It can come when you don't know how to respond to someone in order to get your meaning across. This may feel dull when trying to reach them; it sometimes feels hopeless when you have tried so much, and nothing works."

Nurses may feel despair when they do not obtain positive results. Nurses also become confused when they assess a patient as ready to leave the clinic but the patient does not manage to integrate back into society. They feel indecisive and seek explanations for why.

"It can be a hassle with a patient group that would not need to be cared for in our clinic. It often is so anyway because of

all the relapses, which leads to an extension of care times. It's not so much an annoyance as a sense of hopelessness. But it's special here—with the long times of care."

Long-term care may result in a sense of powerlessness and lack of control among nurses since they do not see the results of their work in patients' development. Coming up short of unrealistic demands and not reaching expectations feels wrong and reinforces feelings of hopelessness. Being part of an environment that gives what is considered bad care could be demoralizing for the nurse. Not seeing the results of their work despite their ambitions is expressed by nurses feeling anonymous and powerlessness.

Being disappointed

Being disappointed means becoming aware of the let-downs that could arise when caring in forensic psychiatric care. It is a challenge to meet the feelings of disappointment with colleagues. The work does not, at times, feel fair. According to the nurses, the fact that they are responsible for care is something that they must "live with."

"It's hard to always be the one who says no, and you get upset when the patients are on you all the time."

Nurses expressed that interacting with individual patients also means having an overall sense of the patient, which he or she brings to the next meeting. Becoming aware that it is not always easy to show understanding towards the patient and that it can be difficult to live up to expectations can evoke anger and a sense of failure.

"I may carry with me some frustration from a previous meeting; then, it might be easier for me to overreact and get frustrated in a similar situation."

Becoming aware of how to work, think, and act is important for nurses. Nurses expressed that long-term care can affect them negatively, with feelings of frustration due to the patient's illness that sometimes does not show any improvement. Wanting to help and then being rejected by the patient fosters nurses' sense of frustration. However, both becoming aware and recognizing their own shortcomings helps nurses cope with this frustration.

"I can link it directly to work effort—how much commitment I have put into this, how many mind maps, how many whiteboard pens I have worn out on this patient, [and] how much feet I have rasped. When I finally present that, 'I think you and I have come up with the solution,' the patient responds, 'that sounds hard.' Then, the frustration grows."

Theme 2: protecting oneself

The theme of protecting oneself includes encounters that evoke negative feelings among nurses. This

theme consists of three subthemes: to shy away, being on your guard, and being disclosed.

To shy away

Working in forensic psychiatric care means being exposed to patients who have committed heinous crimes, such as violent crimes and sexual abuse against children. Nurses explain this as a reason that it is sometimes difficult to approach the patient and that they are uncertain in the care they must provide.

"I feel like I'm getting angry. He tried to murder a little girl in the most brutal way I heard of. There goes my own limit to be able to feel goodness and love. I could not care for him in the same way I care for other murderers. For me it was the exception."

Nurses know what the patients need; however, they cannot satisfy it. Instead, the situation is handled by avoiding contact with the patient. The nurses expressed that, whatever they do, everything feels wrong.

"There's one patient where I find it difficult to feel goodness and love. It's a patient that I thought was horrible. He was a pedophile. Many considered him the best patient. Because he did exactly what you said. [He] handled himself perfectly; but, I could not see him in the eyes. I just said hello and what was necessary."

Distancing also resulted from nurses feeling that patients were a threat and that they could lash out in violence. This fear led to uncertainty in their care, which affects nurses' actions and the caring relationship. This also led to contradictory emotions, because sometimes nurses are not prepared to pay the price that it can cost to handle their feelings.

"It's worse when you get scared. When you feel that you're about to get hit, or when you feel that the whole situation is threatening, you have to put down all of your energy to be able to cope with the situation."

Being on your guard

Working as a nurse in forensic psychiatry means being on your guard. There is a nagging feeling that, at any time, a situation can occur. To prevent dangerous situations the nurse needs to be constantly on guard. Sometimes the patient's history and professional experience help the nurse stay one step ahead.

"With some patients, you have to be on your guard. You don't let them behind your back. Such times, it's not entirely safe to be at work. You know what they have done. Perhaps they have a history of being rowdy."

"For some reason, I got a weird feeling when he walked by. Something wasn't right—a gut feeling. So, I turned around because I felt he was behind me. He was one of those who you needed to have your eyes on."

New patients create uncertainty because there is a lack of knowledge about the patient. Therefore they

need to proceed with caution when encountering new patients. Sometimes the distrust is linked to the patients' experiences. The nurses work experience indicates that a frightened patient may be dangerous.

"[It] reminds you of that one time a patient attacked you, for example. It also means that you might be a little more cautious when you are going to meet this patient. Maybe you keep a little more distance because you do not feel completely safe with him. I didn't know him. [I] didn't know what he was capable of. He was very wound up and frightened."

Being disclosed

Being humiliated by a patient can affect nurses, especially if it occurs frequently or in front of other people. Feeling disclosed is hard to defend against and may make nurses lose their composure.

"I think this person has found a sensitive point in me—where I am somehow vulnerable or become offended. Sometimes I can withstand almost anything while sometimes I can withstand almost nothing; those times I will be sincerely offended."

Being unable to change the situation was problematic for nurses. Nurses want to handle the situation and stand up for themselves. Instead, there's a feeling of being disclosed and an inability to act like they do with other patients.

"I took it personally. A thing that normally does not concern me; but, he managed somehow to get under my skin."

Theme 3: being open-minded

Being open-minded refers to nurses' ability to understand patients' history and disease. It is needed for an effective patient–nurse relationships. This theme consists of three subthemes: being confirmed, developing trust, and developing compassion.

Being confirmed

Being confirmed means that nurses' engagement increases. The feeling of not being alone in the situation decreases when nurses receive validation from their colleagues. They feel that they are easily understood by colleagues who have similar experiences in forensic psychiatric care and thereby understand the caring relationship. This evokes a willingness to provide care.

"I think it matters for my commitment. I think we, in the staff group, are still quite good at ... when someone manages to do something good. That you get to hear it. I can feel, that if I receive praise, [that] it's something I want to maintain."

Patients' expressions of gratitude contribute to the caring relationship. The nurses appreciate when the patients value good nursing care, which increases

nurses' self-esteem and fosters continued commitment. Long-term forensic care with severely ill patients is so arduous, that when there is success with a patient, it brings nurses joy and validates the work they do.

"The patients don't show much gratitude; but some do it. Then, you get energy and a great feeling in the body. Then, I feel that you're doing something meaningful."

Developing trust

Developing trust is vital for the caring relationship and means having the courage to open up to the patient and taking the patient seriously. Showing confidence in the patient means that the relationship becomes predictable.

"If I can trust the patient I also dare more—like, sharing myself. When I learn how to respond to him, I feel more secure. Then you dare more. I can't feel the mood of the patient if I go around being scared or don't feel safe."

Trust also means that the balance of power is reduced by the patient's participation. Knowing the patient may also mean being together, through that the distance and paternalistic relation between the two parties is decreased.

"For me, I think the key has been that I managed to create trust through my encounters. You should meet his needs and listen. He should feel involved."

Developing compassion

Letting the patient make an impression means seeing "the person" and not just "the patient." Becoming aware of and recognizing the vulnerability of the patient's situation characterizes these interactions.

"She then told me about her whole life. To hear about how her life has been—about why she committed the crime she had done. It all felt very tragic."

It is not only the patient's life that makes an impression on the nurse; the patients' temperament is also of importance. If the patient is perceived as a child, the nurse may find it easy to provide care since feeling sorry for the patient evokes empathy.

"All of a sudden, he begins to cry. It all became very different very suddenly. You felt how frightened he was—how small he was. I felt very sorry for him."

Reflecting on the patient's expressions over time promoted a deeper relationship between nurses and patients. Which may also create a more caring relationship.

"I've been with these patients for several years. I've established stronger ties with them. Thus, I become more personally involved in them. Over time, it has surely become so that I maybe care more about them."

Theme 4: striving for control

This theme consists of two subthemes: sensing mutual vulnerability and regulating oneself.

Sensing mutual vulnerability

Sensing mutual vulnerability refers to the feeling that occurs when the nurses are affected by the patients' expressions. Nurses feel vulnerable when they perceive patients' vulnerability. It was described as frustrating when patients' wellbeing and health were at risk. Feelings of sadness and loneliness affected patients, which seemed to arouse a sense of compassion among nurses. Nurses used intuition and empathy to guide their responses to some patients.

"I feel it's tough; [it is] hard to be among these patients because they feel so amazingly bad. I already felt before that he was afraid. It was as if he felt crowded. He could not flee even if he wanted to. He could just as easily become aggressive to deal with the situation."

Regulating oneself

Regulating oneself refers to nurses' responsibilities, including legally, concerning patients' care. Care is described as special, because the patient group has complex problems and partly because the institution environment is characterized by a high level of security. In nursing care, the nurses must balance between patients' rights and the safety of society. The care is complicated as patients may be ill, aggressive, and provocative.

"If they're being aggressive, then you've to stop and think before going into a situation. Some may be so provocative; but, if you can find your own sense of security and calm—if it's from colleagues or whatever—the encounter with the patient will be better. You have to keep track of your own feelings in order to take care of someone else's feelings."

If nurses are unable to cope with their feelings, there is a risk that they will lose control of themselves and the situation. Regulating oneself in such a situation means, if possible, taking a step back to finding room to take a breath.

"If I am overcome by emotions and find myself losing control, I try to pull myself out of the situation until the level of affect decreases. Then I can ponder the situation [and] think about what has happened—why did I react so strongly? I would say that the feeling that is most difficult for me to distance myself from, or to regulate, is fear. Anger is, in a way, more manageable."

Comprehensive understanding

The overall interpretation is based on the authors' preunderstanding and naive understanding, themes, subthemes, and reflecting upon them in relation to the research question, context, and literature. The

meaning of encountering patients with mental illness in forensic inpatient care is characterized by the asymmetric relationship between the nurse and the patient. This constitutes a fundamental moral challenge that nurses must cope with. For the nurses, the encounters involved being frustrated, protecting oneself, being open-minded and striving for control. Patients' expressions of threat, violence, and provocative behaviour threaten nurses' professional identity. Nonetheless, nurses attempted to empathize with patients' experiences and displayed competence in assessing patients' expressions. Nurses placed themselves in a vulnerable position by acknowledging patients' uniqueness and individual needs. This strategy fostered self-reflection, situational assessment, and compassion for patients. This allows nurses to control themselves, the patient, and the situation.

Discussion

The aim of this study was to illuminate the meaning of nurses' lived experiences of encounters with patients with mental illnesses in forensic inpatient care. We found four themes, further broken down into ten subthemes, that shed light on interviewees' lived experiences: "Being frustrated," "Protecting oneself," "Being open-minded," and "Striving for control." We found that patients' expressions emotionally affected nurses' caring actions and preferences as well as their professional self-esteem and moral identity.

Working in a forensic environment challenges nurses' identity as a healthcare professional because of their obscurity and vulnerability in stressful work situations. Moral distress is an inherent risk in forensic psychiatric care with its complex patient group that have varied problems. This leads to an institutional environment characterized by a high level of security in the interface between law and psychiatry (Carroll, Lyall, & Forrester, 2004). Nurses may experience distress when dealing with their own fear owing to patients' potentially provoking and violent behaviour. This means that the provision of competent and compassionate care can be compromised by nurses' fear and lack of knowledge. The care approach may also fail owing to a lack of self-confidence or courage in nurses' interactions with patients. However, this is a balancing act, and power is an underlying issue. Nurses are empowered by their expertise and their mission but disempowered because they must try to adjust to patients' complexities.

Working in forensic psychiatry means providing nursing care for long periods. Patients who are calm are often perceived as accepting of the care given and following the rules according to Eivergard, Enmarker, Livholts, Alex, and Hellzen (2018). Nurses often expressed **being frustrated** by not being able to

reach patients or make progress in their treatment. A major part of forensic nursing is being firm, setting limits, and defining boundaries, which affect the nurse–patient relationship (Bowen & Mason, 2011). There is always a risk that the encounters are viewed as paternalistic (Hörberg et al., 2012; Norvoll & Pedersen, 2016; Selvin, Almqvist, Kjellin, & Schröder, 2016). Forensic inpatient care is strenuous owing to long hospital stays (Rao et al., 2009), and nurses with negative perceptions may be more likely to provide poor care quality (Kukulu & Ergun, 2007).

According to Jacob, Gagnon, and Holmes (2009), feelings of frustration, disappointment, and resignation can be obstacles that nurses must overcome. These feelings can make nurses doubt their own actions, which becomes clearer if these feelings occur for a long time (Dennis & Leach, 2007). This could also influence patients to experience insecurity and powerlessness. This is because nurses do not see the patient as dynamic individuals; rather, they are viewed as or she is but static, one-dimensional people (Lilja & Hellzén, 2007). According to Olausson et al. (2019), a relationship can be a lifeline—saving the patient from loneliness and contributing to their well-being. If patients sense that nurses are attempting to empathize with them, it may foster trust and open the lines of communication. Strengthened by the ethos of caring and ethics, nurses must engage with patients, which too will promote trust (Rydenlund et al., 2019).

The theme **protecting oneself** refers to nurses' lived experiences concerning facing the unpleasant. Nurses expressed a distance between themselves and the patients as a way of dealing with mixed emotions that arises when caring for patients who committed despicable crimes. However, nurses must strive to look beyond patients' crimes and backgrounds, instead focusing on support and recovery (Bowring-Lossock, 2006). This is difficult when feeling unsafe or afraid, which negatively affects the caring environment (Leutwyler & Wallhagen, 2010). Being exposed to threats, violence, and provocative behaviour was described by all the nurses, and this can contribute to a distance in the nurse–patient relationship. Consistently, patients' ability to follow the rules and not showing aggressive behaviour is deemed acceptable patient behaviour in the eyes of nurses (Eivergard et al., 2018).

Results from this research indicate that within a highly regimented context, nurses are socialized to incorporate representations of the patients as being potentially dangerous. Thus, they distance themselves from idealistic conceptions of care. The results also emphasize the implication of fear in nurse–patient interactions, particularly how fear reinforces nurses' need to create a safe environment. This results in a consistent negotiation between risk and security, in which nurses are forced to scrutinize their actions

and preventing nurses' future engagement. This can be contradictory since not knowing or uncertainty about a patient is a source of feeling unsafe. Continuity and being present leads to the patient feeling safe in the nurse–patient relationship, which creates opportunities to further establish a good relationship and, in turn, increases the ability to make the patients' needs visible (McCann & Phillips, 2007).

Our findings showed that not knowing the patient makes it unpredictable and difficult to determine how to best care for the patient, which was also suggested by Holmes, Murray, and Knack (2015). Forensic psychiatric care is a restricted environment, and beyond what is considered a “normal” life (Olausson et al., 2019). Patients express a longing for encounters in which the nurse is the one taking a step forward and not disappearing when times are tough (Lindström, 1995). Not feeling safe also fosters hopelessness, and it can be an obstacle to understanding patients' views on health, wellbeing, and existence. A state of being non-judgemental, present, and open towards the patient is desirable for forensic nurses (Bowen & Mason, 2011).

Nurses can facilitate patients' path to health by expressing a willingness to understand patients' experiences (Rydenlund et al., 2019). In forensic psychiatry, fear is considered a part of the milieu. Nurses present a front—not showing fear as a way of dealing with these emotions. It is a self-protective strategy that is necessary to see the patient as a human being, regardless of whether the patient is evoking fear. This is considered an obtainable professional value (Jacob & Holmes, 2011).

Like all nursing care, nursing practice in forensic psychiatry care is grounded in ethics, and the ethical responsibilities underlie all nursing interactions towards individuals, next of kin, and colleagues (ICN, 2014). When caring for a patient who emotionally touches them, it was revealed that the nurses were opened themselves to patients' vulnerability. Expressing sympathy towards patients and **being open-minded** are critical aspects of nursing care.

Developing compassion can promote nurses to be fair, respectful, consistent, and knowledgeable in their encounters with patients (Maguire, Daffern, & Martin, 2014). The nurse–patient relationship in forensic psychiatric settings should be grounded in trust and confidence, and patients require opportunities for emotional reconciliation, as suggested by Salzman-Erikson, Rydlo, and Wiklund Gustin (2016). Being a nurse in forensic psychiatry is a complex role, and there is a tension between maintaining safety and promoting a therapeutic and patient-centred approach (Green, Shelly, Gibb, & Walker, 2018). Nurses strive to maintain professional boundaries and aspects of therapeutic communication, including establishing “trust” and “validation,” according to

Doyle et al. (2017). Establishing a trusting relationship with patients in forensic psychiatric settings is viewed as a less oppressive way to control patients and guide them in directions that are preferable for the nurses and for society. This could be achieved through encounters in which the gap between the patient and the nurse is reduced (Salzmann-Erikson et al., 2016). Encounters in forensic psychiatry invite nurses to carry the burden of guilt and suffering during long periods (Rydenlund et al., 2019), which our findings suggest is made possible by having trust and compassion.

Our findings also suggest that nurses were often emotionally affected by patients' expressions of threat, violence, and provocative behaviour. This situation forced a nurse, when the situation become too severe, to take a step back and distance him/herself from the patient as a way of **regulating oneself**. Sometimes forensic nurses need to distance themselves from their patients because of policies or procedures around control (Gillespie & Flowers, 2009). It is a challenge for nurses to maintain a positive relationship with patients, especially when they have been threatened, harassed, insulted, or physically injured by a patient. Nurses must move past their own feelings towards the patient and attempt to help the patient regain trust in them to preserve their relationship (Holmes et al., 2015).

Nurses described that encounters also means facing suffering and their own reactions to it. Trying to maintain a positive relationship through encounters that vary from "normal" everyday circumstances, nurses must look past the problematic behaviours and understand that what they are seeing in patients is the illness and not actual "bad" behaviour, as described by Holmes et al. (2015). Our findings show that, when nurses understand this, they can see beyond the façade. This enables nurses to detect patients' conceptions of themselves. This indicates that the caring encounter is formed by patients' needs. The nurses described that facing patients' suffering sometimes required that the nurse take a step back—not to abandon, but rather to come closer, which is also described by Vincze, Fredriksson, and Wiklund Gustin (2015).

The findings in our study can be understood considering the Danish philosopher Løgstrup (1983), who stated that vulnerability is a fundamental condition of human life. Our findings indicate the importance of nurses' vulnerability when participating in another's life. According to Løgstrup (1997), meeting another's expressions is also ontologically, an inter-human act where each one of the actors turns to each other in a person-to-person encounter in which they are guided by their perception and vulnerability. For nurses, the challenge is also how professionalism plays in to their interpretation of the situation. Our

findings indicate that in some occasions the caring encounter is formed by the patients needs and the nurses ability to regulate their own expressions. Regulation means inviting the patient into the "room of awareness," where the two parties meet each other and themselves (Devik et al., 2013). Through regulation, nurses can open the "door" to the "room of awareness" and let the patient's expression make an impression without hiding behind the protection of one's own foreknowledge and a stereotyped view of forensic psychiatry patients.

Logically, the "key" to the "room of awareness" is nurses' ability to interpret patients' expressions. According to Løgstrup (1983), interpretation is in the movement between perception and understanding. Our findings clearly indicate that nurses' perception were affected, which was also seen in other studies (Vincze et al., 2015). According to Løgstrup (1978), understanding can also create a distance and is linked to our preconceptions, where cultures and knowledge are embedded. The nurse is moved and affected, present in the perception of something that does not leave him or her untouched (Vincze et al., 2015).

In other words, being present with the patient is challenging when the nurse is confronted, not only with the patient's expressions, but also with their own reactions. If a nurse encounters a patient with his/her prior knowledge and with a preparedness to categorize what has been said, the "room of awareness" may become locked (Hellzen & Asplund, 2002). Encountering patients' expressions may be a painful and frightening experience; however, nurses must have the courage to stay with the patient and evaluate both their own and patients' safety. One way to deal with situations like this is to narrate their experience of patients' behaviour without questioning it. Instead a true interest, manifested as an effort to understand the patient's experience and encourage openness of feelings, is awoken in the nurse. As Løgstrup (1983) states, interpretation of sensation is a way of being in the world, sensing openness to people who wanting us something. This means that in the interpretation the nurse experience what it means to be not only human in the world but also how she relates to what touches her in the perception, an appeal of caring for the other based on compassion.

In conclusion, to care for patients within forensic psychiatry means facing numerous of situations that threatens the nurse's professional identity. Letting the patient's expression make an impression, taking a step backward to be able to take a step forward by regulating own emotions. Such strategies, creating a temporary distance, enables nurses to come closer to the patients to be able to alleviate suffering, despite sometimes facing threats, violence and humiliation, making decisions based on compassion and the patient's needs.

Methodological considerations

Trustworthiness depends on truthful narratives of lived experiences (Lindseth & Norberg, 2004). The first author was known to most of the participants, which hopefully meant that the participants could speak truthfully and freely. On the one hand, this might facilitate trust and that participants could speak freely and truthfully. On the other hand, this could cause participants to be cautious and afraid to reveal weaknesses. On the third hand, it also challenged the first author's pre-understanding and ability to discover implicit messages. To overcome this obstacle, the author tried to be attentive and ask questions so that new and unexpected elements could be revealed. The first author has strived towards self-awareness of which has been encouraged through self-reflection and discussions with the other authors. The first author conducted all interviews, transcribed the text, and conducted initial analyses. Some of the other authors lacked first-hand knowledge in forensic care and contributed with contesting throughout the analysis. However, all authors contributed significantly to this manuscript. The two main questions were formalized as either positive or negative, which could suggest that the narratives from the participants could be affected in either direction, which could also mean that some encounters or a certain group of patients were forgotten. By requesting both negative and positive experiences from encounters, the intention was also to trigger the participants' memory when narrating. It may be easier to remember experiences that have been emotional touching, and asking for specific incidents is a recognized technique when working with narrative inquiry (Drew, 1993).

This article does not present an absolute truth or distinct evidence; rather, it can shed light on nurses' lived experiences of encounters with patients with mental illnesses in forensic inpatient care. Hopefully, it will encourage more research concerning how patients' expressions impact nurses and the care they provide. It should be considered that forensic psychiatry is governed and controlled by laws that may differ nationwide; therefore, the current results should be viewed as lived experiences in the Swedish context.

Acknowledgments

The researchers express our gratitude to those who participated and contributed to this study.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Paper II



Contents lists available at ScienceDirect

Archives of Psychiatric Nursing

journal homepage: www.elsevier.com/locate/apnu

The path of compassion in forensic psychiatry

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ARTICLE INFO

Keywords:

Compassion
Encounters
Forensic nursing
Forensic psychiatry
Hermeneutics
Lived experience
Nurse-patient relationship
Nursing

ABSTRACT

We aimed to deepen our understanding of the concept of compassion in caring for patients with mental illness in forensic psychiatric inpatient care settings. Qualitative analysis was used to illuminate themes from interviews conducted with 13 nurses in a prior study. The audiotaped interviews, which had been transcribed verbatim, were analyzed following a hermeneutic approach. Results revealed the main theme of “being compassionate in forensic psychiatry is an emotional journey” and three themes. Overall, compassion was seen as a changeable asset, but also an obstacle when absent; sensitivity to one's own vulnerability is necessary to overcome that obstacle.

Introduction

The wellbeing of nurses is the foundation of forensic psychiatric care, which involves working with mentally disordered people who have been involved in criminal activity or have encountered other legal issues. Forensic psychiatric nursing care is often provided in prison hospitals and other secure institutions, and it can be a struggle to work with mentally ill patients in such environments and maintain good management of one's own emotions, being compassionate, consistent, and staying connected to the patients. (Sturzu et al., 2019). While challenging, providing care within a forensic setting creates unique opportunities for nurses to affect the wellbeing of patients (Rydenlund et al., 2019) and alleviate the suffering of offenders with severe mental illnesses (Nedopil et al., 2015). To be effective, this requires relationship-based care (Encinares et al., 2005; Schafer & Peternej-Taylor, 2003). However, establishing relationships can be one of the greatest challenges for forensic nurses (Austin, 2001) as it involves making sense of an incomprehensible world and developing relationships based on empathy, genuineness, and compassion (Møllerhøj & Os Stølan, 2018; Wyder et al., 2015).

According to Kanov et al. (2004), compassion is a process involving three key elements: “noticing” another's suffering, “feeling” the others pain, and “responding” to that persons suffering. It is also described as an intentional response to gain an in depth understanding of a person, recognize their needs, and ameliorate suffering through relational understanding and action (Sinclair et al., 2018). Letting compassion guide

your actions towards the suffering of others goes beyond gaining the attention of the other to attuning to oneself and engaging an ethical compassion-based action (Halifax, 2014). Compassion and self-compassion is closely linked, as it involves admitting that suffering, failure and inadequacies are part of being human, that all people, oneself included, are worthy of compassion (Neff, 2003).

Compassion is re-emerging as a major topic in the domain of ensuring quality in care (Tveit & Raustol, 2017). Studies indicate the importance of nurse's attuning to vulnerability when taking part in the lives of others (Hammarström et al., 2019). Lögstrup (1997) states that vulnerability is a fundamental condition of human life, meeting another person is an interhuman act, where both parties should be guided by their sensitivity. Conversely, not being able to compassionately understand expressions of suffering can obstruct the building of stronger relationships and thus hinder a patient's recovery (Hsu et al., 2012). Compassion involves empathy and concern and, in nursing, is both a resource and a necessity (Mills, Wand, & Fraser, 2015), but it can also become an obstacle to overcome. Considering the vulnerability of patients and the demands on the nurses who see to their care, compassion is arguably nursing's greatest value (Halifax, 2014).

Compassion is also a principal component of caring for patients who suffer from mental illness (Crawford et al., 2014), and nursing is based upon compassionate encounters with others, even in challenging situations (Chang et al., 2005). However, striving away from paternalism and towards compassion can be especially challenging in forensic inpatient care units (Young, 2018). Nurses working in forensic psychiatry

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<https://doi.org/10.1016/j.apnu.2020.07.027>

Received 5 March 2020; Received in revised form 11 May 2020; Accepted 22 July 2020

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often struggle to remain empathetic and provide compassionate care; thus they risk depersonalizing the nurse-patient relationship (Sturzu et al., 2019). The forensic psychiatric environment involves working with patients who often oppose care (Selvin et al., 2016). Rushton et al. (2009), asked, “How can nursing be based upon, and continue to be based on, compassion when facing the multifaceted and complex encounters in today’s care?” For example, how does one access compassion when caring for offenders who may have abused children and whose expressions of suffering involve a longing and affinity with catastrophic consequences (Sjögren, 2004). Forensic care also means facing aggressive patients and intimidations (Greer et al., 2019), feeling unsafe, and, at times, having your very existence threatened (Hörberg et al., 2012). Coping with stress affects wellbeing and when facing threats people instinctively focus on self-defense (Crawford et al., 2014). Interfacing with aggressive patients can awaken emotions such as anger, fear, grief, and humiliation (Carlsson et al., 2006), posing challenges to sustained compassion. Hence, emotional regulation may influence encounters and nurses’ behaviors towards patients within a forensic setting (Oostvogels et al., 2018).

Forensic nurses who face perplexing behaviors need to manage emotions to avoid resorting to restrictive strategies that could infringe on a patient’s freedom and involvement (Davies et al., 2016). Helping nurses understand themselves may provide them with insights that allow them to empathize a patient, regardless of challenging behaviors, see the patient is a person (Oostvogels et al., 2018), and gain greater insight into the patient’s lifeworld (Hörberg, 2018). To support the wellbeing of psychiatric nurses and ensure the quality of care for patients, further understanding and clarification of the concept of compassion are needed (Tveit & Raustol, 2017). Therefore, the aim of this study was to gain a deeper understanding of nurses’ compassion in providing forensic psychiatric inpatient care.

Materials and methods

This study employed qualitative research, as it is appropriate when exploring an issue that needs further explanation to gaining a detailed, complex understanding, derived from the stories of people (Creswell & Poth, 2018). An understanding will appear through the fusion of horizons of participant and researcher, together reaching a shared understanding (Fleming et al., 2003). A hermeneutic interpretation was used, which means the researchers reflected on the own understanding, and the knowledge upon which it is based (Gadamer, 2004) in approaching the content of the interviews. A bridge of understanding is thereby created through a hermeneutic circle where preunderstandings are constantly questioned (Gadamer, 1976).

Procedure and setting

This study was based on the data collected in a previous study (Hammarström et al., 2019). Narratives are unique data in that they are collected primarily for single use but can also be stored with the intent that they may be valuable for secondary use in future research. Our secondary supplementary analysis involved a more in-depth investigation of an emergent that was not fully addressed in the previous study (Heaton, 2004). The data were derived from narrative interviews with 13 participants at one forensic hospital in Sweden where nurses encounter patients, the majority of whom are male, who have been transmitted to forensic care—with a background of violent crimes—and who suffer from various mental illnesses.

Participants and data collection

The participants were selected using purposive sampling, with the inclusion criterion of having experience caring for patients with mental illness in forensic inpatient care. The participants’ ages ranged from 28 to 67 years (median (Md) age = 36 years) and they had worked in

forensic psychiatric care between 5 and 46 years (Md = 11 years). The interviews lasted from 41 to 60 min (M = 48 min) and were recorded individual interviews with open-ended questions (Mishler, 1986). The participants were asked to narrate about their lived experience of encounters with patients with mental illness in forensic inpatient care. The main questions included, “Can you tell me about an encounter with a patient that evoked negative feelings?” and “Can you tell me about an encounter with a patient that evoked positive feelings?” Further questions included, “How did you feel?” “Can you tell me more?” and “Has that happened before?” In our first analysis (Hammarström et al., 2019), the questions provided an opportunity to understand the range of feelings and vulnerability nurses experienced when encountering their patients. We found that the nurses tried to empathize with patients’ experiences and displayed competence in assessing patients’ expressions. Their strategy fostered self-reflection, situational assessment and compassion for patients. The identification of the narratives’ potential of providing information about development of compassion argued for a secondary analysis. The first author transcribed the interviews verbatim. The participants (10 men and 3 women) consisted of 5 registered nurses and 8 assistant nurses. In the presentation of the results, all staff were referred to as “nurse” to conceal identities.

Ethics

Interviewees were informed about the study verbally and in writing. All interviewees provided written consent, which was stored by the first author. Partaking was voluntary, and confidentiality was guaranteed. The data used during the secondary supplementary analysis did not contain any identifying details about the participants. All participants were provided with the first author’s and supervisors’ contact information. Ethical approval was granted by the regional ethical review board (no. 2018/157-31) and was conducted per the Declaration of Helsinki (WMA, 2008). Permission to conduct the study was granted by the head of the clinic.

Analysis

Understanding of the text was gained through a systematic analysis in the Gadamerian hermeneutic tradition and went through four steps according to Fleming et al. (2003). During the first step, the text was read as a whole. Based on preunderstandings of earlier conceptualizations of compassion (Halifax, 2014; Kanov et al., 2004; Sinclair et al., 2018) and other research findings (including findings from our first study), the first author articulated the fundamental meaning of nurses’ experiences of compassion as a response to patients’ suffering. The fundamental meaning was later reflected upon by all the authors. In the next step, the fundamental meaning (*nurses’ response to patients’ suffering*) guided the identification of sentences and content in the text that could be related to or convey meaning about nurses’ response to patients’ suffering. Each sentence was examined to expose the meaning of understanding; themes and subthemes were formed. In the third step, a hermeneutic movement was conducted. Each sentence or setting was related to the text as a whole, thus gaining an expanded understanding of the whole text.

The hermeneutic circle was essential to gaining an understanding; each sentence and its subthemes and themes were related to the initial fundamental meaning of the text as a whole which, then, shed further light on the understanding of the text as a whole. The fourth and final step included finding passages that gave further insight into the phenomenon and clarified the mutual understanding between researchers and participants. The entire process was repeated numerous times until the authors settled upon a shared understanding, at which point the circle was closed.

Table 1

Overview of main theme, themes, and subthemes.

Main theme	Being compassionate in forensic psychiatry - an emotional journey		
Themes	Recognizing suffering and need for support	Responding to patients suffering	Reacting to one's own vulnerability
Subthemes	Suffering is obvious	Complying with the patient	Becoming persistent
	Suffering is hidden	Persuading the patient	Becoming resigned
	Suffering is frightening	Adapting oneself to the patient	Feeling shame

Results

The results are presented in one main theme: being compassionate in forensic psychiatry—an emotional journey, which entailed three themes—recognizing suffering and need for support; responding to patients suffering; reacting to one's own vulnerability—and subsequent subthemes (see Table 1).

Main theme: being compassionate in forensic psychiatry—an emotional journey

The nurses' narratives described an emotional journey and an inner negotiation. The fundamental meaning of experiences revealed the nurses' interpretations and responses to patients' suffering and their own vulnerabilities, where compassion could be seen as an answer to suffering. Caring for patients in forensic psychiatry meant meeting individuals who committed serious crimes and may have been suffering from severe mental illness for long periods of time. A nurse's ability to interpret the pleas of their patients was crucial for developing compassion. In patient encounters where nurses perceived an appeal for help, the nurses experienced compassion for the patient. Encounters that awoke negative feelings of dislike or uncertainty were those that involved struggling with deciphering the patients suffering. However, letting suffering make an impression made it easier to develop compassion. Despite how expressions of suffering made an impression and affected compassion, it was changeable over time. The emotional journey fluctuated: nurses either protected themselves from their own vulnerability by turning to control and rules or they became sensitive and compassionate.

The nurses' narratives revealed an inner negotiation between their own reactions to a patient's expression and the care that was professionally expected and personally wanted. This negotiation reflected their response to their own suffering as much as their response to the patient's suffering.

"It feels sad when you don't reach them. It feels hopeless when you have tried so much, and it is useless... with some patients it may take several years before they trust you... But enduring and staying in it can make you come closer to each other in the end."

The emotional journey and inner negotiation are further described in the themes and subthemes.

First theme: recognizing suffering and need for support

The first theme reflected what the nurses recognized as suffering and a need for support. The nurses described being in a complex environment with contradictory tasks, caring, guarding, and protecting while at the same time connecting with the patients and alleviating suffering. Despite the complexity, nurses viewed each patient as different. Expressions that made impressions forced them to turn their eyes inward and face emotions that were triggered.

Suffering is obvious

Feelings of compassion were easily aroused when the nurses perceived that a patient was really in need of help. Sometimes these expressions were clear and obvious, such as when a patient threatened to end his or her own life. One nurse talked about a female patient who

expressed suicidal thoughts:

"She wanted to change her life; she told me she wanted to live. She didn't want to die. You could see she was withdrawn, from the beginning she didn't want to share, but she trusted me. We formed some kind of bond."

Other times the patient's expression of suffering was not so visible, in which case the expression was interpreted based upon the nurse's professional experience caring for patients with mental illness. Once a good relationship was established, it awoke a feeling of being wanted and needed, giving the nurse a sense of success.

"He was often walking down the hall with his hood down, staring at the floor. He often turned to me and eventually we had a good relation after all...when you have managed to reach someone, you feel needed and you want to do good."

Suffering is hidden

Sometimes a patient would not show any desire to be helped or cared for. Instead, such a patient would withdraw and spend most of their time alone in his/her room, leaving nurses wondering how to approach the patient. In these situations, nurses expressed that the patient's suffering was evident to them. However, when the patient kept their distance, that is, when the patient does not want contact with the nurse, it was hard to comprehend what they wanted and what the expression of suffering stood for. Having the patient at a distance made it hard to communicate and establish a relationship, as getting to know the person is the essence of being compassionate.

One nurse said:

"Some patients just lay in their bed or keep their distance. It's apparent that they aren't feeling well, I can see that. But it's almost impossible getting to know them when they don't want to speak to you."

Other patients were perceived as unwilling to take part in some sort of daily activity. Not being able to get close to the patient obstructed the nurse's ability to understand the patients suffering. These caring encounters were seen as negative and a foundation of frustration, constantly repeating caring activities without getting any response.

"One thing that's difficult is when the patient is hiding from us. Some of them just stay in their rooms, making it hard to reach them. Of course, they feel bad, but it makes it hard to know how to help them, like we don't have the right tools, it's frustrating."

Suffering is frightening

At times, nurses found themselves in situations where their very existence was threatened. When the patient's expression of suffering was provocative and threatening, nurses experienced feelings of insecurity and fear.

"You have to remember that you're dealing with patients with a severe mental illness, but every time I talk to this patient he either focuses on how bad I am as a person or he's angry about something. It just doesn't make any sense."

Being confronted by violence and intimidation awoke a sense of

anxiety and fear within the nurse. Not being able to decipher the patient's suffering could end up in nurses finding themselves in situations they do not know how to handle.

"I remember this time, this guy wasn't feeling good. He was very psychotic at the moment. I tried to talk to him, I was calm and collected and approached him. Without warning, he jumped me; I didn't see it coming and I got scared."

Second theme: responding to patients suffering

The nurses' narratives exposed the process of making sense of and gaining meaning from encountering patients in forensic psychiatry. Despite facing different types of encounters, the complexity of care was always present and the nurses must carefully control their responses to the various expressions of suffering.

Complying with the patient

In some encounters, the nurse responded immediately to expressions of suffering with compassion, in a way that felt obvious and natural. Providing care for patients who explicitly requested help felt right and left the nurses with feelings of having done a good job.

"When they come by themselves and want help, it goes without saying that you are there for them, it sorts of becomes a proof that you have done the right thing when they themselves want help."

In encounters with patients, the nurses expressed that adherence made it simpler to maintain control of the situation and to give care, which awoke feelings of enthusiasm. Taking advantage of these meetings seemed to be valuable and strengthened nurses in future encounters.

"It's much easier to help them when they want to receive the help I can give them...it also makes it easier to motivate myself and stay committed".

Persuading the patient

In situations when patients hid their suffering or opposed help and did not realize it would be for their own good, the nurses spent a lot of energy on trying to persuade and influence the patients to adapt to the care. The nurses found it tedious having to treat and guide patients who were consistently reluctant. Although the nurses' responses were grounded in concern for the patients, these experiences influenced how the nurses engaged with them in the long run.

"It's hard when they just disappear from you and don't want to receive the help we can give. You want what's best for them, you want them to move forward. Because it's about what you have to cope with yourself, too. It's tedious to have to nag the patient."

Adapting oneself to the patient

When nurses found themselves in a situation, in front of an unpredictable patient, they had to first adapt to the situation, not letting fear, anger or frustration take overhand. Despite being worried the nurses did not show this to the patients. Instead, they tried to show a façade of calm and comfort.

"Sometimes it happens that you are at the front of a situation and have to confront someone. That is extremely intimidating. Then it's hard. Then it's so...I do not want to communicate to the patient that I am afraid. I want to hide it, while this feeling is stirring up inside me. I don't have so many tricks other taking a deep breath, far down in the belly... Try to keep control of my voice."

Making the effort of gaining control of the situation was not only an act of what's best for themselves, not making a decision based only on the effect, but also on what was best for the patients, an act of what was

best for the other, an act of compassion. However, if the nurses were unable to maintain control of themselves and they let their emotions take over, they rapidly took a step back in order to be able to give a more adequate response to the patient's expression of suffering. This allowed them to regulate and adapt to the situation, thus gaining control of both themselves and the situation.

"I notice that he often turns to me, it's me he wants to talk to; you have to think about the patient's situation. I always try to think that they are ill, that's why they are here. At the same time, it's a protection for me not to take everything that happens personally when they choose to take out their bad feeling on their surroundings...if my feelings take over I will most certainly not be able to handle the situation, then I must take a step back"

Third theme: reacting to their own vulnerability

Becoming persistent

It was clear that the nurses invested a lot of time and energy in providing the best possible care for the patients. When they received positive feedback from the patient and succeeded in gaining contact and mutual respect, this meant both self-respect and renewed commitment. This investment could be seen as the nurses' attempts to alleviate their own frustration and suffering in times when patients did not cooperate. Sometimes it was just the passing of time that led to a changed situation.

"It took time, we had to take many walks and car rides, but eventually he started to trust me, we got to know each other, all the hard work paid off. We developed a special bond, I got to know the person behind his illness and crime... I got a whole different understanding of him as a person. I really wanted what's best for him."

Caring in a forensic setting meant being confronted with non-comprehensible expressions. Having time on your side helped the nurse to respond to the patient's plea. Feelings of hopelessness decrease and the nurse could more easily unravel the patient's suffering as well as her own.

"It's not as hopeless as you might think, sometimes the patients who are the most ill are the ones you develop most compassion for over time; you just have to get to know them, but it takes time".

Becoming resigned

The opposite of becoming persistent was also a topic in the interviews with the nurses. Being in an environment where they are not seeing any results during long periods of time, awoke feelings of discouragement and difficulty in feeling empathy. In this way, experiences of criticism and resistance could feel like a state that could never be changed. Feelings of failing both as a human and a professional were admitted and could result in low involvement and even resignation.

"Much of this job can be uphill. You get so much negative critic and criticism from the patients; it affects you over time. All the nagging makes you go from being engaged and empathetic to getting a bit of numb and cold in the end."

Nurses expressed difficulties staying dedicated and feeling compassion when facing negative comments and resistance during great periods of time. At some point, it seemed like they just had to convince both themselves and the patient, about the direction of the care.

Feeling shame

Nurses shared narratives about encountering patients that not directly awoke feelings of compassion; instead, they were perceived as intimidating or arduous. Nurses felt they had to care for them, feeling compassionate, despite the initial unpleasant emotions that occurred. A feeling that was experienced as difficult to handle and awoke a sense of

shame.

“Of course, some patients you like more than others. Some can be quite intimidating or annoying, I’ve found myself struggling to feel for some of them. It’s not something that you’re proud of, rather the opposite.”

Sometimes the nurses struggled with setting their own emotions aside and had to admit that they were not always proud of their own handling. One of the nurses was embarrassed that she was unable to handle emotions of not being compassionate.

“Well, I must say, that it’s hard sometimes to care for these patients. They have done terrible crimes and can be quite threatening. But at the same time, it’s my job to take care of them, wanting that’s best for them, and when I can’t. It feels kind of strange, it doesn’t feel professional, like something you don’t want to talk about.”

Discussion

The present study focused on exploring and interpreting nurses’ compassion when caring for patients with mental illness in forensic psychiatric inpatient care. This study presented one main theme: “being compassionate in forensic psychiatry - an emotional journey”, which was further broken down to three themes: “Interpreting the patients suffering”, “Response to patients suffering” and “Response to own suffering”, which was further described in six subthemes.

The main theme gives insight into the emotional journey nurses went through when encountering patients with severe mental illness in a context that can be focused around control and coercion, over long periods of time. The nurse’s narratives entailed that compassion is not static, but instead dynamic and changeable derived from the nurse’s own ability to interpret and respond to the patients suffering. Letting the patient’s expression make an impression and thus responding to their own suffering. Being compassionate seemed to be closely linked to the nurses’ ability to cope, respond, and reflect upon patients who are forthcoming, withdrawn, or being erratic. Nurses were invited to share the patients suffering; this meant confronting their own feelings of not knowing or being unable to help, thus also risking acting in order to alleviate their own suffering and not only the patients suffering. Staying compassionate could be seen as a key component of being able to endure and making expressions of suffering understandable.

The result contained narratives about encounters between nurses and patients, where the nurses are interpreting the patient’s suffering, which actualizes that giving is in a dialectic relationship with receiving, caring seems to be a mutual dependency. Where nurses not only are giving and the patients are receiving, but also the other way around. As stated in the theme, patients’ expressions of suffering are either perceived as a cry for help, patients fleeing or becoming unreliable. Being in an asymmetric, mutual ethically challenging relationship with the patients, also means challenges perceiving the other and maintaining professionalism when there is a risk of being rejected or not understanding (Hem & Heggen, 2004). Compassionate response towards the other starts with gathering attention and recalling intention, an internal process that allows compassion and reliance to emerge in the nurse-patient encounter (Halifax, 2014). Encounters in forensic psychiatry invite the nurses to always be ready to shift focus being able to gain a deeper understanding of expressed suffering, which is gained from a hermeneutic conversation together with the patient (Rydenlund et al., 2019). Factors of understanding one’s own profession and oneself illustrate how the confusion of nurses about their own roles and responsibilities must be made clear through self-reflection in order to improve psychiatric nursing (Hem & Heggen, 2004). Nurses’ narratives also described the development of compassion and not being taken for granted. Being able to understand “the other” is based upon a mutual, sincere, and honest relationship. When facing ethically challenging encounters over long periods of time, personal chemistry and

establishing a mutual ground to understand the other can just be too difficult, and facing aggressions can become a substantial problem (Mourset et al., 2018). Being in “togetherness,” finding meaning over a long time, means becoming relatable and understandable (Olausson et al., 2019). To understand suffering, nurses ascribe meaning to erratic behavior, as finding the cause of suffering is a way to make it comprehensible (Vincze et al., 2015). Being confronted with suffering can have a serious implication for nursing; interpreting and attending to the patient’s suffering allows for establishing a more compassionate connection, seeing the “whole person” and not just the illness (Kanov et al., 2004).

The second theme further entails the dynamics of compassion: when the nurses must form a response to patients suffering, an expression of how the patient is suffering is interpreted. This theme further entails the mutual dependency that comes from a nurse trying to give a respectful response to the patient’s suffering; this also describes how nurses must respect themselves in order to be able to respect the other. How nurses approach the patient is of great importance (Gustafsson et al., 2013). Nurses try to establish trust and normality in their bond with the patient—a bond that is a foundation of care (Gildberg et al., 2012). Nurses also feel a responsibility for responding to the patient’s behavior adequately in order to correct bad behavior (Kumpula et al., 2019). If suffering is not understood correctly, the response may further inflict suffering, especially when the response is in form of a demand or ultimatum (Vincze et al., 2015), given in order to keep the calm in a turbulent environment (Salzmann-Erikson et al., 2011). Our results indicate that a nurse’s response to suffering is rooted in compassion when suffering is well-defined or even when the patient is avoiding nurses. However, when the patient’s suffering is hard to grasp or comes disguised as threats and violence, it challenges the nurses to feel the others pain and give a compassionate response. Being compassionate means suffering with, connecting to the others hurt, noticing pain means feeling something for the other, but compassion also involves the will to do whatever it takes to alleviate suffering (Kanov et al., 2004). Our findings suggest that despite finding themselves in encounters that are experienced as tedious or uncertain, the nurses did not surrender or distance themselves; despite the obvious risk, nurses stood their ground, not abandoning the patient in need. Instead, nurses adjusted to the demand with the intention of being professional (Vincze et al., 2015).

“Response to own suffering,” which is the third theme, reflects upon how the patients’ suffering affects the nurses over time. There is an evident risk of nurses confusing a patient’s suffering with their own suffering, which creates the danger of the patient becoming a means for the nurses to alleviate their own suffering. Our findings suggest that time is of the essence, and compassion is not static. When the patient’s plea becomes understandable and the response to suffering is adequate, nurses become motivated. However, when suffering becomes difficult to understand, nurses narrate of struggling with staying compassionate. Our results imply that caring means facing vulnerability—not only the patients’ but also their own. When nurses are entrusted with the patients’ stories of suffering and are expected to alleviate and respond accordingly, there is a risk that nurses hide behind a façade to not unveil their inner fear and shame (Fredriksson & Lindstrom, 2002). In contrast, nurses who have the courage to care without knowing can provide a change in influencing compassion and ascribe meaning to the patient’s life (Vincze et al., 2015). Experiencing self-conscious emotions in forensic psychiatry needs to be regulated; otherwise, the person can become impaired of feeling compassion, emotions such shame and guilt can arise instead and take overhand (Verkade et al., 2019). Being compassionate also means being faced with emotional and existential distress, an in-depth view of personal uncertainty, which seems inevitable when providing emotional support (Sinclair et al., 2018). But could also be seen as a sign of self-compassion, as nurses allowed themselves to see and relate to the others suffering in accordance to oneself, not suppressing own painful feelings. As reacting to own

vulnerability means realizing that suffering and own letdowns are shared with others, reducing the degree of blame and judgment, as kindness and understanding are generated for all who are in pain, including oneself (Neff, 2003).

The results of our study can be understood as nurses, during their emotional journey, in their contact with the patients are touched on an interpersonal and intrapersonal level. Our study indicates that compassion on an interpersonal level means that the nurse makes a move, takes the initiative to understand the patient. On the intrapersonal level, the nurse takes in the patient's suffering, which means allowing themselves seclusion and distance to examine their own thoughts and reflections about the patient and they are careful not to infringe upon the patient. The Danish philosopher Lögstrup (1997) says that being a human means living with demands and different challenges. As human beings, we become challenged and exposed to expectations. This means that we as human beings live in the light of the expectations of ourselves and of others about taking care of ourselves and each other. This means that, as professionals, nurses need both knowledge and humanity in relation to both patients and colleagues. Lögstrup (1997) also states that vulnerability is a fundamental condition of human life and that meeting another's expression is an interpersonal act where each of the actors turns to each other in a meeting between people where we are guided by our perception and vulnerability.

Caring and sensitivity belong to each other and come to concrete expressions in difficult care situations where we feel insecure and ask ourselves "How should I act?" Such situations demand sensitivity. To gain experience and gain insight, attention is central. Lögstrup (1997) states that it is not enough to know the demands, the law, and the rules, as they are rarely complimentary. The demand can be met through insight and sensitivity and is in itself possible to fulfill, but it does not determine the intent of our actions. The demand points to the care responsibilities we have for each other and is a call to use our imagination to interpret and understand the situation and to be able to answer the question "How should I act?"

The challenge lies in how nurses, in their sensitivity and interpretation and through their involvement in meeting the patient are able to "open their eyes" and see the other. By using his/her imagination and his/her sensitivity, the nurse can figure out how to act in the situation. As Lögstrup (2014) writes, education is of minor importance, what is more important is interpersonal interactions and one's contact with and view of their own personal vulnerability, their courage to approach the other, and personal wisdom.

Limitations

As stated by Fleming et al. (2003), objectivity in hermeneutic research can be seen as an ideal that is difficult to achieve, interpreting text and analyzing is done from own horizon. This article does not only challenge the authors' pre-understanding as a whole. But also the pre-understanding of the interpreted text, since this is a secondary supplementary analysis (Heaton, 2004). The text was viewed as truthfully and as new. This article presents findings from a secondary analysis of interviews with focus on the lived experience of nurse-patient encounters (Hammarström et al., 2019) and not directly about compassion. When researching a phenomenon like compassion the intention was not to describe or explain it, but instead to understand the experience of it as expressed in narratives of lived experience. Asking explicitly about compassion would have provided a different type of knowledge. In order to deepen the understanding of compassion in the forensic psychiatric context, perhaps new narrations are needed on specific interview questions about compassion. Achieving trustworthiness and understanding of the text was accomplished when the authors achieved a consensus of the whole and the parts of the text (Gadamer, 2004). First, the author conducted all the interviews, transcribed the text, and conducted an initial analysis. The authors draw upon various nursing perspectives and experiences, two of the authors have worked

as nurses in forensic psychiatry. Although all of the authors are nurses with various experiences from different fields within nursing which lead to rich discussions, which was viewed as an asset. Dialogues which also played a major part in order to curb and handle pre-understandings, not letting pre-understandings getting in the way but instead becoming a foundation of understanding the studied context and phenomenon. All the authors contributed to the making of this manuscript. The first author was known to most of the participants which could suggest that participants being careful and watchful to disclose own limitations. Being known can also be seen in the light of trust, where participants could speak freely, and, hopefully, truthfully. Conducting interviews in a familiar setting also challenged the first author's pre-understanding to become truly objective.

In secondary research there is always the pending risk of problems with data "fit as the used data was originally collected for another purpose. However, qualitative data sets that are relatively unstructured tends to be rich and diversified. Allowing researchers to determine which topics to further investigate. Problems with data "fit" are especially current when data is missing, data is derived from a deductive standpoint or when there is a divergence between aims of the two studies as well as methods. It is less likely to be an issue in supplementary secondary analysis where the focus of the second inquiry is on matters which are, by definition close to the original work. Reusing own data is also an advantage as the author is "close to own data" (Heaton, 2004).

These findings do not represent a total belief, instead, they should be viewed as points of view on nurses' lived experiences of encounters with patients with mental illnesses in forensic inpatient care. We must also take into consideration the fact that forensic psychiatry is controlled by laws that vary worldwide; hence the findings of this study should be viewed as lived experiences in the Swedish context.

Conclusion

Caring for patients with mental illness in forensic psychiatric inpatient care means being confronted sometimes by incomprehensible expressions of suffering. Being able to understand these expressions facilitates compassion and enables nurses to give adequate responses and simplify care. When suffering is difficult to unravel, nurses still stood their ground, not abandoning the patient in need, which could be seen as a sign of compassion. Time seemed to be of the essence, and being faced with suffering over long periods of time also meant risking relating to rules and laws instead of becoming sensitive to their own vulnerability and patients' expressions of suffering and, thus, realizing the laws' true intents. Time influenced compassion to be seen as dynamic and unfixed; nurses were forced to handle and regulate their own emotions. In order to achieve a sense of trust and mutual dependency, breaking the pattern, sensibility and compassion could be seen as that link. Therefore, it seems important to create a permissive environment where it is allowed for nurses to be given the opportunity to reflect and act based upon their own wisdom.

Acknowledgment

The authors are thankful for the participants of the study who shared their narratives.

Declaration of competing interest

The authors declared no conflict of interest when conducting this study.

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