Disconfirmed in one’s otherness: A comparison between the nurse’s view of the patient’s past, present and future and the patient’s own view of the past, present and future

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Abstract

This study is part of a larger project, the aim of which is to elucidate “mental health nurses’ attitudes towards their patients’. In this study, nurses’ and patients’ attitudes are described from the perspective of both parties using a qualitative approach. The informants were selected from a rehabilitation unit for young adults, below 40, suffering from psychosis at a psychiatric clinic that provides acute psychiatric care. The informant group consisted of three dyads: three patients with various diagnoses and three nurses with primary responsibility for the patients’ daily care. The aim of this particular study was to extend our preliminary understanding of nurses’ attitudes towards psychiatric patients in the context of psychiatric in-patient care, by elucidating the patient’s ‘inner’ picture of her/his past, present and future and the nurse’s picture of the same patient’s past, present and future. Data were collected and analysed using a phenomenological-hermeneutic approach and the narrative picturing technique. For each picture and group, 15 related sub-themes emerged, on the basis of which six themes were formulated. The findings show that the nurses overrate their own importance when it comes to the patient’s well-being on the ward. All the nurses emphasize confirmation and safety as the basis of their nursing care, while in the patient’s picture the nurses represent a replication of childhood demands, which probably means that nursing care risks becoming a continuation of the patient’s childhood estrangement.

Key words: Interviews, narrative picturing, nursing, phenomenological-hermeneutics, psychiatry

Introduction

This study is a part of a larger project, the aim of which is to elucidate “mental health nurses’ attitudes towards their patients’. Earlier in this project, nurses’ attitudes have been described from a quantitative point of view. Findings showed that nurses had a strong tendency to use typologies in relation to the patients, leading to a distanced relationship and to their not seeing the patient as an unique person (Lilja, Ördell, Dahl, & Hellzén, 2004), and their having a strongly medical approach to their patients (Lilja, Hellzén, Lind, & Hellzén, 2006). To increase our understanding it is important to go further in our studies about attitudes and try to determine whether there is harmony or a discrepancy between nurses’ and patients’ view of the patient’s former life, hospital stay and caring goals. Therefore, in this study, nurses’ and patients’ attitudes are described from the perspective of both parties, using a qualitative approach.

The literature makes it clear that the value of nurses and patients working together is an important factor for patients’ well-being (e.g. Hupcey & Miller, 2006). There are also several studies showing that nurses’ attitudes in the health care sector could be an increasing obstacle to providing good nursing care (e.g. Asplund & Norberg, 1993; Willaing & Ladelund, 2005; Norbergh, Helin, Hellzén & Asplund, 2006). This problem is found within the field of psychiatric care (e.g. Lilja et al., 2004; Hellzén, Lind, Dahl & Hellzén, 2005; Marland & Cash, 2005), where it may be an important obstacle on which to focus, since relationships are the basis of mental health care.
According to Scheff (1999), stereotyped imagery of mental disorders is learned early in life, including the commonly-held view of a person suffering from mental disorder as being potentially dangerous (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000), unpredictable and less intelligent than others (Angermeyer & Schulze, 2001). In the media, bizarre symptoms are still often emphasized, leading to reaffirmation of the stereotypes about insanity (Nunnally, 1961; Bauman, 1995). The stereotyped and conforming view of the mentally ill resembles the so-called “labelling theory” (Becker, 1997), which gives a potential explanation of how the process of segregation enables the creation of outsiders, on the basis of a deviance perspective.

Studies show that people suffering from mental disorders usually expect negative reactions from people around them (e.g. Link, Struening, Rahav, Phelan & Nuttbrock, 1997; Andrews, Henderson & Hall, 2001). According to Warner (1984), internalized stereotyped imagery of mental disorder leads to a view of oneself as being incapable and worthless. This, in turn, leads to confirmation of oneself as symptom and treatment dependent (Farina, 1998) and as labelled as different and seen as a deviant person. A person with mental disorder who sees herself/himself as deviant and who absorbs the stereotypical images of the mentally ill, may lose status, feel discriminated against and begin to depreciate her or his own value. The result is a sense of loneliness and estrangement (Link & Phelan, 2001).

However, there is evidence that positive social support can affect the recovery process in people with mental disorders (Zlotnick, Shea, Pilkonis, Elkin & Ryan, 1996). For example, studies show that close relationships increase in-patients’ chances of recovery (Dickson, Green, Hayes, Gilheany & Whittaker, 2002; Lin & Peck, 1999). Therefore, Underwood (2000) stressed that it is important that nurses play a more dominant role for in-patients during the hospital stay by helping them take advantage of their strengths and supporting the patients’ positive coping resources. To do this, nurses must be sensitive to the patients’ suffering and use their empathy to achieve a personal understanding of the patient’s situation (Martinsen, 1996). Empathy is defined as a persons’ learned ability to understand another person’s feelings and to confirm the other person, guided by that understanding (Basch, 1983). According to psychoanalytic theory, a person can capture the feelings of another by unconscious perception (Levenson & Rief, 1992). It is generally believed that a person must be emotionally touched by an understanding process that focuses on feelings of another if her or his reaction is to be regarded as empathy. In other words, an emotional response, conscious or unconscious, has to begin inside the person (Hoffman, 2001).

We searched several databases (Cinahl, Medline, PsycINFO, SWEMED) using keywords in different combinations, but found no studies of nurses’ attitudes that explicitly focus on the concordance between nurses’ and patients’ pictures of the patients’ past, present and future. In this study, three patients on a hospital ward for people suffering from psychoses were interviewed. Our aim was to extend our preliminary understanding of nurses’ attitudes towards psychiatric patients in the context of psychiatric in-patient care by elucidating the patient’s “inner” picture of her/his past, present and future and the nurses’ pictures of the same patients’ past, present and future.

Method

A qualitative approach was chosen in this study (Patton, 2002). When studying human experiences and understanding about people’s lives and life worlds, it is important to talk to them, with the aim of understanding the world from their point of view. A person’s lived experience can be described by getting her/his narrate stories about it. Data from which the interpretation originates represent personal statements/stories about personal experiences, which must always be regarded as unique.

Research procedures

The informants were selected from a rehabilitation unit for younger people, below 40, suffering from psychosis at a psychiatric clinic that provides acute psychiatric care. The nursing was traditional (Swedish standards) and the ward was organized on the basis of a “contact person” system, i.e. each patient has one nurse (her/his contact person) with primary responsibility for her/his daily care. One predominant point of focus in the unit’s perspective was task-oriented nursing care based on different routines. A central principle in the “ward” philosophy was to help and support residents in their daily lives from a psychoanalytical perspective, based on a normalization approach.

Using consecutive typical case sampling (Polit & Beck, 2004) of age, gender, hospital stay and diagnosis it was possible to select three dyads out of eight possible ones. The selection criteria were that the informants had experience of each other and that they were willing to share and describe their experience with the interviewer. Patients and nurses who expressed an interest in participating in the study met with the researcher (LL) and they were informed...
about the study aim and procedures. The informant group consisted of six individuals: three patients with varying diagnoses, all of which are included in the category of psychosis (Table I), and three nurses (Table II). The specific selection criterion for the patients was that they had been on the ward for at least six months and for the staff that they were each respective patient's contact person. A summary of the background data is shown in Tables I and II.

Interviews using a narrative picturing technique (Stuhlmiller & Thorsen, 1997) were performed in a reception room at the ward. The interviews began with the collection of background data (see Tables I and II), and information about the diagnosis was collected from the nurse and validated by checking each patient's medical notes. After the background data were collected, the interviewer continued with a dialogue about ordinary topics with the aim of creating a safe, relaxed and confirming climate. The next step in the interview involved the researcher giving examples of what a narrative picture was and giving examples of what a picture of this kind could look like. One example of such information was “If you think about summer what picture appears? Let's say that the picture that appears to you is a warm and sunny day at the beach with splashing waves together with a friend. Can you describe it? How does it smell? What are your feelings?”

When the interviewer felt that the atmosphere was relaxed and safe for the interviewees and the instructions about narrative picturing had been completed, the interviewer used the following broad-based open-ended questions to encourage narrations about the patient’s “inner” picture. Questions given to the patients:

Can you tell me what picture emerges when you think of your history?
Can you tell me what picture emerges when you think of your present situation?
Can you tell me what picture emerges when you think of your future?

Questions given to the nurses:

Can you tell me what picture emerges when you think of the patient’s history?
Can you tell me what picture emerges when you think of the patient’s present situation?
Can you tell me what picture emerges when you think of the patient’s future?

When it became clear that the informants “saw the picture” and that memories and mental images were surfacing, the informants were encouraged with questions like, “What do you feel? What’s happening? What do you see?” The interviewer aimed for openness and was restrictive about preconceptions, and the informants were encouraged to reflect upon their experiences and asked to explain their statements with questions like “What do you mean? Can you tell me more about that? How was that for you? Can you give me another example?” All the interviews ended with questions about the way the informants experienced the interview situation. The reason for ending the interview in this way was that there is always a risk, when using this kind of interview technique that the interview will touch upon unconscious traumas and experiences. In addition to this way of ending the interview, each informant was offered the opportunity to debrief.

All the interviews were tape recorded and transcribed verbatim by the first author. The interviews lasted for 34–65 min (median = 48) and were transcribed into text with pauses, sighs and laughter indicated. In the analysis, all the narratives were regarded as one text. The first author (LL) analysed the data and the second author (OH) read the interview material and the analysis in order to address the question of trustworthiness and to discuss possible interpretations until a consensus was reached (Patton, 2002). When the consensus was established, communicative validation (Mayring, 1993) was performed to ensure the credibility of the study. In this process, the participants were informed about the findings and interpretations as a way of seeing whether the study portrayed the informants’ true experience.

All participation was voluntary. Informed consent was obtained from all participants after the details of the study had been described both verbally and in writing. The interviews were coded and transcribed, and confidentiality was guaranteed by changing the data so that no participant or ward/hospital could be recognised in the report. In this paper, all respondents

<table>
<thead>
<tr>
<th>Patient</th>
<th>Sex (male/female)</th>
<th>Age</th>
<th>Time on ward</th>
<th>Diagnosis (DSM-IV number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No 1</td>
<td>Male</td>
<td>23</td>
<td>2 years</td>
<td>Psychosis (No. 295.90)</td>
</tr>
<tr>
<td>No 2</td>
<td>Female</td>
<td>28</td>
<td>2 years</td>
<td>Borderline personality disorder (No. 301.83)</td>
</tr>
<tr>
<td>No 3</td>
<td>Female</td>
<td>27</td>
<td>1.5 years</td>
<td>Psychosis (No. 295.90)</td>
</tr>
</tbody>
</table>

Patient No. 1 has nurse No. 1 as her/his contact person and so on.
are referred to as “she”, regardless of their sex. All the procedures in the study were reviewed and approved by ethics committee the Medical Faculty, Umeå University as complying with ethical standards. There was no dependence between researchers and informants. To minimize the risk that informants could feel violated by the close questioning, they were allowed choose what they wanted to narrate and they were informed that they could conclude their participation whenever they wished.

Narratives and narrative picturing interviews

The results of two earlier studies (Lilja et al., 2004, 2006) indicated that in order to reach a deep enough understanding of the nurses’ attitude, a new research strategy was needed. Consequently, a phenomenological-hermeneutic approach was used (Lindseth & Norberg, 2004) with the narrative picturing technique (Stuhlmiller, 1994) as a way of bringing to conscious awareness memories the body has stored. This is a method for bringing to consciousness human experience as seen from the point of view of the experiencer, where the interviewee is the sole arbiter of what is real or unreal, good or bad for her, that is, she is respected as the ultimate authority on her own universe. By directing the respondent to picture a phenomenon and then describe and narrate it, immediate “as-if-there” experience emerges. A narrative in this context is a detailed description of a certain lived experience, that is, an episode in the interviewee’s life. Narratives can also stimulate dialogue and, in order to make a narrative more “dynamic”, narrative picturing interviews can be used (Stuhlmiller, 1994).

Narrative picturing (Stuhlmiller, 1994; Stuhlmiller & Thorsen, 1997) comprises methods developed by therapists (Gerbode, 1989) for use when treating patients with traumatic experiences, and they have been shown to be effective in that clients project experiences/episodes in the picture in a way they would not have thought of themselves. The method synthesizes experiences and understanding of the world in terms of the human ability to create mental images or see in the “mind’s eye”, that is, to retrieve pre-reflective or pre-linguistic information (Samuels & Samuels, 1975). In the procedure, interviewees are asked to close their eyes and image the concept or picture of an experience. Then, with open eyes, the interviewee is drawn to scenes outside the body; again with the eyes closed, the person is directed to thoughts, feelings, experiences and images that depict spontaneously created their world of understanding lived or fantasized to be. Tapping pictorial memory allows fragmentary, symbolic and emotional experiences that are particularly vivid or dramatic to be recalled. Asking the respondent to describe their pictures then organizes the information into personal narratives that can be used as data in qualitative analysis (Stuhlmiller, 1996). According to Stuhlmiller and Thorsen (1997), narrative picturing is comprised of six steps:

- **Select** the narrative picturing mode or combination based on the research question.
- **Direct** the respondent away from dialogue towards a pictorial monologue using simple and clear instructions. The intent is to allow the viewer to move freely by herself/himself as guided by her/his own thoughts and feelings.
- **Picturing** requires space and quiet. Do not interrupt, interpret or probe the respondent while she/he is picturing.
- **Narrating** involves asking the respondent to describe in detail what she/he has pictured.
- **Explore** the pictured information. When reasonably certain that the respondent has completed narration ask how the picturing experience was, which will provide an opening for further exploration of the topic.
- **Debriefing** the respondent of her/his picturing experiences at the conclusion of the research session.

Furthermore, the picture described becomes more “real” when the interviewee can be reminded of smells, colours and feelings connected to the specific picture. A story that is frequently narrated changes over time, while a picture does not change to the same extent. This means that the narrated picture provides a less reflected and arranged story. The picture is close to the patient’s lived experience and the nurse’s mental image.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Sex (male/female)</th>
<th>Age</th>
<th>Time in psychiatry</th>
<th>Education</th>
<th>Time as contact person</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 1</td>
<td>Female</td>
<td>43</td>
<td>21 years</td>
<td>EN</td>
<td>2 years</td>
</tr>
<tr>
<td>No. 2</td>
<td>Female</td>
<td>50</td>
<td>18 years</td>
<td>EN</td>
<td>2 years</td>
</tr>
<tr>
<td>No. 3</td>
<td>Male</td>
<td>33</td>
<td>16 years</td>
<td>EN</td>
<td>1.5 years</td>
</tr>
</tbody>
</table>

Table II. Background data for the nurses.
Phenomenological-hermeneutic analysis

The text was interpreted using a phenomenological-hermeneutic method inspired by Ricoeur's (1976) writings, and developed and applied to nursing research in Sweden and Norway by Lindseth and Norberg (2004). The interpretation constitutes a research in Sweden and Norway by Lindseth and Norberg (2004). The interpretation constitutes a comprehensive understanding. A naïve reading involves capturing the meaning of the text as a whole within its context. The text is read through a number of times and the superficial understanding obtained provides direction for the structural analysis. The purpose of the structural analysis is to explain parts of the text and validate/invalidate the understanding obtained from the naïve reading. Through a variety of critical examinations of the different parts of the text, this understanding is developed and deepened. Gradually, a comprehensive understanding of what the text indicates or points to is obtained. This comprehensive understanding is based on the author’s pre-understanding, the naïve reading, the structural analysis and the literature. For an example of this process of analysis, see Table III.

Interpretation process and findings

Naïve reading

The naïve understanding emerged from listening to the tapes together with several readings of the whole text. This process revealed that the meaning of the “inner” pictures narrated by the patients and their nurses differed between the two categories, primarily when it came to the view of the patient’s life. During the reading, it became obvious that the nurses had a more pessimistic view of the patients’ life than the patients had. In addition, the naïve reading indicated that nurses have significantly higher demands and goals than the patients and that their view of what is a meaningful future for the patient differed from that of the patient. This means that there is a balancing act for the nurses between, on the one hand, the challenge of being a good “parent”, trying to accept the patient’s psychotic language and actions as meaningful communication and to uncover the concealed meaning; and on the other hand, playing an active part in coercions to reduce psychotic behaviour and protecting the person with the psychosis, her fellow patients, the nursing staff and relatives from harm.

After performing the naïve reading, we asked ourselves the following questions:

What feelings/wishes is the patient trying to convey in the narrative pictures?
What feelings/wishes is the nurse trying to convey in the narrative pictures?

Structural analysis

In the structural analysis, each narrative picture was analysed with reference to each interview group, that is, each nurse’s narratives were seen and analysed as a separate unit and all patients’ narratives as one unit. In an attempt to confirm or reject the understanding obtained from the naïve reading, thematic structural analyses were performed repeatedly in a movement back and forth between the whole and parts of the text. Each “picture” was seen as a whole text and analysed individually for each group. The whole text was divided into meaning units. A meaning unit consisted of several words, a sentence or a

<table>
<thead>
<tr>
<th>Meaning unit</th>
<th>Sub-themes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>... happiness, as something ... as some kind of affinity with ... yes ... friends with nature. It was like an enormous peace. No disturbance ... it was like everything was as it should be ... I think, if I experience this, it would be the only time I really feel ... how shall I say ... a calm and peace and no one interrupted a peace that only was there ...</td>
<td>Longing for relationship</td>
<td>Being alone</td>
</tr>
<tr>
<td>... sometimes it feels like one cannot ... is not allowed to change opinion or improve ... The fact that one changes ... improves and finds new solutions ... it’s the hardest, it feels like they don’t accept it ... Sometimes it’s like they don’t give up until they get the answer they want ...</td>
<td>Feelings of powerlessness</td>
<td>Being unfree</td>
</tr>
<tr>
<td>... but ... it’s not always fun to think about the future as much as you have ... you don’t know how it will work out. I want go back to a normal life ... look like and be a Mr Jones, an ordinary person with an ordinary flat. Only one room ... with a colour TV set ... other ordinary furniture.</td>
<td>Creating one's own home</td>
<td>Living one's own life</td>
</tr>
</tbody>
</table>
whole paragraph. The meaning units were condensed in two steps, the first remaining as close as possible to the text and the second interpreting the meaning. The second condensation formed the basis for abstractions, for each picture and group (patients or nurses), into 15 related sub-themes (seven from the patients’ pictures and eight from the nurses’ pictures), from which six themes were formulated. To reveal meaning units that rejected the themes, the whole text was re-read, but nothing that contradicted the findings could be found. Tables III and IV show the themes and sub-themes revealed during the structural analyses. The themes are neither hierarchically ordered nor as consequences of each other.

**Picture 1 — The past**

The results of the structural analysis showed that both the patient’s and nurses’ views of the patient’s past can be summarized in the theme of “being alone”. In this theme, each patient and each nurse told about episodes earlier in the patients’ lives. However, patients’ and nurses’ pictures differed with reference to when in life the episodes happened. Most of the nurses’ pictures were taken from the patients’ early ages, before seven, while the patients’ pictures were from their teenage years. The meaning of the patients’ picture of the past was abstracted into the sub-themes: “feelings of demands” and “longing for relationships” and the nurses’ picture to: “feelings of abandonment”, “feelings of betrayal” and “feelings of fear”. The following text shows the findings from each group’s pictures.

**Patients’ own views of their past**

For the patients, feelings of demands, meant feeling that overwhelming responsibilities were put upon them. For a teenager, having a job, taking care of a dog or living up to parents’ expectations is demanding. For example, feeling expectations from parents and employers not to oversleep in order to get to work on time or having the main responsibility in the family for walking the dog can be experienced as overwhelming. These feelings are comparable with to be engulfed, which lead to an all-embracing burden of demands in life that arouse feelings of being isolated, an outsider and not belonging to the group. Being an outsider and not a part of the family was experienced as humiliating, and expressed by one patient as equivalent to being enslaved. She said:

There were always rules at home . . . for everything . . . even how to eat a sandwich . . . in which order. What to eat . . . I don’t think there was anything that didn’t have a rule back then. You had to be terminally ill to be excused. Otherwise I had to do everything mum wanted. Sometimes she phoned me and said they were going to have guests that evening. Then I had to bake buns and cookies and when the guests came I had to serve them at dinner . . .

The patients’ way of express their longing for relationships varied. They either expressed their longing covertly as a positive and unique memory of not being alone or overtly as a personal negative experience of being alone. The patient’s overall feelings of being alone and marginalized seemed to trigger their longing for relationships. Attempts to make contact usually ended up in disappointment and humiliation, feelings that accelerated when other people laughed at her or teased them when they contacted other people. All the patients’ positive feelings about relationship were about non-human ones, about the feeling of appreciation that a dog gives its master or the spiritual feeling of being at one with nature. Such non-human relationships gave the patients a sense of peace, stillness and safety that human relationship did not. Some patients felt that a dog was their only friend, the only one they could rely on and find comfort with.

<table>
<thead>
<tr>
<th>Narrative picture</th>
<th>Sub-themes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients’ own views of their past</td>
<td>Feelings of demands Longing for relationship</td>
<td>Being alone</td>
</tr>
<tr>
<td>Nurses’ views of the patients’ past</td>
<td>Feelings of abandonment Feelings of betrayal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feelings of fear</td>
<td></td>
</tr>
<tr>
<td>Patients’ own views of their present</td>
<td>Feelings of powerlessness Feelings of being parented</td>
<td>Being unfree</td>
</tr>
<tr>
<td>Nurses’ views of the patients’ present</td>
<td>Feelings of mistrust Being together Feeling that the patient is in progress</td>
<td></td>
</tr>
<tr>
<td>Patients’ own views of their future</td>
<td>Creating one’s own home Being able to live and make your own decisions</td>
<td>Living one’s own life</td>
</tr>
<tr>
<td>Nurses’ views of the patients’ future</td>
<td>Developing one’s skills Increasing one’s knowledge Meeting someone</td>
<td>Becoming a person</td>
</tr>
</tbody>
</table>
Nurses’ views of the patients’ past

According to nurses’ narrations, a feeling of abandonment was a manifest and predominant sense in the patient’s life, rooted in early childhood. Feeling abandoned corresponded to feeling alone and isolated from others. A child longs to be near and together with her mother; she may try to make contact but may not be seen. It is as if the child does not exist and it is not seen by her parents. For example, one of the nurses narrated an episode early in a patient’s life:

She is sitting in a baby seat, rocking . . . in her bouncer cradle, in the kitchen. She is crying but no one hears her. She’s screaming, crying . . . appealing for confirmation but nobody sees or hears her. She can only see legs going back and forth in front of her.

Being no one appears to contribute to feelings of betrayal by a significant other, which was experienced consciously in life in both childhood and adulthood. Betrayals hurt, and can be expressed as dependence on an abusive husband or maltreatment in marriage or when parent kills a child’s dog without telling her why before doing it. In both situations, according to the nurses’ picture, the perpetrator does not understand the magnitude of the betrayal. For example, putting the dog to death, the only close friend the child has, is almost the same as killing the child.

All the nurses’ stories about the patients’ lives are permeated by feelings of fear, a fear that is interwoven with the patients’ sense of betrayal. In adulthood, the fear is experienced consciously when there is domestic violence or when the patient lives with an unpredictable partner. Fear, both in marriage and in childhood, is about physical and psychological violence experienced in connection with a husband or parents. The patient is preoccupied by the thought of not bothering the people around her, which leads to developing a life strategy of not being seen. Sometimes the absence of understanding from others about her situation makes it feel impossible for her to contact other people, which enlarges her feelings of fear.

Picture 2—The present

The structural analysis showed that the patient’s and nurses’ views of the patient’s present differ. From the patients’ narrations, this view can be summarized in the theme of “being unfree”. In this theme, the patients told about episodes in their present life situations. The nurses’ narrations, however, told about a present situation coloured by cooperativeness, summarized in the theme of “being confirmed”. There were discrepancies in the two parties’ pictures of the present. Patients’ pictures of their present all had a negative atmosphere while nurses’ pictures had a positive atmosphere. The meaning of the patients’ picture of the present was abstracted into the sub-themes: “feelings of powerlessness”, “feelings of being parented” and “feelings of mistrust”. The meaning of the nurses’ picture of the patient’s present was abstracted into the sub-themes: “being together” and “feeling that the patient is in progress”.

Patients’ own view of their present

When patients had to be committed to the hospital, they felt restricted. Being hospitalized meant no freedom to make independent decisions and a reality where they had to ask nurses for permission for almost everything. The narratives also revealed how badly the patients wanted to have a normal life and the desire to “go out and meet life again” because life on the ward gave them feelings of powerlessness. In the patients’ stories, the nurses were either absent or present in a negative way. If nurses were present, they acted more as a reminder and a repetition from the past than as the patient’s advocate. One patient said:

I feel trapped . . . I can’t get away. It’s like it was then back home with mum and dad . . . they (the staff) stop me, they ask questions . . . ask and ask and usually I become more and more upset and angry . . . I become confused by their idiotic questions. What does it matter to them? I’m trapped . . . I feel as though I’m caught in a cage, not in a cage with iron bars but in a human cage . . . with people standing in my way . . .

According to the patients, the nurses’ main task in their nursing care was to socialise the patients to become “good citizens”. Being restricted in their present life and not seen as independent gave the patients’ feelings of being parented. That experience is closely connected to the nurses’ inability to see them as adults able to make their own decisions. This experience was difficult and made the patients desperate to get out of the hospital. According to the patients, nurses’ efforts to socialize them were synonymous with an overall demand for conformity. In their stories, all the patients expressed feeling forced into conformity. One of them said:

I feel a bit like steel wool . . . packed up in a package. I have to be like all the others outside . . . like someone in the crowd, not as an individual but as a member of some vague group.
I feel as though I'm tightly packed here. All the rules ... we have no freedom here ...

Hospitalization and being forced to live their lives on the ward, provoked feelings of mistrust. To be seen, from the nurses' point of view, as unreliable and not trustworthy meant in daily life that the nurses tried to inflict their opinions on the patient. The patients learned be quiet and not say too much and were not allowed to change their opinions, which made them feel disappointed in nurses and mental health care. Nurses did not change their views even if the patients tried to find new solutions to their problems. The patients felt that if the nurses had a negative opinion of them it was almost impossible to reverse. Patients' mistrust was sometimes based on their belief that the nurses could not handle a difficult situation or on fear of reprisals. For example, one patient narrated her suicidal thoughts, thoughts that she did not want to share with the nurses because of the risk that it would influence her chances of being discharged from the hospital.

Nurses' views of the patients' present

Being together with other healthy people was seen as an important factor for the patients' recovery, either the nurses themselves or people from the outside. Just being a person the patient can rely on was emphasised by the nurses as the most important role in their relationship with the patient. “Passive activities”, that is, nurses being present without any special activity taking place, were stressed as one of the most important activities in nurses’ work with the patient. According to the nurses, to feel and mediate hope in the patient’s situation, when they were together, is to see possibilities and not exaggerate the gravity of the patient’s obstacles and illness. It is believed that the patient has every chance of succeeding in her daily endeavours and supporting her in her healthy progress. Being together implies hope for the future.

Being together appears to be interwoven with, and an active part of, the patient’s progress. According to nurses, it is usually the close and trusting relationship between patient and nurse that makes the patient take the step into society. Feeling that the patient is in progress is a clear treatment goal expressed by the nurses. Feeling that the patient is in progress is synonymous with being confident, believing in the patient’s ability to handle different situations. The role the individual nurse plays in this process is to give the patient the courage to take the step, to believe in her. After the patient takes the first step outside the hospital, people from outside were emphasized by the nurses as important and health giving for the patient. The benefit of people from the outside is that, in addition to being together and doing things with the patient, they also represent a healthy dimension, something different from the psychiatric ward.

Picture 3—The future

The structural analysis showed that the patient’s and nurses’ views of the patient’s future differed. The patients’ narrations can be summarized in the themes “living one’s own life”. In this theme, the patients told about their wishes, focusing on ordinary goals in life. The nurses’ narrations, however, were about large, fundamental goals in life that can be summarised in the theme of “becoming a person”. The meaning of the patients’ pictures of the present was abstracted into the sub-themes: “creating one’s own home” and “being able to live and make your own decisions”. The meaning of the nurses' picture of the patient's present was abstracted into the sub-themes: “developing one’s skills”, “increasing one’s knowledge” and “meeting someone”.

Patients' own views of their futures

Creating one's own home is primarily a question of living and creating one's life. Having an apartment is an important part of recovery and returning to a normal life. Being an ordinary Mr Jones was the goal, not being someone special. The patients did not dream about luxury. Instead, they wanted ordinary lives with, for example, cosy furniture, a TV, and a bed.

None of the patients had any major plans for their future apart from restarting their lives and striving to become mentally stable and healthy. Being able to live and make one's own decisions was the main goal in life as expressed by the patients. All three patients had previous experiences of unsuccessful discharge episodes; now they were not going to have any major plans and structure when discharged. Living without major plans and structure is a defence against one's own disappointment. The most important thing in the future was that all their plans should be their own and not governed by others:

I wish that I could feel ... like ... no, I don’t want accept this, I don’t want to do it ... plans ... only because there must be plans, because it’s in the regulations. I have had enough of that. Back home it was too much, rules for everything ... no one is allowed to rule me, I won’t accept it.
Nurses’ views of the patients’ futures

The nurses all had the same main view of the future for the patients in this study. They all had to take the opportunity to develop all their available skills in the future. Developing one’s skills, usually associated with music and art, was important for the patients’ continuous recovery. Interwoven with this sub-theme, the sub-theme of increasing one’s knowledge was elucidated. From the nurses’ stories, it became clear that developing skills was not enough. The patients also needed to increase their knowledge through education. The nurses’ dream was that the development of skills and increased knowledge could be combined. Getting an education and developing one’s skills would make it possible for the patient to restart her life.

However, the nurse did not see this as sufficient. From the nurses’ perspective, meeting someone should be an important goal in the patients’ life. All the nurses stress the desirability of a relationship for the patient, because the patient’s former family is not a foundation on which the patient can build her future. When restarting life a close relationship, someone who cares about and loves the patient is important because her family is not a secure base on which to build a new life. According to the nurses’ stories, the patient will always hate her parents and her family, and therefore, has to restart her life from scratch.

Comprehensive understanding

When the nurses and patients were interviewed about their pictures of the patients’ past, present and future differences between the groups could be identified. According to the patients’ narrations, it is clear that being an in-patient at a rehabilitation unit for younger people suffering from psychosis, which provides acute psychiatric care means being a lonely person with experiences of heavy demands and with a strong desire for relationships. The time at the hospital ward is characterised by an overall feeling of being unfree. In relation to the nurses, the patient felt powerlessness and not being trusted. The nurses’ focus is on training and socialising the patients. The expressed goal on the part of the patients is to get out of the hospital and live their own lives. To live one’s own life means, to the patients, having own home and making their own decisions.

Being a nurse for an in-patient with a psychosis means, to the nurses, taking care of a person characterised by loneliness in her past, a person who has been abandoned and whose life is marked by fear and betrayal from childhood to adulthood. Through the nurses’ care, according to the nurses, the patient is confirmed as a unique person. As they spend time together the nurse is part of the patient’s progress towards recovery. It is clear that the goal for the nurse is for the patient to become a whole person and this can be done through developing skills and increasing knowledge. However, the goal of becoming a person cannot be achieved without creating new relationships, free from parents and family. The incongruence found between the two parties’ pictures of caring relationship points at the risk that nurses’ view of the patient’s past, present and future conceal her uniqueness and through that obstruct the nurse’s ability to see the meaning underpinning the patient’s actions (McCurdry, 1998). If nurses do not see any meaning in the patients’ actions and lives they are at risk of not seeing any meaning in their caring for the patients and, by objectifying the patients, becoming objectified themselves (Norberg, 1994).

Discussion

To gain a deeper understanding of the meaning of the nurses’ attitudes towards psychiatric patients in the context of psychiatric in-patient care by elucidating the patient’s “inner” picture of her past, present and future and the nurse’s picture of the patient’s past, present and future, the authors chose to interpret the findings from the theoretical framework of the French sociologist Maurice Halbwachs (1992), who states that human memory can only function within a collective context and that human memory is always selective. Some findings from previous research are referred to in the context of this interpretation.

In the literature on general psychiatric nursing care, the nurse-patient relationship is considered important (Morrison & Burnard, 1991; Tschudin, 1995), and the verbal interaction between the two parties and the support given are described as the cornerstones of psychiatric nursing care (Dexter & Wash, 1997). When investigating the nurse-patient relationship it is important to study and attempt to understand nurses’ attitudes. We can understand them as opinions based on an individual’s memory, which is sustained by the interaction among human beings, and the wisdom that emerges from it. In other words, a person’s view of her fellow human beings is dependent on her own experiences of the other, and on her subjective knowledge drawn from social relationships. Human memory also requires continuous nurturing from collective sources, and it is sustained by social and moral props (Halbwachs, 1992).

The present study shows that, in terms of the patients’ history, there is concordance between the
patients’ and the nurses’ views of the patients’ loneliness. Because the nurses and the patients do not share the same autobiographical history, their pictures are different. The patient has her own experiences, her autobiographical history, from the past. For the patient, the theme being alone means a personal experience of specific events in the past while nurses’ interpretations of the patient’s past are based in their collective memories (Halbwachs 1992). When describing the narrative picture of the patient’s past the nurse has only the collective memory, that is, shared knowledge (casebook texts and literature about mental illness), society’s perception of the causes of mental illness and the individual nurse’s own and her colleagues’ work experiences with psychiatric patients to rely on. When the patient narrates episodes in which she experiences her longing for relationships or feelings of demand, she tells about memories of directly experienced events, which according to Schuman and Scott (1989), have a deeper impact than events of which people have merely read or heard. The nurses describe pictures that are influenced by the collective memory of psychiatry.

For the nurse, the patient’s past is based on “the theory of a betrayed child” whose existence is violated, a picture that agrees well with the traditional view of the psychiatric patient given in Swedish nursing education (Cullberg, 1999). Looking more closely at the nurses’ views of the patients’ past, one logical explanation could be that the past can be seen as a social construction of the present. If so, the patient’s loneliness is shaped by the concerns of her present, as it is understood by the nurse. This means that the nurses can use the past as an argument for their own beliefs, interests and aspirations in relation to their own views of the patient’s present. This means that the patient’s history will not be seen as continuous, but only as snapshots taken at different times and expressing various perspectives on her life, as perceived by the nurses. As a result, the nurses are able to use arguments to justify the care they give.

The nurses’ and patients’ narrated pictures of the present situation show strong incongruities. It seems clear that in the patients’ pictures, the nurses over-rate their own importance when it comes to the patients’ well-being on the ward. All the nurses emphasise confirmation and safety as the basis of nursing care. According to Rask and Brunt (2006) there is discrepancy between in-patients’ and nurses’ views of the extent of their verbal and social interactions. Being confirmed means that the nurses’ argumentation is reinforced by the patient’s history, based on snapshots from her past that strengthen and confirm the nurses’ perspective on the patient as lonely and as an outsider in need of normalization to fit into society. The collective memory could be regarded as synonymous with what Foucault (2004) calls “the powers of normalization”, that is, when nurses force the patient towards a state of conformity that society uses as defence against people viewed as abnormal.

This means that the individual nurse, through her attitude, is moved cognitively and affectively by the patient, a reaction that would be impossible without a socially constructed notion—a collective memory. According to Nabert (1969), using the knowledge that is implicit in one’s attitudes is a way of freeing oneself from all self-interest, from being moved by the patient’s situation. This knowledge is probably influenced by the fact that the individual nurse allowing herself to be affected by the general public’s negative expectations of people with mental illness (Wahl, 1999). This then enables the nurse to use the structural forgetfulness, that is, the absence of self-reflection that lies in an attitude or the collective memory.

The patients’ own narration gives quite a different picture. In the patients’ picture, the nurses represent a replication of childhood demands, which strengthen the patients’ feeling of being unfree. It is reasonable to suppose that this means that if nursing care is stuck in traditional attitudes, there is a risk of this care being a continuation of the patients’ childhood loneliness. Even if the nurses share each of the patients’ autobiographical history, they do not seem to be able to get in touch with the empathetic dimensions (Hellzen et al., 2005). One possible reason could be that the nurses are using a symptom-focused perspective, only focusing on the patients’ inabilities and shortcomings instead of their abilities and strengths (Normann, Asplund & Norberg, 1999; Hellzen, Kristiansen & Norbergh, 2003). Another possible and complementary explanation to this view could be the general public’s view of people suffering from mental illness as being potentially dangerous (Crisp et al., 2000), unco-operative, and not very intelligent (Angermeyer & Schulze, 2001). Attitudes thus create a situation that is figuratively expressed as the two parties being entrenched in a world of imaginary peace and order but where both actors’ existence risks being illusory because of their asymmetric way of living (Friedman, 1983). Through these attitudes, the patient’s feelings of loneliness are even further reinforced (Lindstrom, 1995).

The parties’ pictures of the future are a logical extension of their past and present. Obviously, there is difference between the two parties’ view of the future. The meaning of the patients’ wishes could be interpreted as living their own lives when, in their
narrations, they focus on material desires such as having television set. Nurses, on the other hand, focus on the development of skills, knowledge and relationships. Again, from the nurse’s perspective, her collective memory guides her towards an opinion of a desirable end for the patient’s treatment—“the golden goal of psychiatric care”.

The incongruence between the patients’ and nurses’ views of the patients’ future probably acts as an obstacle to the relationship and to the outcome of the ongoing treatment. Allen, Tarnoff, and Coyne (1985) have shown that this relationship is closely connected to the patient’s well-being. Svensson and Hansson (1999) believe there is a connection between the relationship and the degree of the patient’s self-understanding and ability to troubleshoot. If this is true, the findings of this study indicate that there is no potential for developing a therapeutic relationship between the two parties because of the distance between them regarding their views of the patient’s past, present and future.

The findings elucidate the discrepancy between the nurses’ views of the patients and the care offered and the patients’ views of themselves and the care they receive. When nurses do not share the individual patient’s memories, experiences and fantasies, the patient is stripped of her dignity; the patient changes from a unique individual to a generalized caricature of herself. Thus the patient is “naked”, exposed and deserted and thereby in a vulnerable position in her relationship with the nurses. From the findings, it seems clear that nurses fail to react to the patient as a unique person; instead, they react to her by encouraging her to be a conforming individual, a person who needs to fit into the nurse’s generalized picture of a psychiatric patient. Thus, the nurse responds in a way the patient experiences as a violation of her integrity (cf. Carlsson, 2003).

The aim of this study was to convey insights into the meaning underpinning factors governing the congruence or incongruence between nurses’ views of the patient’s past, present and future and the patients’ past, present and future. The incongruence between the patients’ and nurses’ views of the patients’ future probably acts as an obstacle to the relationship and to the outcome of the ongoing treatment. Allen, Tarnoff, and Coyne (1985) have shown that this relationship is closely connected to the patient’s well-being. Svensson and Hansson (1999) believe there is a connection between the relationship and the degree of the patient’s self-understanding and ability to troubleshoot. If this is true, the findings of this study indicate that there is no potential for developing a therapeutic relationship between the two parties because of the distance between them regarding their views of the patient’s past, present and future.

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The aim of this study was to convey insights into the meaning underpinning factors governing the congruence or incongruence between nurses’ views of the patient’s past, present and future and the patients’ images of the past, present and future, so as to give nurses an opportunity to understand their own practice in a different way. In nursing practice, it is important to reflect on the fact that the patient’s behaviour can influence nurses both positively and negatively. When caring for people with mental illness, the question of the nurse’s own confirmation should not determine the parties’ time together. With this in mind, it is important to reflect on the risk of accepting the narrow view of the patient’s life world based on the conforming view of the stereotypes of mental illness. The interpretation addresses the importance of reflecting on the patient’s life from the individual patient’s point of view instead of from a collective memory perspective. One way for nurses to be more sensitive and to practice their own ability to identify with the patient’s narrations not only cognitively but also emotionally is to apply the method used in this study, the narrative picturing method, in their daily work. Doing this may allow them to consider on their own empathetic distress response (Hoffman, 2001) and increase their emotional sensitivity towards patients.

Methodological considerations

Narrative picturing is a useful method for collection of meaningful data by giving the respondent access to her unreflected knowledge. However, the interview strategy contains a risk of triggering memories and emotions that have been repressed and that may be unpleasant or even painful. According to Pearls (1969), in therapeutic conversations the interviewee instinctively withholds or discloses such memories. Fagan and Shepherd (1970) state that significant matters of life need to be talked about, and that the way we work with such memories as an interviewer, are much more important than what we know. Our capacity for here-and-now relationships is a basic prerequisite in the interview situation and is developed through extensive integration of learning and experience.

When participants, using narrative picturing as a method, were helped to remember events and memories, their memories were very rich and detailed. Using narrative picturing we were able to get closer to the patients and nurses, and to give them the ability to capture and describe episodes in a significant way. This way of interviewing helps interviewees to discover rich and meaningful data and the informants are able to give examples and describe their feelings in a way that probably could not be illuminated in traditional in-depth interviews.

A narrative method was used in this study. The intention was to focus solely on the everyday care given to three individuals who manifested psychotic behaviour. According to Reissman (1993), it is extremely difficult to speak about particular experiences in life that affect an individual’s deeper levels of meaning, but to give such lived experience a narrative form helps individuals to name their experiences. Ricoeur (1991) states that interpretation should follow the direction of the thought opened up by the text and should be sensitive to the demands the text puts on the reader. The analysis of the transcribed narrative interviews indicates that the caring situations give rise to incongruent care when the patients’ narratives indicated that they wanted to be seen by the nurses as unique individuals, while the nurses’ narratives indicated
that the patients were labelled on the basis of an attitude encouraging conformity. It is important to remember that this interpretation is only one of several possibilities, and the findings of this study cannot be generalized but should be seen as arguments in an ongoing discourse.

Acknowledgements

The authors would like to thank both the patients and nurses whose participation made this project possible. We are also grateful to Professor P.O. Sandman, Umeå University, for initiating this project and to Linda Schenck, who revised the English.

References


