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ORIGINAL ARTICLE

“Being good or evil”: Applying a common staff approach when caring for patients with psychiatric disease

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Abstract
This study was performed to gain a deeper understanding of how psychiatric staff, when caring for patients with psychiatric disease, experience situations that include a common staff approach directed toward an individual client. Nine nurses were interviewed. The interviews were analyzed with a phenomenological-hermeneutic method in order to illuminate the lived experience of applying a common staff approach. The results revealed several meanings: shedding light on carers’ mutual relationships; being deserted by nurse colleagues; being aware of one’s own basis of evaluation, and that of others; being judged by the patient as good or evil; and becoming sensitive to the patient’s suffering. The comprehensive understanding was that the nurse has a difficult choice to focus on relations with one’s colleagues or to focus on the situation of the patient, who seems to suffer when a common staff approach is used.

Key words: Common staff approach, phenomenological, hermeneutic, nursing, psychiatry

Introduction
The personal space of a nurse on a psychiatric ward is constantly invaded by the patients, who follow him/her everywhere, constantly talking and seeking his/her attention. This creates a problem that is difficult to solve. How does the nurse handle such a situation? One example of handling the situation is when the nurses decide to divide the room by drawing a chalk line across the floor. On one side of the line, only staff members are permitted. If the patient crosses the line, he/she is immediately corrected—“We, the staff, have decided you are not allowed to visit this space”. The group of staff has formulated and put into practice a common approach to treating the patient. This example highlights one dilemma with practicing a common approach; its inability to provide an acceptable solution for both the patient’s and the nurses’ needs at the same time.

We have previously performed a grounded theory study, (Enarsson, Sandman & Hellzén, 2007) with the aim of gaining a deeper understanding of the kinds of social processes that lead psychiatric nursing staff to formulate a common approach on how to act towards individual patients in long-term psychiatric care. The study showed how an order-disturbing incident that could not be dealt with within existing routines, and for which no similar previous experiences were available to base solutions on, led the staff to restore order by assuming certain attitudes and/or acting in certain ways towards a patient. It was characteristic of this process that staff negotiated a suitable way of handling the situation among themselves, with the client involved having little or no knowledge about, or influence over, the process. The staff who wished to preserve or restore order formulated a common approach. If the approach was judged successful, that is, if order was restored, then a new routine was formulated for use in similar situations in the future. If the approach was not considered successful, the process might start again, with a new common approach being discussed and then tried out in practice.
Though psychiatric care in Sweden has developed towards a more relationship-orientated approach (cf. National Board of Health and Welfare, 1997, 1999), there still exists care milieus with a custodial approach (cf. Goffman, 1991) in which the nurses set norms (which are seldom explicitly documented) for the patient's behavior while under care (cf. Cooper, 1967). To apply a perspective of “normalization”, care can be seen as an exercise of structural power (cf. Foucault, 1983, 1987, 2003), and the nurses argue who among them has interpretation precedence over what common staff agreement to use. A patient may have an individual care plan, which contains no information about the informal attitudes of the nurses concerning a common staff approach. Caring from the perspective of a common staff approach is often explained by the nurses as being a part of their professional attitudes toward the patient without explaining what each individual nurse intends with a common staff approach and at the same time as dim explanation as part of a therapeutic tradition (cf. Foucault, 2006).

In caring for patients with psychiatric disease, carers may express the opinion that it is of great importance to act alike when they feel they are subjected to pressure from the patient. This is demonstrated when they schedule a patient’s day and follow this schedule strictly, regardless of which carer the patient is being looked after by (Hellzén, 2000). We have previously described the social processes that create the desire in psychiatric nursing staff to reach a common approach on how to act towards individual clients in long-term psychiatric care (Enarsson et al., 2007). We now wish to understand how carers experience the common staff approach in caring.

This study was performed to increase further our understanding of how psychiatric nursing staff experience situations in which a common approach is directed toward an individual patient. The aim of this study was therefore to illuminate the meanings of applying a common approach when caring for patients with psychiatric disease, as narrated by nursing staff in psychiatric care.

Method

Research context and participants

The sample consisted of nine nurses working on three different wards at a psychiatric clinic in mid-Sweden. It was judged likely that the experience of psychiatric care in such a context at some point would have involved a common staff approach in the care of an individual patient. The first inclusion criterion was that the nurse should have a minimum of two years’ experience of working with patients in need of extensive support while admitted to psychiatric care. The second inclusion criterion was that the nurse should have worked in a team with other nurses, preferably on a ward, and participated in discussions about the care of the patients.

The selected clinic provided service for about 75,000 inhabitants in the district, which is located in mid-Sweden. All hospital-based psychiatric care was run by the clinic, which has four psychiatric teams and four wards. Each ward employed about 40 nurses (registered nurses and enrolled nurses). A letter with an inquiry to participate in the study was handed out to all four wards at the clinic. A nurse who was responsible for education at the clinic also provided oral information about the study. Participants were recruited from among nurses working at three different wards: the first for persons in need of psychosis care, the second for compulsory care, and the third for drug addiction care. The first nine nurses giving their consent to participate were included; five were registered nurses and four were enrolled nurses with special training in psychiatric care. Their ages ranged from 24 to 61 years, with a mean of 47 years. Their mean length of experience in caring for psychiatric patients was 10.8 years, and the median was 20 years. Seven were female and two male. Twelve interviews were performed in total, and three nurses were interviewed twice because the initial readings of the interviews revealed a need to expand their narrations further. It means all those who volunteered to participate were interviewed. No one on the fourth ward expressed an interest in participating in the study.

Data collection

The data collection was performed through narrative interviews with broad open-ended questions (Patton, 2002). The interviewees were asked to choose and speak freely about situations where they experienced the use of a common staff approach in the care of an individual patient. The opening question was “Can you tell me about a caring situation that you have experienced, where your actions were guided by a common staff approach?” They were encouraged to narrate about specific situations and to reflect about their emotions, thoughts, and actions (Drew, 1993). Each interview lasted 45–75 min, and was tape-recorded and transcribed verbatim. Nine interviews were carried out in a space within the ward, chosen by the interviewee, and the remaining three were carried out in the office of the first author. In several cases, the interviewees spontaneously expressed a general view concerning the benefits of applying a common
staff approach. However, most of the stories told (approximately two thirds) concerned negative experiences of applying a common staff approach.

**Analysis of data**

We used a phenomenological-hermeneutic approach, inspired by the philosophy of Ricoeur (1976), to illuminate the nurses’ lived experience of applying a common staff approach when caring for psychiatric patients. Ricoeur (1991) states that when there is a language of symbols and metaphors, there is also hermeneutics. Single acts must be seen in a relationship, and the relationship must be seen in light of the single act. The text comes with a meaning (utters meaning), and the reader then makes the reduction and seeks his or her meaning depending on the phenomenon that is to be illuminated (utterance meaning). The authors of this study have pre-understandings that might influence our interpretations. All three authors have experiences of working in psychiatric care facilities; and one author performed his major research in the field of psychiatric care (Hellzen, 2000). The method combines phenomenological philosophy with hermeneutic interpretation in a dialectic process (cf. Ricoeur, 1991). It was developed for use in nursing research at the Department of Advanced Nursing, Umeå University, Sweden, and the Unit of Nursing Science, University of Tromsø, Norway (Lindseth & Norberg, 2004), and has been used in several qualitative studies, such as Rasmussen, Sandman and Norberg (1997); Skovdahl, Kihlgren and Kihlgren (2003); and Graneheim, Isaksson, Ljung and Jansson (2005).

In this analysis, we sought the utterance meaning, that is, what the text talks about. The analytical process was performed in three steps:

1. First, a naïve reading was performed in order to formulate a preliminary interpretation of the text, and a naïve understanding of the meaning of applying a common staff approach was formulated as a starting point for further analysis of the text.

2. The second step comprised an analysis of a number of “wild guesses” that had emerged in the naïve reading, in order to verify or falsify them. This second step involved several different analyses. The first was an analysis of metaphors in the text, since the naïve reading had revealed that the interviewees found it difficult to express their thoughts and feelings and therefore used pictures and metaphors to convey their experiences. The second analysis concerned the use of the personal pronominal, since it seemed from the naïve reading that whenever a question required a personal standpoint from the interviewees, they would talk in terms of “we” when speaking of a common staff approach in general, but “I” when they did not hold the same opinion as their colleagues. The third analysis was a thematic analysis. In order to expose the meaning, the text was sorted on the basis of different narrations of experiences, guided by questions such as “what situations are the nurses talking about when applying a common staff approach directed toward an individual patient?”, and thereafter condensed and thematized. The pieces of text that expressed meaning were then arranged in themes (Table I).

3. In the third and final step, an interpreted whole was formulated on the basis of the naïve reading, the structural analysis (including the use of metaphors and the personal pronominal), and the authors’ pre-understanding.

**Ethical considerations**

The Ethics Committee at Örebro University, Sweden granted permission for the study on 21 May 2002 (registration number 989/01).

**Results**

**Naïve reading**

A common staff approach can be understood as a strategy for taking action in difficult care situations, that is, those that nurses perceive as overwhelming or difficult to handle, for example, when they feel they have to act in order to protect themselves or to prevent the patient from hurting himself/herself.

Formulating a common staff approach together with others means becoming involved in a conversation where you are made aware of the ideological standpoints of yourself and of others. To act towards a single patient from the perspective of a common staff approach means a contradiction, because one aim of a common staff approach is to achieve unity and security among the nurses, yet the application of this approach could result in an experience of disunity and insecurity towards fellow nurses.

One other meaning of applying a common staff approach is the experience of becoming valued by the patient. Feelings of shame and discomfort may be experienced when the judgment deviates from one’s own personal image. Applying a common staff approach can also mean becoming alert to the patients situation and becoming aware that the approach is violating the patient; maintenance of the approach then feels pointless. Applying a
common staff approach, could also mean that the nurses experience feelings of shame and guilt over how the approach is carried out.

Analysis

The analysis is presented in five themes as follows:

- Shedding light on mutual relationships
- Being deserted by nurse colleagues
- Being aware of one’s own basis of valuation, and that of others
- Being judged by the patient as good or evil
- Becoming sensitive to the patient’s suffering

Theme: Shedding light on mutual relationships

Caring from the perspective of a common staff approach could be understood as shedding light on the nurses’ mutual relationships. This occurred when the nurses used a verbalized strategy in an attempt to create security and unity within the group of staff using a common staff approach. For example, the nurses described how the experience of security and unity within the group of staff meant a reciprocal confirmation that they were thinking and acting correctly—that they were going in the same direction:

If we've agreed within the group of staff [upon a common agreement], then that’s the way it is. But no, it is surely when someone has had a disagreement [with the patient] earlier—it is then we make a common agreement on how to act.

The nurses used metaphors to describe this mutual relationship, for example “the chemistry is good” (between colleagues), and “no one [nurse] is left out”.

Yes, it is positive [with a common staff approach]! It sounds so positive, I think. But no, I think it sounds, it sounds warm in a way, yes. That you feel secure within the group of staff, yes. You know where to find each other in all situations.

The security that the nurses stressed through mutual relationships could be recognized in situations when the nurses acted as one—as “we”—and thus left only a limited space for the patient “to set the nurses against one other”. The nurses also used the pronominal “we” when they wanted to emphasis...
unity among themselves. It was important not to let anything come between them. They also used metaphors such as “it is important to be hard as a rock—to be united” when dealing with the patient, and not to let him/her take control and threaten the mutual relationships between the nurses:

How important it is that everybody says the same thing all the time... Yes I think it is great, everybody gets to hear it. How important it is that we always say the same thing. That we are hard as a rock on those matters, that we are united in the group of staff.

**Theme: Being deserted by nurse colleagues**

Another aspect of caring from the perspective of a common staff approach was that when the unity within the group of staff turned into disunity, the nurse felt deserted by his/her colleagues. This was described in relation to situations when the group of staff had failed to keep up a common staff approach, meaning they were about to lose their unity in terms of how to treat the patient. The nurses described how, when unity was lost, they started to blame each other regarding whose fault it was that the common staff approach could not be kept up. Being deserted by one’s fellow nurses was a struggle:

Because I say: but I don’t see it like that. I don’t want it to be like this [the common staff approach]. But then in the end, it gets too bothersome. Then you just quit... that’s the way it is.

And some [colleagues] are very strong in their beliefs, thinking they are doing the right thing.

When describing the experience of being deserted, the nurses used metaphors such as “start throwing [accusations] at each other” or “what we decide just floats away”. The nurses described how they could be deserted by colleagues who failed to stick to the decision regarding a common staff approach, meaning they did not want to jeopardize their relationship with the patient by carrying out the common staff approach:

But then there are those who let him go outside, there is... Yes, no, well, this is the way it turns out: But okay then, I don’t give a damn either. Then he is supposed to go outside, then. Now he has already been able to go outside so why should I be the wicked one and make him stay inside?

When the nurses spoke about their colleagues failing to stick to the decision regarding a common staff approach, they used metaphors such as “coddling the patient who will fool you in the end”, thus marking their distance from their colleagues’ way of handling the situation.

The maintenance of a common staff approach could be seen as meaningless, for example, in situations when the patients managed to get around the rules and regulations set by the nurses on how to handle the patient—the patient defeated the nurse. One nurse used the metaphor “the patient is king” when describing this. The experience was a contradictory one—the nurse expressed the intention to avoid a schism within the group of staff by using a common staff agreement, but the schism occurred anyway when the agreement is used, because the patient managed to sort the nurses into “good” and “bad” ones:

And then we sit at workplace meetings and plan how to we should act in order not to—I don’t know about this with split and those matters—but not to let the split continue, in a way.

**Theme: Being aware of one’s own basis of valuation, and that of others**

Caring from the perspective of a common staff approach could also be understood as a possibility of becoming aware of the reasoning of oneself and one’s colleagues in relation to how to solve different problematic caring situations. This was experienced as an increased awareness of one’s own basis of valuation, that of others, and the differences between them. Each nurse began to reflect upon his/her own approach towards the patient, as well as that of others. Caring from the perspective of a common staff approach also meant experiencing a lack of ideological unity among one’s colleagues, and becoming aware that those colleagues held a different comprehension of how to care for the patient. This caused insecurity for the nurse, who could not know how to act when consensus was not achieved. For example, when the majority of nurses decided not to give the patient tranquillizer in the amounts and at the times demanded by the patient:

And then there were we nurses, of whom four were completely in accordance that it was not about the medicine. Instead it was about him [the patient] searching for some sort of confirmation... But
two, two, one was certain the medicine helped and the other was seventy percent sure it was the medicine that helped and thirty percent it was—well that maybe wasn’t the medicine that helped.

The different ideological standpoints of the nurses became visible in situations where they experienced a lack of unity, for example when deciding how to care for a patient with eating disorder. The common staff approach that was decided on could be experienced by the individual nurse as contradicting both the values associated with good care and his/her opinion of what characterized a good nurse. When the nurse experienced pressure to adopt a common staff approach that is alien to him/her, it was inconsonant of him/her to act against his/her own ideological standpoints. When describing such situations, the nurses used metaphors such as “being run over” by colleagues when deciding on a common staff agreement, or being from “different worlds” when talking about their and their colleagues’ different values.

And some punishment, reward – punishment . . . . And if he [the patient] behaved of course, then he got his privileges. For example, of course it was the eating disorder too, he went into his room and vomited, and you should see to the door to his room was looked so he could not go there and vomit. And that is not in concordance with my beliefs.

The interviewees expressed a call for conformity in their actions towards a single patient. This demand could be rooted in values other than those held by the individual nurse, and hence experienced as impossible to fulfill in the unique meeting with the patient:

So then there is, well, I feel I experience it now and then anyway, that there is a demand everybody shall act identically, everybody shall be exactly alike. But what the heck, that is not the way it is, it is not possible!

Theme: Being judged by the patient as good or evil

Using a common staff approach meant being forced to adopt different roles, roles that may differ from the nurse’s own image of himself/herself. Being forced to adopt a certain role was experienced as unpleasant and sometimes even painful. Adopting a certain role also meant that the nurses may be judged by the patient as “good or evil”, or “black or white”—the latter expression was frequently used by the interviewees. To be looked upon as an “evil or black” nurse by the patient was described as producing feelings of shame, and an experience that the patient regards one as a person who hurts other people. To be judged as “good or white” could be interpreted as being idolized, which carried the risk of never being left alone by the patient.

The nurses also described experiences of colleagues who adopted the patient’s view, and started picking on each other, with a consequent split within the workgroup and feelings of insufficiency and anger.

But anyway, I can be like them [colleagues] and think: well now it’s her time to be black and to put up with it, because it happens to everyone . . . But it is difficult because this is not how to behave lovingly to each other. Because it is extremely stressful to be black, and to be made black in front of everybody in the end.

When using a common staff agreement, the nurses described efforts to escape from being judged by the patient—to avoid being classified as a good or bad nurse, and striving to be seen as one in a collective:

Because before we decided we should be all three [contact staff] at her, she could just walk away to other patients and shout that we were insane and . . . yes, and partly to escape this split then. But however it is, it surely is bothersome to be black! It is bothersome to be white also, yes it is . . .

However, when the nurses managed to prevent the patient from judging them and splitting them into different roles, they did find that when the patient felt better he/she expressed his appreciation for the nurses who had stood firm in the common staff approach that had been decided on in order to promote his/her well-being.

Theme: Becoming sensitive to the patient’s suffering

Another meaning of applying a common staff approach was understood as becoming sensitive to the patient’s suffering. When a common staff approach was applied, the nurse could feel that this violated the patient. The nurses described how they became more exposed, and were made sensitive to the patient’s situation. They described experiences of the care becoming unworthy when a common staff approach was applied towards the patient:

But it was difficult with this patient: and we started to talk about the fact we could not keep
up the common care plan or what was planned—because it was the very opposite of dignified care.

The use of a common staff approach was also experienced as revealing the patient’s defenselessness, fear, and inability to speak for himself/herself when dealing with the nurses; for example, when extensive restrictions were placed on the patient’s right to move, when and what to eat, or when to smoke. The nurses might feel that the patient had a hard time understanding, and that there was no need to confront him/her so forcefully. Metaphors used by the nurses who saw the patients suffering included the phrases “superstructure” and “the patient does not adapt to the system” when talking about how colleagues treated the patient. Furthermore, the nurses could also experience the patient being punished by colleagues, who slapped him/her and withdrew his/her privilege to come and go as he/she pleased:

He was, he was afraid of them. . . . Because the staff, it was them who gave the patient a box on the ear from time to time then . . . there it was, he should do as, as he was told, right. He, he should get up on time in the morning and eat breakfast, lunch and everything, fixed rules.

Becoming aware of the patient’s vulnerability also involved experiencing a bad conscience and feelings of shame when applying a common staff approach and being an active part of the patient’s care:

And then there was also a kind of restriction decided on, and when she was completely in despair you should not let her in [to the ward]. And how fun is that, when she was in agony and feelings of panic, throwing her clothes at the walls? I had a hard time accepting this standpoint when I first started working here: No she should not come here—she has an apartment of her own, she should be there . . . But, hello, we can’t do it like this. And when I occasionally did it I got a damned bad conscience, so I will never do it again in all my life, no.

Comprehensive understanding

In this study, the meaning of using a common staff approach was understood through the naïve reading as a strategy for acting in difficult care situations. That is, those situations, which nurses perceived as overwhelming or difficult to handle, and from the following themes in the structural analysis: shedding light on mutual relationships, being deserted by nurse colleagues, being aware of one’s own basis of valuation, and that of others, being judged by the patient as good or evil, and becoming sensitive to the patient’s suffering. It is important to consider each of the themes as a whole, with dialectic relationships between them. The meaning of using a common staff approach was understood as a difficult choice—to focus on relations with one’s colleagues or to focus on the situation of the patient, who seems to suffer when a common staff approach is used.

Discussion

A narrative method was used in this study. The intention was to focus solely on the meaning of applying a common staff approach as narrated by nurses. According to Reissman (1993), it is extremely difficult to speak about particular experiences in life that affect an individual’s deeper levels of meaning; although to give such lived experience a narrative form does help individuals to express their experiences. Ricoeur (1991) states that the method of 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 applying a common staff approach gave rise to a paradoxical situation in which the nurse’s intention to establish unity among the staff ended up in feelings of loneliness. It is important to remember that although this interpretation is only one of several possibilities, the results of this study cannot be generalized but should be seen as an argument in an ongoing discourse (Ricoeur, 1976). A qualitative result is depending on many factors, as attitude and quality of researchers, social desirability and conditions of worth (Hewitt, 2007). Nine nurses were interviewed, and 12 interviews were performed in total. All interviewees recalled situations involving a common staff approach. It should be noted that the nurses on one of the four wards choose not to participate in the study—we can only speculate as to why. However, Kvale (1996, p. 101) states on the topic of how many to interview in this kind of study: “Interview as many subjects as necessary to find out what you want to know”.

To gain a deeper understanding of the meaning of the nurses’ common approach directed towards an individual psychiatric patient in the context of psychiatric in-patient care, we choose to interpret the findings from the theoretical framework of the Russian philosopher Nicolas Berdjajev (1960, 1994), who states that man is bound to choose between alternatives that are reciprocally of equal good, thus causing a tragedy due to not being able to choose both (cf. Berdjajev, 1960).
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 the meanings of applying a common staff approach as narrated by nursing staff. However, reality is not always comparable with the ideal. Sometimes patients do not wish to receive the care offered by nurses; nurses can handle such situations in different ways, for example through using a common staff approach (Enarsson et al., 2007).

In this study our data indicates that the nurse, when applying a common staff approach, is caught in a dilemma where he/she can focus on either the relationship with his/her colleagues or his/her relationship with the individual patient. When “shedding light on mutual relationships”, the nurses became aware of their colleagues’ way of thinking. The nurses stressed that feelings of security and unity within the group of staff were important, and talked about the group of staff as a group with homogeneous attitudes. Outside this community was the patient the alien. In other words, this meant that the individual nurse could focus either on his/her own longing for a safe unity with his/her fellow nurses, or on the suffering patient. If the nurse, when applying a common staff approach, choose not to recognize the suffering patient, and to alienate himself/herself from the patient, the patient was turned into a non-human—an object, a stranger (cf. Bauman 1995; Hellzén, 2000). Different studies have shown that nurses in psychiatric care have a strong tendency to use typologies in relation to the patients, leading to distanced relationships and to their not seeing the patient as an unique person (e.g. Lilja, Ördell, Dahl & Hellzén 2004). Foucault (2006) talks about a pessimistic perspective based on the carers’ paternalistic view of the patients. According to Scheff (1999), stereotyped imagery of mental disorders is learned early in life, including the commonly held view that a person suffering from a mental disorder is potentially dangerous (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000), unpredictable, and less intelligent than others (Angermeyer & Schulze, 2001). For example, patients diagnosed with borderline personality disorder diagnosis are stereotyped as “difficult” and “demanding” by staff (Gallop, 1988) and long-term schizophrenics can still be seen as “empty shells” without any ability to think, feel, or act (Davidson & Stayner, 1997), and are therefore judged by staff as being stupid, incompetent, or ignorant (Lilja, Ördell, Dahl & Hellzén, 2004). Nurses also tend to overrate their own importance when it comes to psychiatric patient’s well-being (Lilja & Hellzén, 2007). However, psychiatric patients have stressed their opinions that the care providers should be ‘genuine’ humans in their meeting with the patient (Peilert, Asplund & Norberg, 1995), based on an individual relationship.

Our data also indicated that adapting to a negotiated common staff approach carried a risk of putting the nurse into a vulnerable situation. This can be understood in the theme of “being deserted by nurse colleagues”, that is, being in conflict with both colleagues and oneself. Berdjajev (1960, p. 47) writes that the tragedy lies in the conflict between our own and other’s values. Only a few of the nurses in the present study expressed experiences of success in maintaining a common staff approach, with a joint facade, towards a specific patient. However, they all had some experience of the failure of a common staff approach, and through that, the experience of desertion. Therefore, it seemed difficult for nurses to see any meaning in such an approach when it was usually associated with failure. For example, by experiencing colleagues who were disloyal to the common staff approach, who did not defend the nurse when the patient characterized him/her as bad, or when the patient managed to fool him/her and colleagues, creating a feeling of schism amongst them, not being able to talk to each other. If the nurse feels deserted, and does not see the meaning of the common staff approach, it seems logical that he/she will experience himself/herself as being unworthy. This means that he/she finds himself/herself in a position where he/she is being deprived of his/her ability to be a nurse; that is, he/she loses his/her identity as a nurse. It is reasonable to assume that the nurse feels exposed and divested of the value he/she has assigned to himself/herself. According to Schechtman (1996), identity is the set of characteristics that make the individual nurse the person he/she is; these characteristics are formed by collective emotional bonds and narrations. This means that the nurse is in a situation where the bonds to colleagues are broken, and he/she is no longer an active participant in the formation of his/her identity (cf. Ricoeur, 1992).

When the nurses perceived that their colleagues held ideological standpoints based on different values than their own, they “became aware of their own and others’ basis of valuation”. It seemed as though each nurse had no criterion other than himself/herself and his/her own personal experience for guidance in how to act in relation to himself/herself, his/her colleagues, and his/her patient. The tragedy (cf. Berdjajev, 1960) was that if he/she followed the way advocated by his/her colleagues;
he/she might have serious pangs of conscience, while if he/she followed his/her will, or the patient’s, he/she might come into conflict with his/her colleagues. This can be recognized as a conflict and struggle between the social norms held by colleagues, and the personal moral conscience (cf. Berdjajev, 1960, pp. 58, 71).

If the nurse does not see the patient, that is, the person behind the actions, he/she only sees and judges him/her from his/her exterior. This fact emphasizes the risk of developing a social context characterized by non-egalitarian relationships (Foucault, 1978), and of the relationships between patients and staff being characterized by techniques and tactics (Jaspers, 1970; Foucault, 1987; Hellzén, 2000). It is clear from our data that the nurse stands alone in his/her choice, and depending on how he/she chooses, he/she abandons either himself/herself or his/her colleagues. It seems impossible to incorporate all actors in the “good solution of his/her choice”. The adoption of a common staff approach could be seen a form of covert exercise of power directed not only towards the patient but also towards the individual nurse who is forced to “give up” his/her moral attitude. According to Eriksson (1994), covert exercise of power can be seen when the nurse feels that he/she is not being taken seriously by his/her colleagues, which creates feelings of powerlessness.

When the nurse perceives himself/herself as “being judged as good or evil by the patient”, it evokes feelings of the patient getting the better of him/her. This means that the nurse becomes objectified by the act of the patient—he/she is forced to adopt a role that differs from his/her own self-image. According to Berdjajev (1960), a person who is reduced to a social role is exposed to tyranny and is a victim of evil. This means that when the patient constructs a meaning, an unpleasant meaning for the nurse, he/she is objectified and met with “raised arms” by the patient. According to Jaspers (1970), such situations, where nurses have faulty knowledge, usually lead to a search for methods, techniques, and tactics to handle the relationship with the patient. One interpretation of this is that by maintaining a social distance, the nurse is able to protect his/her own vulnerability (Lindseth, Marhaug, Norberg & Uden, 1994). A study by Skovdahl et al. (2003) of the attitudes of caregivers when handling aggressive behavior in dementia showed two different attitudes displayed by the caregivers; one group achieved a balance in handling problematic behaviors, while the other felt an imbalance when speaking about aggressive behavior of the patient. Several of the latter group felt powerless or felt that their own integrity was violated in these demanding situations.

This study evoked the question of whether, when the patient objectifies the nurse and takes the preferential right of interpretation from him/her, the patient also destroys the nurse’s own meaning of the situation (cf. Berdjajev, 1960). The nurse becomes the one that suffers and tries to escape from feelings of being judged by hiding behind the mask of the collective in adopting a common staff approach.

The theme of “becoming sensitive to the patient’s suffering” indicates that one meaning of applying a common staff approach is choosing to see one’s fellow human. The nurse recognizes that the common staff approach hurts the patient, and that to go along with it would be to violate the nurse’s own principles of worthy care. This means that the nurse finds himself/herself being forced to choose the patient’s perspective over the perspective held by his/her colleagues and synonymous to the negotiated and decided common staff approach. It seems as if instead of blaming the patient for frustrating his/her as a professional and accusing the patient of forcing him/her to become “like a warder again” (cf. Chambers, 1998), he/she blames his/her colleagues. It is possible that the adoption of a common staff approach touches upon the nurse’s moral aspects of human existence (Hellzén et al., 1999). Suffering seems to open up the ethical perspective of inter-humanity; for example, the patient’s suffering evokes a response in the nurse and becomes suffering in him/her. Thus, suffering is not always useless; in an interhuman perspective it has a meaning (Levinas, 1988).

The paradox is that even if the nurse’s initial wish in a severe and threatening caring situation is to establish unity within the staff group based on a negotiated common staff approach, in the end it leads to feelings of loneliness. When applying this common staff approach, the nurse is left all alone with his/her own decision (cf. Berdjajev, 1960). Even if the individual nurses know that the verbal interaction and support given are the basis in psychiatric nursing care, the caring reality threatens his/her identity, his/her sense of who he/she is as a nurse. That means that his/her sense of self-worth is cracking, when he/she is only confirmed in his/her role as alone (Thesen, 2001). According to Åström, Jansson, Norberg and Hallberg (1993), nurses in ethically difficult care situations expressed either loneliness or togetherness in relation to colleagues.

As in the present study, the nurses also referred to colleagues as “we” or “they”, depending on their relationships with their colleagues and co-actors. Ethics and moral acts are strongly influenced by social life, and this is highlighted in psychiatric care (cf. Durkheim, 1964), where it is the nurses who
decide what normal behavior is. When we determine what ethic is the “right choice”, as when deciding and applying a common staff approach, we are surely under the pressure of social norms. However, at the same time, we can only fall back on our own experiences, from ‘me’. Berdjajev (1960) states that it is only in spirit that a person can know what is good; we are free to act, but at the same time we know that every human choice involves cruelty.

When reflecting on or making interpretations, it should be borne in mind that restricting the psychiatric patient is often explained as a part of the ongoing treatment—that the patient needs structure in his/her daily life at the ward. Such behavioristic thoughts can be seen in the current Swedish psychiatric reform (National Board of Health and Welfare, 2003), and can support the nurses’ superior right to interpret situations and their task of correcting unwanted behaviors in the patient. There seems to be a connection between a high level of disability in the psychiatric patient and the nursing staff’s experience of the patient’s being ‘difficult’ to handle (cf. Finnema, Louwerens, Sloof & van den Bosch, 1996; Moore, Ball & Kupiers, 1992; Shepherd, Muijen, Dean & Cooney, 1995). In addition, this study has shown that a common staff approach is by no means a part of a formulated care-strategy. It is not a formulated care plan; instead, it is a way to experience of the patient’s being cared for when staff employ a common approach.

References


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