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

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

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

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

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

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

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

Introduction
The theory and practice of psychiatric nursing has two aspects. For patients, nurses are both health professionals and fellow human beings. In their therapeutic work, nurses must employ their diagnostic insights and precise knowledge of illness. At the same time, they must also be able to encounter patients as unique individuals. The profession bears the
traditions of both biomedical knowledge and humanistic psychology. It is expected that nurses have both a professionally objective, scientific stance and sensitivity to patients and their suffering. In short, inflexible schematic thinking must be combined with empathy. The ability to quantify must go together with the ability to be present as a fellow human being.

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

Theoretical context

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

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

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

There are a number of obvious problems connected to such an ideal. One of them is that there may be too great a nurse–patient distance. A body of research indicates that, when there are low personnel resources and fast and effective treatment of very ill patients is needed, nurses experience an unpredictable work situation (Delaney et al. 1995, Ryrie et al. 1998, Cleary & Edwards 1999). Under such conditions, they experience feelings of powerlessness (Thomas et al. 1999a, 1999b) and appear watchful and controlling (Gijbels 1995). Co-ordination, administration and management dominate their practice, at the expense of planned patient-focussed activities (Ryrie et al. 1998). However, research also shows that nurses might be custodial and task-oriented, irrespective of resources (Clarke 1996). Such conditions create distance between patients and nurses.

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

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

The study

Purpose

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

Background and methods

In this article we draw on a larger empirical study of a medium-sized Norwegian psychiatric hospital in the autumn
Experience before and throughout the nursing career

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


Data analysis

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

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

Ethical considerations

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

Case study: a difficult nurse–patient relationship

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

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

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

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

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

Being sidelined

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

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

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

Stubborn empathy

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

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

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

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

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

Being professional and being human

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

The nurse’s description: vulnerability

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

There is a clear danger of romanticising the importance of nurses’ accepting their own vulnerability and using it for the benefit of patients. We do not advocate that it should be an ideal for nurses always to ‘be themselves’. Neither do we dispute that patients are most aware of (Porter 1992, Wifstad 1997). It seems that patients’ vulnerability is recognized, there is little acceptance that nurses may be vulnerable too.

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

As far as the notion of vulnerability is concerned, the literature that we have found is not based on what predominant philosophers in Scandinavia have come to realize. Nortvedt (2002), for example, emphasizes that a nurse’s responsibility for looking after a patient is established by ‘a single person’s helplessness, vulnerability and suffering’ (p. 31). To acknowledge vulnerability, dependency, fragility and mortality as essential human qualities must be regarded as fundamental to every kind of help or care (Henriksen & Vetlesen 1997, Løgstrup 1956, 1997). It is dependency and vulnerability, fragility and mortality that...
make a human being a human being. If one expects nurses to act as moral persons, this requires that they are aware of patients’ vulnerability and dependency and, moreover, that they admit that they are vulnerable and dependent themselves, accepting vulnerability and dependency as essential human qualities. Only if nurses are able to realize their own vulnerability and dependency are they able to identify with patients’ needs and feelings (Henriksen & Vetlesen 1997, Vetlesen 2001).

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

Professional ideals

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

Signals from colleagues

The third aspect we focus on is the importance of colleagues for the nurse’s self-image. Nothing in the interview or observation data indicates that her colleagues saw the strength or positive aspects of her vulnerability. They seemed to think that professionals should be strong and well-controlled. However, such an attitude creates a problem. It suggests to us that it is not merely the stress caused by external demands for effectiveness and high patient turnover that explain why this particular nurse was unable to express her own humanity and vulnerability. We must also critically consider the behaviour of her co-workers. A number of interesting questions present themselves. Can it be the case that attitudes to patient care that encourage patients to ‘be positive’ and ‘look ahead’, and that discourage introspection, might be transferred to relations between nurses? Does such an ethos discourage a focus on dynamics processes, and the possibilities and insights that this can bring about? Do we here touch upon what Cleary and Edwards (1999, p. 477) suggest, namely that the belief that ‘something always comes up’ is one that makes nurses less sensitive towards relational processes? Is it the case that nurses are uncertain about the essential nature of their own professional competence (Gijbels 1995)? Is this why the nurse in our example does not receive the support and understanding of colleagues, who feel incapable of offering any specific professional advice?

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

Conclusion and practical implications

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

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

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

What is already known about this topic

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

What this paper adds

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

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

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