Rejection – a neglected phenomenon in psychiatric nursing

M. H. HEM¹ RN RPN MH Sc & K. HEGGEN² RN PhD
¹Research Fellow, ²Associate Professor, Section for Health Science, Faculty of Medicine, University of Oslo, Norway

Correspondence: Marit H. Hem
Section for Health Science
University of Oslo
PO Box 1153 Blindern
NO-0316 Oslo
Norway
E-mail: m.h.hem@helsefag.uio.no

Introduction

Psychiatric nursing and ethics – introductory remarks

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

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

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Focus and background of the article

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

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

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

Literature review

Nurse–patient relationship – a central idea in psychiatric nursing

Many clinicians and researchers emphasize the importance of establishing a nurse–patient relationship in which nurses use themselves as therapeutic tools. Influential researchers as Mereness & Taylor (1982), Peplau (1992), Porter (1992) and Stuart & Sundeen (1991) have all focused the importance of interpersonal processes and therapeutic interaction in psychiatric nursing. The concrete aims of the nurse–patient relationship are, as Gallop et al. (1990) point out, to explore and become familiar with the patient's own understanding of her/his present situation and the past, and to contribute to the patient's well-being and personal growth (Peplau 1992, Müller & Poggenpoel 1996). Furthermore, a functioning nurse–patient relationship is considered a necessary condition for providing care, which is looked upon as the very essence of nursing (Schafer 1997, p. 206).

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

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

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

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

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

**Løgstrup’s ‘ethical demand’ and the role of trust in human relationships**

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

‘It is a characteristic of human life that we normally encounter one another with natural trust’, Løgstrup says (Løgstrup 1956/1997, p. 8). Moreover, he contends that all human interaction involves or presupposes basic trust. ‘To trust means to expose oneself and thus to run the risk of being rejected’ (Løgstrup 1956/1997, p. 17). Abused trust causes mistrust. These notions lead us deeper into Løgstrup’s idea of what the basic character of trust is supposed to be and how it functions in human relationships: in every personal encounter we are confronted with an unspoken demand to take care of what is given to us: A person never has something to do with another person without also having some degree of control over him or her. It may be a very small matter, involving only a passing mood, a dampening or quickening of spirit, a deepening or removal of some dislike. But it may also be a matter of tremendous scope, such as can determine if the life of the other flourishes or not. (Løgstrup 1956/1997, pp. 15–16)

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

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

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

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

**Sample and methodology**

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

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

**The case – ‘I’m a human being’**

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

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

Analysis of the case

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

Vulnerable and confident

The starting point is a common situation between nurses and patients without a shared interactive focus or purpose. At first Ann sits in the sofa laughing. She then disrupts the situation by howling. The disruption may be unintended, the laughter, and then the howling being a spontaneous expression of mental torment and suffering. An alternative interpretation is that Ann wants to attract the nurse’s attention by laughing. If not successful she starts howling, and this is the first deliberate step towards changing the setting.

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

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

Fighting for dignity

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

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

On the other hand, the statement mirrors Ann’s hopeless struggle against chaos and the feeling of being lost. As such, it is directed towards the nurse as a desperate appeal for help. With regard to her existence being threatened, Ann gives the impression that she is working hard to tell Elisabeth that she is a person worthy of respect. The fact that she does not stop communicating, although she is convinced that everybody knows everything about her, might
be a sign that she does not feel completely ‘lost’. She is, in fact, quite confident, because she finds it worthwhile to talk about herself. The fact that she reveals so much of her inner state of mind is not only a sign of trust, but also a way of expressing hope that Elisabeth can help her.

Rejection of the patient

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

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

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

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

Discussion

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

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

The psychiatric nurse and ‘the patient in her hands’

Elisabeth is invited to join Ann in her world and to share her experiences. Elisabeth, however, does not seem to be able to understand Ann’s behaviour as an invitation. According to Løgstrup (1956/1997) she is not able to decide what the content of the demand is. In order to understand the patient’s message, the nurse should have used her imagination, insight, and knowledge (ibid.). In the case of this patient the nurse gets much information about the patient’s feelings and thoughts. If she had acknowledged the importance of Løgstrup’s ‘ethical demand’, she would have had to inquire into the patient’s underlying needs and motives and – in order to accomplish this – she would have had to use her imagination, insight, and knowledge. Furthermore, in order to create trust, the nurse must be able to show empathy, compassion, understanding, acknowledgement and affirmation. To accomplish this Elisabeth would have had to go beyond an attitude of ‘friendly distance’ (Müller & Poggenpoel 1996). The ability to transcend this attitude is, in our view, exactly what is meant by the notion of ‘the therapeutic use of oneself’ (Mereness &
Taylor 1982, Stuart & Sundeen 1991, Peplau 1992, Porter 1992). There are, in fact, some striking parallels between Løgstrup's concept of 'the ethical demand' and the concept of 'the therapeutic use of oneself'.

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

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

The complicated professional distance

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

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

Alternatively, it is important to mention that distance also can be used to secure the patient's dignity. It might be that the patient's unveiled expressions can create indignity. Or it might be that the nurse, if she confirms the patient's inner understanding and feelings, is running the risk of increasing the patient's despair and hence make his/her psychosis even worse. In letting the patient loose his/her 'normal' reality, the nurse might create an unworthy situation for the patient. The nurses might try to maintain the patients' dignity by creating a distance to the patients' reality. Lawler's (1991) study of nurses caring for patients in hospitals shows that nurses deliberately create distance, for instance in the way they use their body, in order to keep up dignity in intimate and fragile care situations. Undoubtedly, there are situations when nurses care for psychotic patients, in which dignity is maintained by creating distance between the patient and her/his fellow patient. Patients exposing themselves sexually are one example where protection and separation of patients are necessary in order to restore the patients' dignity. In the presented case study we argue that it is reasonable to interpret that the lack of acknowledgement of the perspective of patient's world is a rejection. There is no lack of dignity in the way the patient acts; however, there is lack of dignity in the way the nurse behaves.
There may, obviously, also be rejection for a third reason: a simple personal dislike. One can not take for granted that the patient–nurse relationship will be a mutual, sincere, attached, and honest one. The personal chemistry and establishing the same wavelength can simply be too difficult.

Conclusion and outlook

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

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

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

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

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

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