To do good might hurt bad: Exploring nurses' understanding and approach to suffering in forensic psychiatric settings

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Abstract

Patients in forensic psychiatric settings are likely to suffer not only from their mental illness but also from memories of criminal activities and, furthermore, from being involuntarily hospitalized. The aim of this study was to explore how nurses in forensic psychiatric care understand and approach patients' suffering. Data was generated by semi-structured interviews with psychiatric nurses from two different forensic psychiatric care units in Sweden. Data were analysed by means of a hermeneutic approach inspired by Ricoeur's hermeneutics. The findings are reflected in four main themes: 1) Ignoring suffering 2) Explaining suffering as a natural and inevitable part of daily life in the forensic context. 3) Ascribing meaning to suffering, and 4) Being present in suffering. To engage in alleviating suffering is a struggle that demands courage and the strength to reflect on its character and consequences. To encounter suffering patients means that nurses are confronted with patients' suffering as well as their own reactions while being present for those patients. If suffering is not seen or encountered, there is a risk that even actions taken with the best of intentions will hurt the patient.

Keywords: Caring, forensic psychiatry, nurse-patient relations, psychiatric nursing, trust

INTRODUCTION

Being a patient in a forensic psychiatric setting often means being forced to adjust to circumstances that differ from ordinary life. Forensic psychiatric care is a specific context. It is regulated in part by different laws than those governing health care in general, but nevertheless, the same basic principles apply. Thus, even though there is a responsibility to protect not only the patient but also society, there is also a legal as well as an ethical and professional responsibility to treat patients with respect, to provide the best possible care, and to promote patient participation as much as possible (ICN 2012). The ICN code of ethics for nurses states that one of the four fundamental responsibilities is to alleviate suffering (ICN 2012). According to Fredriksson and Eriksson (2001), patients in psychiatric care suffer when they do not understand what is happening to them, when things are perceived as unacceptable, and when they fear or experience insecurity concerning their future. Furthermore, patients may suffer from guilt, shame and other experiences related to the crime, as well as from various psychiatric symptoms (Jacob et al. 2009). Drevdahl (2013) argues from a perspective grounded in Paul Ricoeur's ethics that suffering includes not only physical or mental pain, but the destruction of the capacity to act, experienced by the individual as a violation of integrity. In this perspective, suffering becomes a broader concept involving illness, the care itself, and life as a whole as causes.

As these experiences can be difficult to talk about with caregivers, patients might communicate their suffering nonverbally, for example, through anger or violent behaviour (Pereira et al. 2005). If nurses lack patience and understanding in such situations, patients adjust their behaviour in order to gain benefits (Hörberg et al. 2012) and hide their suffering for fear of misunderstanding and rejection (Hostick & McClelland 2002). Not being able to express suffering verbally also contributes to the development of destructive emotions (Carlén

& Bengtsson 2007) and to a perception of the nurse as a guard rather than a caregiver (Hörberg et al. 2004).

Therefore, in forensic psychiatry, nurses are challenged to establish safe, trusting relationships with patients. When nurses feel that they are in a safe environment, they can approach patients in a way that enables caring relationships and therapeutic interventions directed at alleviating suffering. Then the encounter can be transformed into a learning experience, through which patients are able to ascribe meaning and gain a new perspective on their suffering (Hörberg et al. 2012). However, when nurses are socialized into a context where patients are presented as potentially dangerous, they tend to distance themselves from patients (Jacob & Holmes 2011). A distant position can block nurses' understanding of patients' expressions of suffering, so that instead of facilitating patients' understanding of and reconciliation with suffering, they might focus on restrictions and fostering interventions (Hörberg et al. 2004, Martin & Street 2003). The nurse-patient relationship is also challenged when nurses need to carry out interventions – for instance, implementing restrictions – in order to protect the patient and other persons from harm. On those occasions, nurses justify the infliction of suffering here and now with the perceived benefits in a longer perspective (Hummelvoll & Severinsson 2002). This can affect the care given and also be stressful for nurses, who are torn between their desire to maintain a caring relationship with the patient and the need to diminish or eliminate the risk of violence towards themselves and others (Livingstone et al. 2010). This motivates further research into forensic psychiatric nurses' experience of nursing care as a way to relieve suffering. Therefore, the aim of this study was to explore how nurses in forensic psychiatric care understand and approach patients' suffering.

MATERIAL AND METHODS

This study employed a qualitative design, where transcribed interviews were subject to hermeneutic inquiry.

Data collection

Six nurses, five women and one man, from two different forensic psychiatric units in Sweden participated. The unit's security level was high in a national classification system with three levels (low, high and very high). The nurses were 27 to 49 years old and their experience as forensic psychiatric nurses ranged from two to 15 years. An interview guide with open-ended questions was used, starting with the introductory question, "Tell me about a situation in which you and your colleagues succeeded/failed in understanding a patient's suffering?", followed by questions such as, "How do you think patients experience being cared for in the forensic setting?" and "Do you think care can change depending on the understanding of the patient's suffering?" The participants were encouraged to speak as freely as possible, and follow-up questions were asked to explore participants' reasoning. The interviews lasted between 23 and 56 minutes and were recorded and transcribed verbatim.

Analysis and interpretation

The hermeneutic approach in this study was inspired by Ricoeur's (1991, 1995) hermeneutics and his idea about interpretation as a movement between explanation and understanding. This approach has been used and developed in previous studies (Fredriksson & Lindström, 2002; Wiklund, Lindholm & Lindström, 2002). This dialectical relationship contributes to a scientific approach to interpretation, as it comprises systematic means not only for analysis but also for bridling the researchers' preconceptions. The first step focused on repeated and thorough readings of the interview transcripts in order to obtain a first, naïve understanding of the text. The researchers strived to remain open to the text, and to interpret the message of the

text as a whole. This step conveyed a first understanding of the meaning of the text on a descriptive level.

In the second step this naïve interpretation was challenged by a systematic and rigorous analysis, focusing on the structure of the text. By dividing the text into meaning units, which were then condensed, the text was de-contextualized and ‘interrogated’ in order to explain the meaning. This was accomplished by relating similar meaning units to each other in the formation of sub-themes and themes, thus relating parts to the whole. Finally, in the third step, the themes were critically reflected upon in relation to each other, to the naïve interpretation and to theory, with the aim of opening up a new world beyond the text.

Ethical considerations

The study was conducted in compliance with the ethical guidelines of the Declaration of Helsinki (World Medical Association 1964/2013). All participants were informed of the study’s aim, as well as confidentiality and voluntary participation, and gave their oral and written consent prior to the interviews. In line with the Swedish Ethical Review Act the study was subject of an ethical seminar at the university, and approved by the heads of the forensic hospitals.

FINDINGS

The presentation of findings follows the three analytical steps presented above, thus making the interpretive process transparent.

Naïve reading

This first interpretive step gave rise to a naïve understanding of nurses in forensic care as having opposing views in regard to understanding and approaching patients’ suffering. Both the patient’s background and issues relating to power within the forensic hospital were recognized as sources of suffering, but they were approached in different ways, either by focusing on the suffering patient, by focusing on the patient’s problems or by viewing

suffering as inevitable in forensic care. These opposing views were also described as a potential source of conflict among the staff with regard to how patients' suffering could be relieved. This study found conflicting opinions focusing either on caring and alleviating suffering or on guarding and fostering patients.

Structural analysis

The structural analysis indicated that forensic nurses' ways of understanding and approaching patients' suffering could be understood in light of four themes, 'ignoring suffering', 'explaining forensic care as a cause of suffering', 'ascribing meaning to suffering' and 'being present in suffering', and their supporting sub-themes (table 1). The four themes are presented under the subheadings below, while sub-themes are under lined in the text.

TABLE 1: *Structural analysis*

Theme	Sub-theme
Ignoring suffering	<i>To disregard suffering</i>
	<i>Closing one's eyes to suffering</i>
	<i>Focusing on behavioural change</i>
Explaining forensic care as a cause of suffering	<i>Being a subject of forensic care</i>
	<i>Structures of power</i>
	<i>Failure to establish trust</i>
Ascribing meaning to suffering	<i>To find the sources of suffering</i>
	<i>To give answers</i>
	<i>To understand why threat and violence appear</i>
	<i>To see behind the façade</i>
Being present in suffering	<i>To never abandon the patient</i>
	<i>To invite patients to communion</i>
	<i>To allow the patient to set the pace</i>
	<i>Creating possibilities for growth</i>

Ignoring suffering

One way to deal with suffering was to avoid it by ignoring it and thereby create a distance to it. Sometimes the nurses chose, or were forced by the circumstances, to disregard suffering.

This was evident when patients suffered in silence, as nurses tended to prioritize more expressive patients. When this occurred, silent patients became almost invisible, as the nurses' attentions were focused on patients regarded as 'troublemakers'. Suffering was also disregarded when nurses experienced the patient as lacking insight into his/her problems or behaving inappropriately. In such cases, the patient could be abandoned while the nurse waited for him/her to adjust to 'reality', i.e., the context, and its demands. Thus, the responsibility to initiate a conversation about suffering was placed on the patient, rather than regarding conversations about suffering as a part of nursing care. If a patient expressed anger towards a nurse, the cause was attributed to illness, rather than to the nurse's demeanour, and the patient's anger was not taken seriously. If the patient expressed suffering, for example, by crying, this might also be seen as a means of getting attention rather than as suffering, or as Cecilia put it:

But he was easily diverted, so I don't know how much sorrow was in that, or if it was a way to get attention.

By diverting the patient's attention, nurses could avoid approaching suffering. Even when there was a suspicion that the patient was suffering, nurses sometimes chose to disregard it. Furthermore, when patients failed to express suffering, nurses failed to acknowledge it, and it was not until something happened that the nurses understood the person was suffering. As a nurse, Johanna, has experienced this:

Now, after it has happened, it is possible to see that he [who committed suicide] conveyed different, but small, messages about not feeling well. But there were too

many people, and nobody received the whole picture; he didn't give that much to a single person. Rather, he dropped a little here and a little there.

This unawareness was interpreted as closing one's eyes to suffering. Another way to close one's eyes to suffering was also evident in data, namely the assumption that as the patient lacks insight into his/her illness, he/she does not suffer.

Focusing on behavioural change instead of listening to the patient's story was also understood as a way to ignore suffering. Nurses described how a more or less persuasive argument was used to motivate patients to accept the hospital's rules and engage in different activities. A common staff approach was viewed as a means to providing a structure that could facilitate a patient's adjustment to the hospital. If these rules were violated by a colleague, nurses understood this to be 'unprofessional behaviour'.

Explaining forensic care as a cause of suffering

Another way to understand and approach suffering was to explain its causes in a way that makes it an inevitable part of daily life at the hospital. In this way, suffering was understood on a general level, rather than in relation to the patient as a unique person. Thus, being a subject of forensic care was itself understood as causing suffering, as Ann sees it:

It is very offensive when someone tells you what you shall do, that things have to be right, that you are unable to decide what is best for you; I believe that that is incredible offensive, just to be here, to have us around, 24 hours a day, watching.

The nurses are responsible not only for taking care of the patient but also for security. Thus there are regulations that must be followed, such as restrictions on personal freedom. These restrictions were considered a cause of suffering that could not be removed. Furthermore, more or less visible structures of power were assumed to contribute to patients' suffering.

Martin said, 'The doors are opened by keys and codes, and we can't prevent them from not feeling inferior.' These structures of power were considered unavoidable, and nurses stated that patients did not have any other alternatives than to adjust to the regulations – or act out frustration and agony, thus contributing to a downward spiral of suffering and restrictions. Even when the nurses understood that patients experienced themselves as misunderstood, they nevertheless had to uphold the structures of power. To facilitate adjustment and avoid conflicts, they tried to convince the patient and teach him/her how to behave. Cecilia describe it as:

Well . . . forcing and forcing. . . . But we tell them 'this is how it is', and 'this is what will happen.' And 'this is how you should work.'

Thus, the nurses were aware that patients' dignity could be violated by the restrictions, but they accepted that as an unavoidable part of life at the hospital. The fact that they needed to perform coercive acts in order to safeguard both the patient and co-patients and also themselves added to the patient's earlier experiences of being neglected and abandoned and became an obstacle to a working alliance with the patient. This failure to establish trust is also related to nurses being suspicious and vigilant regarding patients' motives and behaviours. That too was accepted as part of a professional attitude, while being 'too soft' was considered a sign of letting go of professionalism.

Ascribing meaning to suffering

Another way to approach the suffering patient was to ascribe meaning to suffering by striving to understand why the patient acted as he/she did and to facilitate the patient's own understanding of his/her life and suffering. This made it easier for the nurse to relate to the patient, as behaviours that can be hard to acknowledge and accept became understandable. Thus the nurse, together with the patient, tried to find the sources of suffering. These sources

were understood as related to the patient's background and to earlier experiences, but also to the present situation, such as missing one's family and not being able to communicate one's suffering to others. This understanding also provided the basis for nurses as they strived to give answers to patients who sought to understand their personal misery. This was understood as a means to provide comfort and establish a platform for caring. It was also perceived as contributing to patients' insight into their present situation. Furthermore, to understand why threat and violence appear was also a way to approach suffering, instead of simply disqualifying expressions of suffering as 'bad behaviour'. Johanna has understood this in her daily work as a nurse:

Many of them have from an early age used this as a means to communicate. In a moment of frustration, a moment of aggression, they don't use language as a way to communicate, the kinds of tools we use. They use other means of expression, through behaviour.

The nurses stated that forensic patients seldom cried; rather, they became angry and acted out their agony.

Patients who had difficulty enduring suffering were described as lacking competence to deal with problems. Instead, the nurses believed, patients tried to escape painful situations by taking drugs, or by 'making themselves big' through violent behaviours. However, when a nurse understood this problem, he/she was able to see behind the façade. This enabled nurses to detect patients' conception of themselves and focus further interventions in order to alleviate suffering.

Being present in suffering

This theme was identified on the basis of nurses' descriptions of being engaged in a caring relationship with the patient as a person. Thus nurses also related suffering to the patient's

lifeworld, and not only to the context. This was a challenge for nurses, as it required them to be present with the suffering patient. In those situations, nurses also encountered their own shortcomings when their capacity to alleviate suffering was insufficient due to the circumstances as well as to the severity of the patients' poor psychiatric health. The basis for this presence is to never abandon the patient, no matter what happens. This also meant that nurses gave up their own assumptions about patients' problems and the best thing to do, and endured being in a 'not-knowing' position. To never abandon the patient was also described in the context of advocating for the patient's perspective in discussions with peers. When the nurse was genuinely interested in the patient as a person, the patient was invited to a communion rather than forced into conversations about the crime. Within the safe frame of this caring communion, nurses allowed the patient to set the pace for the development of a safe and functional relationship. To Lisa, this may look like the following:

For some, this is a fast process, while it appears that others are stuck. But you can't change patients and try to form them into your own preferences. You must start where they are.

Letting the patient set the pace was considered a way to comprehend the patient as a unique person and described as a means to promote patients' active participation rather than 'fostering' adjustment to a common approach.

Thus the caring encounter to a great extent is formed by the patient's needs. The nurses also claimed that the intensity of a patient's suffering sometimes required that the nurse take a step backwards, not in order to abandon, but rather in order to come closer. Emma experiences this as:

It is also a question of acceptance. Sometimes the patient doesn't want to talk about it. If the patient has expressed that, I believe it is better to let it be, and hopefully you can pick up again after an hour or so.

By acknowledging the patient as a suffering human being, nurses also facilitated the patient's narration of suffering. When nurses were available and responsive to the patient's needs, they established foundations for approaching the suffering patient in a way that they experienced as creating possibilities for growth, and thereby for the alleviation of suffering.

Critical reflection

In this final step, findings from previous steps are further explored in relation to relevant literature. The literature was chosen on the basis of the findings in the previous steps. The naïve interpretation concluded that different understandings about patients' suffering and how to approach it contributed to conflicts among staff, as they gave rise to different opinions about how nursing care should be delivered. The structural analysis contributed a more explanatory view by highlighting that differences were manifested not only in different opinions but also in different ways of relating to the suffering person. Therefore, literature focusing on a common staff approach (Enarsson et al. 2007, 2008), different forms of presence (Fredriksson 1999) and caring conversations as a means to alleviate suffering (Fredriksson & Eriksson 2001, 2003) provides the theoretical basis for critical reflection. Further references are used to elaborate on the interpretations in regard to different aspects of the alleviation of suffering. As the critical reflection aims at generalizing by abstraction, the focus is not on the specific participants. Instead, the findings are re-contextualized on a general level (Ricoeur 1991, 1995). This change as regards the level of abstraction is also visible in the change of tense from past to present.

That nurses sometimes ignore suffering is interpreted as a lack of understanding of the patient's perspective. Explaining expressions of suffering as manipulation and disruptive behaviour enables nurses to keep their view of professionalism intact. Furthermore, they can side with their peers, avoiding both being alienated from them and becoming overwhelmed by patients' suffering. As a consequence, patients are met with different strategies aiming at fostering an acceptable behaviour that fits the cultural demands of the unit (Enarsson et al. 2007). By overlooking suffering rather than approaching and alleviating it, nurses can avoid becoming personally involved in and touched by patients' suffering. According to Knobloch, Coetzee and Kloppe (2010), this could be understood as an expression of compassion fatigue. Thus, creating distance from suffering could be understood as a protective stance, adopted when nurses are unable to be present when encountering suffering patients. However, if nurses distance themselves not only from suffering but also from the sufferer, patients' suffering might increase as a result of alienation (cf Younger 1995).

Nurses can also distance themselves from suffering by focusing on the causes of suffering, rather than on the suffering patient. By accepting suffering as an inevitable aspect of forensic psychiatric settings, the nurse's role changes from caregiver to guardian of safety. As suffering is accepted as a reality of the daily life and routines of the hospital, the nurse does not have to engage in alleviating it and can focus on formal and standardized care. The relation is characterized as a 'contact', with limited intersubjectivity as nurses rely on their role and focus on 'being there' (Fredriksson 1999). As suffering is viewed as a 'natural' and inevitable aspect of the specific context, it is not customary to address it on a personal level. If this is predominant in the caring culture, nurses who acknowledge that the patient is suffering are challenged to either approach the suffering from the standpoint of the patient or relinquish his/her own abilities to alleviate it and adjust to the system. The latter could be understood as

a lack of autonomy, as the nurse tends to adjust to the demands of the culture rather than focusing on patients' individual needs (Fredriksson & Eriksson 2003, Enarsson et al. 2008).

Nurses can also ascribe meaning to suffering by focusing on the patient from an outside perspective. Thus a nurse tries to understand a patient's suffering based on his/her own knowledge and understanding of what can cause suffering in people's lives, and strives to provide an answer to the patient's 'Why?' However, the answer to this existential question must arise out of the patient's own understanding and meaning-making process, and cannot be delivered from the outside (Fredriksson & Eriksson 2001). By taking the standpoint of an expert who has the competence to make assessments in regard to a patient's suffering and how it could be alleviated, the nurse remains in a somewhat distant position.

In contrast, being present in suffering demonstrates how nurses adopt what could be described as a reflective openness and responsiveness (Dahlberg et al. 2008). Thus they place themselves not only in a non-judgemental position (cf Rose et al. 2011), but in a 'not-knowing' position, in order to be able to see the person and acknowledge his/her uniqueness and individual needs.

This kind of presence is understood as 'being with' the patient (Fredriksson 1999). Caring relationships are defined by inter-subjective 'connection' rather than being task oriented. In this mode of relating, suffering is not always understood, and nurses struggle to be with the suffering patient without having a fixed solution. When nurses are able to connect to patients and compassionately be with them in suffering without trying to explain or alter their behaviour, a mutual understanding of the patients' suffering arises. This understanding can facilitate a patient's reconciliation with his/her story of life and suffering, as it allows for patients to ascribe a personal meaning to their suffering (Fredriksson & Eriksson 2001).

Presence as 'being with' appears to be primarily rooted in compassion, and an ability to be with the patient and sensitive to the patient's needs. Understanding the patient is not a

prerequisite for this stance; rather, it develops as a mutual understanding arises from presence and a caring communion.

When the themes are related to each other and re-contextualized, the specific challenges associated with alleviating suffering in forensic care become apparent. Patients in these settings are indeed subject to the will of others, and nurses who have the courage to provide care from a 'not-knowing' position contribute to a shift in power, setting the stage for the patient's ability to reclaim the power to ascribe meaning to his/her life. This may be controversial and give rise to conflicts among peers, as it could mean that they exceed the cultural norms. If discordance appears amongst colleagues regarding how to understand and alleviate patients' suffering, a nurse can experience insecurity and ethical conflicts, torn between longing for security and unity with his/her fellow nurses and advocacy for the patients (Enarsson et al. 2008). Thus, it is not only patients who are struggling with suffering; nurses, too, are involved in a struggle, in which they can feel forced to take sides with their colleagues or advocate for the patients' perspective. Depending on the nurse's stance, this can contribute to the nurse adopting a role that diverges from his/her self-image and caring values, thus undermining his/her sense of self-esteem and autonomy or leading him/her to continue striving to balance asymmetric relationships. Furthermore, balancing on an ethical edge instead of being supported by colleagues when confronted with patients' suffering might contribute to compassion fatigue (Knobloch Coetzee & Klopper 2010). A possible interpretation is that taking the distant 'expert-position' is not only a consequence of adapting to cultural values, but also a coping strategy to compensate for perceived shortcomings and protect oneself from suffering. Nevertheless, the distance can cause suffering as the asymmetric relationship between nurses and patients is exploited (Fredriksson & Eriksson 2003).

DISCUSSION

Six nurses took part in the interviews. This is in line with Kvale's (1996) recommendations of 15 (+/- 10) participants in this type of study. However, as qualitative research is not a question of numbers but of meaning it is important to reflect on whether *data* is sufficient, rather than focusing on the number of participants. As the study is explorative and the results contribute new understanding, the data was considered sufficient. Even though there was only one male participant, the themes were recognizable by both males and females. Therefore, without claiming that the result represents all nurses, it is transferable as generalizations are made by abstractions to recognizable themes rather than by numbers.

Data was interpreted by means of a hermeneutic approach inspired by the writings of Ricoeur. A similar approach to phenomenological hermeneutical analysis has been described by Lindseth and Norberg (2004). However, while Lindseth and Norberg strive to obtain consensus among different levels of interpretation, we strongly believe in making use of the dialectic that arises from different interpretations; we consider this beneficial for critical reflection, as it challenges the interpreter to consider the reality as complex, to deal with contradictions and to find an argument that supports interpretations that have been made as meaningful and trustworthy. Trustworthiness depends on truthful narratives of lived experiences (Lindseth & Norberg 2004), and thus also on the dialogue between researcher and participants (Wiklund-Gustin 2010). Therefore, the interviewer (first author) strived to achieve a dialogue in which participants felt free to narrate, rather than experience the interview as an interrogation. As the results also highlight nurses' shortcomings, it is likely that the interviewer's mission was accomplished. Interpretations have been validated as plausible (Ricoeur 1976) through joint reflections between the three authors, and also in relation to a wider audience through dialogues with a group of nurses working in and studying mental health.

Forensic psychiatric care is a specific context. It is regulated in part by different laws than is health care in general, but at the same time, the same basic principles should be present. Thus, even though there is a responsibility to protect not only the patient but also society, there is also a legal as well as an ethical and professional responsibility to treat patients with respect, provide the best possible care and promote patient participation as much as possible (ICN 2012).

Gildberg, Bradkey, Fristedt and Hounsgaard (2012) describe how nurses strive to establish informal and trusting relationships by reconstructing normality. These relationships are supposed to provide the basis for changed behaviour and perceptual-corrective care. However, our findings reveal that nurses' intentions to do good can fail and inflict further suffering if suffering is not understood from the patient's perspective. This becomes evident when nurses try to motivate patients in a way that could be perceived as giving an ultimatum, or that gives patients the impression of having a choice, whereas the only possible choice is to adjust to the demands of the nurse and conform to the culture. Even though this could be understood as nurses striving to keep order in the unit (Bowen & Mason 2012) and obtain equilibrium within a turbulent environment (Salzmann-Eriksson et al. 2011), it could also be a threat to patients' dignity. Thus, if normality is defined from the perspective of the staff (Gildberg et al. 2012), nurses' intentions to do good might hurt the patient.

On the other hand, when nurses are able to validate patients' dignity, the care given is not only beneficial for patients but also rewarding for the nurses. When dignity is acknowledged in forensic care, patients will expect respect rather than violent encounters. Thus nurses' way of approaching the patient, both verbally and nonverbally, is important (Gustafsson et al. 2013). This requires, however, the nurse to be able to deal with his/her own cognitive-emotive reactions and be non-judgemental regardless of patients' behaviour (Rose et al. 2011).

Furthermore, as Rask and Brunt (2006) have demonstrated, even though staff and patients mostly agree on the kind of interactions that are most important in forensic care, their perceptions of the frequency of those interactions differ. Thus, there is a risk that nurses think they are supporting suffering patients while patients experience these interventions as insufficient.

Relieving suffering in the context of forensic nursing care is a challenge. Nurses constantly struggle to do the right thing and to safeguard order and security. If nurses fail to comprehend suffering in relation to the sufferers' lifeworld, and instead relate suffering to the context or even disregard it, there is a risk that even the best intentions could lead to further suffering.

Thus nurses must dare to position themselves in a position of 'not knowing', bridling their preconceptions, in order to approach suffering patients in a way that contributes to the patients' understanding of themselves from a place of respect and restored dignity. This does not mean that nurses should adopt an 'anything goes' attitude towards patients' behaviour.

Rather, they should – together with the patient – strive to reflect on what patients communicate and on what meaning patients ascribe to their suffering. Furthermore, being present with suffering patients is indeed a challenge, in which nurses are confronted not only with patients' afflictions but also with their own reactions. This calls for peer support, rather than critique. Encountering suffering can be a painful and frightening experience, but nurses must have the courage to stay with the patient and at the same time evaluate potential risks to their own and the patient's safety. One way to deal with situations like this is for the nurses to narrate their experience of the patients' behaviour, i.e. crying or threatening, without questioning it. Instead a true interest, manifested as an effort to understand the patient's experience and courage to confirm feelings, is awoken in the nurse.

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Comment:

This article is based on Mattias Vince's Masters thesis. The thesis was written in Swedish, and further reflected on and rewritten in English for the purpose of this article by the three authors in cooperation.